"An Act making a special appropriation to the Department of Health and Social Services and the Department of Commerce and Economic Development for vendor claims; and providing for an effective date."

COMMITTEE REPORT

1/26/76

HOUSE

Mr. Speaker: Date Apr 5, 1976

The Committee on FINANCE has had SB 530 under consideration. A Majority of the members of the Committee

( ) recommends it DO PASS

( ) recommends it DO NOT PASS

( ) recommends it DO PASS WITH ATTACHED AMENDMENT(S)

(X) recommends it BE REPLACED WITH H. FINANCE CS FOR SB 530 WITH A NEW TITLE AND THAT H FINANCE CS FOR SB 530 DO PASS

( ) "and" recommends it BE REFERRED TO THE _____ COMMITTEE

( ) reports it back WITHOUT RECOMMENDATION

( ) "other"

Members signing the Majority report:

Members NOT concurring in the Majority report:

_____ recommends:

_____ recommends:

_____ recommends:

_____ recommends:

_____ recommends:

_____ Chairman

Introduced: 1/19/76
Referred: Finance

IN THE SENATE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

SENATE BILL NO. 530

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Health and Social Services and the Department of Commerce and Economic Development for vendor claims; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. The sum of $5,669.32 is appropriated from the general fund to the Department of Health and Social Services and the Department of Commerce and Economic Development, for the purpose of paying miscellaneous vendor claims, to be allocated as follows:

Department of Health and Social Services	$5,638.24
Department of Commerce and Economic Development	31.08
	$5,669.32

* Sec. 2. This Act takes effect immediately in accordance with AS 01.-10.070(c).

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

JAY S. HAMMOND, GOVERNOR

OFFICE OF THE COMMISSIONER / POUCH C – JUNEAU 99811

March 22, 1976

Honorable Hugh Malone
Chairman, House Finance Committee
Alaska State Legislature
State Capitol - Pouch V
Juneau, Alaska 99811

Dear Representative Malone:

We are requesting an amendment to the "miscellaneous claims" supplemental appropriation bill, SB 530, which is currently in the House Finance Committee.

This change adds one additional stale dated warrant to the list provided in my letter of February 18 in the amount of $50. A revised list is attached.

The title of the bill should be changed to read "An act making a special appropriation for the payment of miscellaneous claims; and providing for an effective date."

The revised amounts requested are as follows:

Department of Health & Social Services	$6,422.06
Department of Commerce and Economic Development	31.08
Department of Revenue	732.61
Total	$7,185.75

Sincerely,

Andrew S. Warwick
Chairman
Budget Review Committee

ASW/MO/co

CS - approp to Dept Admin allocated as above

MEMORANDUM State of Alaska

TO: Ronald Lind, Deputy Director
Division of Budget & Management
Department of Administration

DATE: March 10, 1976

FILE NO:

TELEPHONE NO:

FROM: Richard E. Alexander
State Investment Officer
Department of Revenue

SUBJECT: Request for Payment of Stale Date Warrants - Revised Listing

The following is a list of "Stale Dated" warrants for which the payees have contacted the Treasury Division requesting payment. Each payee was required to forward either the original warrant or a xerox copy of the original warrant as evidence that the item had not been paid. In checking our records of redeemed warrants the items listed below are legitimate claims and have not been paid because of stale date.

Mr. J. Glen Cassity	$ 64.93
Mr. M. H. Shelton	19.74
Richard K. Armstrong	69.49
Lorin T. Oldroyd	152.25
V. E. Baker	22.50
Eagle River Plumbing & Heating	24.48
Jeff C. Jeffers	78.50
Clifford W. Berry	59.11
Mrs. Ruth N. JOrgensen	3.00
Mrs. Ruth N. Jorgensen	33.75
Mrs. Ruth N. Jorgensen	33.75
Mrs. Ruth N. Jorgensen	1.50
First Virginia Bank	49.41
Mrs. Ruth N. Jorgensen	2.50
Paula Terrel	67.70
M. T. Reynolds	50.00
Total	$732.61

REA:ge

SB 530

FEB 19 1976

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPARTMENT OF ADMINISTRATION

DIVISION OF BUDGET & MANAGEMENT / POUCH C — JUNEAU 99801

February 18, 1976

Honorable Hugh Malone
Chairman, House Finance Committee
Alaska State Legislature
State Capitol - Pouch V
Juneau, Alaska 99811

Dear Representative Malone:

We are requesting an amendment to the "miscellaneous claims" supplemental appropriation bill, SB 530, which is currently in the House Finance Committee. Two additional items need to be covered in this bill:

1)	Stale date warrants	$682.61
2)	Health and Social Services miscellaneous prior year's bills	$783.82

We are requesting an additional appropriation of $1,466.43 general funds. Your consideration of this amendment is appreciated.

Sincerely,

V. Kent Dawson
Director

VKD/JC/lw

02-001B (REV. 08-73)

RECEIVED
JAN 27 1976
BUDGET & MANAGEME

MEMORANDUM State of Alaska

TO: Ronald Lind, Deputy Director
Division of Budget & Management
Department of Administration

DATE: January 27, 1976

FILE NO:

TELEPHONE NO:

FROM: John M. Daugherty, Director
Treasury Division
Department of Revenue

SUBJECT: Request for Payment of Stale Date Warrants - Revised Listing

The following is a list of "Stale Dated" warrants for which the payees have contacted the Treasury Division requesting payment. Each payee was required to forward either the original warrant or a xerox copy of the original warrant as evidence that the item had not been paid. In checking our records of redeemed warrants the items listed below are legitimate claims and have not been paid because of stale date.

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Clifford W. Berry	59.11
Mrs. Ruth N. Jorgensen	3.00
Mrs. Ruth N. Jorgensen	33.75
Mrs. Ruth N. Jorgensen	33.75
Mrs. Ruth N. Jorgensen	1.50
First Virginia Bank	49.41
Mrs. Ruth N. Jorgensen	2.50
Paula Terrel	67.70
Total	$ 682.61

JMD:ge

02-001D

STATE
of ALASKA

MEMORANDUM

RECEIVED
FEB 4 1976
BUDGET & MANAGEMENT

TO: Ron Lind, Deputy Director
Division of Budget & Management
Dept. of Administration

DATE : February 3, 1976

FROM: Eugene A. Smith
Acting Deputy Director
Division of Administrative Services
Dept. of Health & Social Services

SUBJECT: Addition to Prior Year's Claims Bill

Please add $783.82 to the supplemental appropriation request to cover miscellaneous prior year's bills as detailed on the attached list. $592.37 of the total is in the Medicaid BRU and the remaining $191.45 in the Crippled Children component of the Child and Family Health BRU.

~50% fed available ?

Attachment

LEGISLATIVE BILLINGS FOR YEAR 1975-76 - SUPPLEMENTAL

SUBMITTED 1/20/76

DIVISION	INVOICE #	SVC. DATE	AMOUNT	DATE RCVD.	CODE	DELAY REASON
PUBLIC ASSISTANCE						
Kent Medical Ctr.		12/29/72-2/13/73	273.60	06/18/75	06-33-6-150-380	Out of State stale-dated wt. still outstanding Revenue approval pay.
Anchorage Com Hosp.	555072	07/01/73	114.64	12/15/75	06-33-6-120-380	Provider unaware of patient eligibility.
Alaska Clinic	58827, 55720	10/16/73-11/30/73	79.10	01/12/76	06-33-6-150-380	As above - Medica
Alaska Clinic	*57689, 57687, 57688	01/10/74-01/26/74	31.41	01/12/76	06-33-6-150-380	" "
Alaska Clinic	185788, 60004. 185790, 185791, 185789	07/19/73-08/23/73	34.78	01/12/76	06-33-6-150-380	" "
Alaska Clinic	185792, 185787, 185786, 185785	07/19/73-08/15/73	42.13	01/12/76	06-33-6-150-380	" "
Alaska Clinic	60005	07/19/73	7.26	01/12/76	06-33-6-150-380	" "
Alaska Clinic	*57689, 58826	10/11/73-11/18/73	9.45	01/12/76	06-33-6-150-380	" "
Sub-Total			592.37			
PUBLIC HEALTH						
Alaska Orthopedics	127395	11/01/73	39.65	07/01/75	06-31-1-687-470	Invoices Lost
Alaska Orthopedics	111596	07/24/73	151.80	07/01/75	06-31-1-687-470	" "
			191.45			
Grand Total			783.82			

*2 months of this invoice covered by different explanation of benefits by Medicare.

10-0018

STATE
of ALASKA

MEMORANDUM

TO: Ron Lind, Deputy Director
Division of Budget & Management
Dept. of Administration

DATE : February 3, 1976

FROM: Eugene A. Smith
Acting Deputy Director
Division of Administrative Services
Dept. of Health & Social Services

SUBJECT: Addition to Prior Year's Claims Bill

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			191.45			
Grand Total			783.82			

*2 months of this invoice covered by different explanation of benefits by Medicare.

FAMILY
Sylvia

PATIENT NO. 042

DARVEILE SYLVIA
324 2ND ST
JUNEAU ALASKA

PLEASE RETURN THIS PORTION WITH PAYMENT

DATE	REFERENCE	DR CODE	FAMILY MEMBER CODE	SERVICE CODE	CHARGES	CREDITS	BALANCE
JAN-0 15	39,822	8	1	10	10.00		
				16	3.60		
JAN-0 15	7,392	8	4	35			
JAN-0 15	7,392	8	1	4	35.00		
				12	200.00		248.60
FEB 15 75	40,818	8	1	10	10.00		
				16	15.00		273.60

06-33-6-150-380

A

PAYMENT IN FULL IS DUE WITHIN 30 DAYS—PAY LAST AMOUNT IN THIS COLUMN

PROFESSIONAL SERVICE CODES

1 ASSIST SURGEON	10 IMMUNIZATION	19	Doctor Codes
2 CAST SPLINT	11 INJECTION	20	1 S. H. ROBERTSON, M.D.
3 COMPLETE EXAM	12 LAB	21	2 J. A. PHILLIPS, M.D.
4 CONSULTATION	13 MATERIAL & SUPPLIES	22	3 A. W. ALMEN, M.D.
5 DRESSINGS	14 MEDICATION	23 PERSONAL PAYMENT	4 R. L. VANCE, M.D.
6 EKG	15 MEDICAL REPORT	24 INS. PAYMENT	5 D. A. BARNES, M.D.
7 EYE-GLASS PRESCR	16 NEW BORN CARE	25 MEDICARE	6 D. S. UNH, M.D.
8 FRACTURE - ARE	17 OBSTETRICS	26 KING COUNTY	7 V. P. MUIR, M.D.
9 HOSPITAL CALL	18 PHYSICAL THERAPY	27 STATE INDUSTRIAL	8 J. H. BALL, M.D.
10 HOSPITAL CALL	19 SUPPLIES	28 WELFARE	9 J. M. RUSSO JR., M.D.
11 HOSPITAL SURGE	20 ULTRA SOUND	29 COLLECTION BUREAU	10 C. C. MELOCH JR., M.D.
12 INCOME PAYMENT	21 X RAY	30 MISC CREDIT	11 R. Y. TOOT, M.D.
13 OFFICE CALL	22 MISC	31 ADJUSTMENT	12 J. P. HENN, M.D.
		32	13 D. W. KALE, M.D.
		33	14 P. Y. YAU, M.D.

KENT MEDICAL CENTER 222 N. STATE ST., KENT, WASH. 98031

CENTRAL OFFICE

06

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

HEALTH CARE FACILITY INVOICE NO. 555072

25 PROVIDER REF Harris, Susan 50029

20 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER: See attached Memo.		NAME OF PROVIDER: Anchorage Community Hospital, 825 L Street, Anchorage, Alaska 99501
NAME OF PATIENT: Susan Harris	RACE	
DATE OF BIRTH: 3 / 26 / 53 SEX: M ☐ F ☒	ELIG. CODE: 20P	PROVIDER ID NO.: ACH 889 CATEGORY: 02
CASE NUMBER: 7634S-01	RESOURCE	PAYEE ID NO. (if different from above)
		ATTENDING PHYSICIAN: Dr. Roberts ID NO.
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? ☒ YES ☐ NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		

21 DIAGNOSIS AND PROCEDURES

DATE OF ADMISSION	REF. CODE	SVC UNIT	PRIMARY DIAGNOSIS	CODE
7 / 01 / 73	01	05	Extension flexion injury to neck	845
BILLING PERIOD: 7 / 01 / 73 — 7 / 01 / 73		TOT. DAYS: 0	SECONDARY DIAGNOSIS: Contusion to hand	CODE: 925
DATE OF DISCHARGE: 7 / 01 / 73		DIS. CODE: 01	PRIMARY PROCEDURE PERFORMED: Non surgical emergency care	CODE
CONSULTING PHYSICIAN	ID NO.		SECONDARY PROCEDURE PERFORMED	CODE

22 STATEMENT OF SERVICES RENDERED

	BLOOD PINTS FURNISHED	PINTS REPLACED	NOT REPLACED	CHARGE PER PINT	CHARGE		
1							
	ACCOMMODATION		DAYS	RATE			
2	1 BED						
3	2 BEDS						
4	3 OR MORE BEDS						
5	INTENSIVE CARE						
6	SELF CARE						
7	NURSERY						
8	OPERATING ROOM Emer. Room				15.90		
9	ANESTHESIA						
10	OUTPATIENT SERVICES						
11	BLOOD ADMINISTRATION						
12	PHARMACY						
13	RADIOLOGY				128.10		
14	LABORATORY						
15	MEDICAL & SURGICAL SUPPLIES				13.04		
16	PHYSICAL THERAPY						
17	OCCUPATIONAL THERAPY						
18	SPEECH THERAPY						
19	INHALATION THERAPY						
20	OTHER (SPECIFY)						
21							
22							

PROVIDER CERTIFICATION

THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR OR NATIONAL ORIGIN. 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.

TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS

PROVIDER'S SIGNATURE: Alice Dawson

DATE: 12/11/75

REMARKS:

06-33-6-120-380

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

23 COORDINATION OF OTHER BENEFITS

OTHER BENEFITS		MEDICARE	
MEDICAID PAID		CO-INS	
[illegible]		DED	
TOTAL		TOTAL	

73%

TOTAL CHARGE	157.04		LESS	-0-	AMOUNT DUE	157.04		114.64

CENTRAL OFFICE COPY

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

15 PROVIDER REF. PEREZ

06 P NO. 58827A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER: 7617453A ~~7617453~~		NAME OF PROVIDER: The Alaska Clinic Dr. Buchan
NAME OF PATIENT: Gladys R. Perez	RACE: W	
DATE OF BIRTH: 12-31-05 SEX: M ☐ F ☒	ELIG. CODE: 20A	PROVIDER I.D. NO.: WSB 105 CATEGORY: 05
CASE NO.: 41531 01	RESOURCE: J	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): ALC 501

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST: Diabetes Mellitus	PRIMARY: 250
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☒ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
112873	IH	HSP. COMP.	90220	73.20	55.50	1	
112873	IH	HOSP VISIT	90240	12.55		1	
112973	IH	2 HV @ 12.55 ea	90240	25.10	48.00	1	
113073	IH	2 HV @ 12.55 ea.	90240	25.10		1	

• PLACE OF SERVICE
DO DOCTOR'S OFFICE
IL INDEPENDENT LAB
H PATIENT'S HOME
IH INPATIENT HOSPITAL
O. OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL
76.40		

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL
19.10	60.00	

	CHARGE	STATE USE ONLY
TOTAL CHARGE	237.75	155.50
LESS	76.40	76.40
UNPAID BALANCE	161.35	79.10

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE: Norman Buchan MD DATE: 12/27/73

REMARKS:

1 35 I.V. 320

RESUBMITTAL INDICATOR

MEDICAL REVIEW

CENTRAL OFFICE COPY

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

06 M

15 PROVIDER REF.

NO. 57689A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: 511795			NAME OF PROVIDER: THE ALASKA CLINIC DR. BEACHAM	
NAME OF PATIENT: RICHARD MILLER		RACE: W		
DATE OF BIRTH: 08/04/44	SEX: M [X] F [ ]	ELIG. CODE: 20C	PROVIDER I.D. NO.: WS6105	CATEGORY
CASE NO.: 52308-01		RESOURCE: J	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): ALC 501	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (CPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
HEADACHE	791
	SECONDARY: 000
	000

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES [ ] NO [ ]

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
011074	DO	LIM EXAM EVAL A/O TREATMENT	90050	16.75	12.75		
H2373	DO	Fluor given	00047	4.00			
H2373	DO	Exam	90050	16.75			
H8873	OH	Emergency treatment	90500	20.95			

* PLACE OF SERVICE
DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
O: OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL
125.64		

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	288.95	157.05	
LESS	125.64		
UNPAID BALANCE	163.31	31.41	

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE: Thomas Beacham DATE: 11/8/76

REMARKS:

Myasthenia gravis
[illegible]
$1.21 billed

RESUBMITTAL INDICATOR

MEDICAL REVIEW

SERVICES WERE PROVIDED BY	FROM MO.	FROM DAY	TO MO.	TO DAY	TO YR.	CHARGES SUBMITTED	CHARGES ALLOWED	REASON CHARGE NOT ALLOWED MEDICARE DOES NOT PAY FOR:	SEE REMARKS
ARCHER			07	19	3	30.75	30.00	MORE THAN THE ALLOWABLE AMOUNT	1 A
ARCHER	07	23	08	06	3	147.60	100.20	MORE THAN THE ALLOWABLE AMOUNT	3 A
ARCHER			08	15	3	30.75	30.00	MORE THAN THE ALLOWABLE AMOUNT	1 A
ARCHER			08	23	3	16.40	13.70	MORE THAN THE ALLOWABLE AMOUNT	1 A
								adj 11/21	
				Totals ▶		225.50	173.90	= 51.60	

		MEDICARE PAID
Inpatient Radiology and Pathology Physicians Charges Not Subject To A Deductible and 20% Coinsurance (Medicare Pays 100%) ▶		
Total Allowed Charges Subject To The $50. Deductible and 20% Coinsurance. ▶	173.90	
This Amount Went Toward The $50 Deductible. ▶	.00	3.78 = 5%
Allowed Charges Over The Deductible. (Medicare Pays 80%) ▶	173.90	139.12
Date OCT 12, 1973 — Total Medicare Payment ▶		139.12

This is a statement of the action taken on your Medicare Claim. Be sure to read the important information on the back of the notice.

0000 0000

You have met $60.00 of the deductible for 1973

IMPORTANT When Writing Please Refer To Both

HI # 574-01-9929A

CO # 3283-80115 328

AETNA LIFE & CASUALTY
CROWN PLAZA BUILDING
1500 S.W. FIRST AVENUE
PORTLAND, OREGON 97201
TELEPHONE NO. 222-6831

Remarks: THE PART B MEDICARE INSURANCE PLAN DEDUCTIBLE HAS BEEN INCREASED FROM $50 TO $60 FOR ALL SERVICES PERFORMED AFTER DECEMBER 31, 1972.

Beneficiary or Representative

DORA P LARSON
600 FAIRBANKS ST
ANCHORAGE AK

06-33-6-150 380 3.78

10/29/73

(MR-69392) THIS IS NOT A BILL — KEEP THIS COPY FOR YOUR RECORDS Printed in U.S.A.

EXPLANATION OF MEDICARE BENEFITS

DETACH ON DOTTED LINE

SERVICES WERE PROVIDED BY	FROM MO.	FROM DAY	TO MO.	TO DAY	TO YR.	CHARGES SUBMITTED	CHARGES ALLOWED	REASON CHARGE NOT ALLOWED MEDICARE DOES NOT PAY FOR:	SEE REVER
BEACHAM			07	19	3	70.00	35.50	MORE THAN THE ALLOWABLE AMOUNT	3 A
BEACHAM			07	20	3	24.60	16.95	MORE THAN THE ALLOWABLE AMOUNT	3 A
BEACHAM			07	22	3	12.30	9.60	MORE THAN THE ALLOWABLE AMOUNT	3 A
BEACHAM	07	25	08	04	3	172.20	118.65	MORE THAN THE ALLOWABLE AMOUNT	3 A
BEACHAM			08	02	3	36.90	16.95	MORE THAN THE ALLOWABLE AMOUNT	3 A
BEACHAM			08	15	3	12.30	10.00	MORE THAN THE ALLOWABLE AMOUNT	1 A
BEACHAM			08	15	3	4.50	3.00	MORE THAN THE ALLOWABLE AMOUNT	1 A
					Totals ▶	332.80	210.65	= 122.15 adj 3/15 (1-2)	

		MEDICARE PAID	
Inpatient Radiology and Pathology Physicians Charges Not Subject To A Deductible and 20% Coinsurance (Medicare Pays 100%) ▶			This is a statement of the action taken on your Medicare Claim. Be sure to read the important information on the back of the notice. 0000 0000 59
Total Allowed Charges Subject To The $50. Deductible and 20% Coinsurance. ▶	210.65		
This Amount Went Toward The $50 Deductible. ▶	.00	(20% 42.13)	You have met $60.00 of the deductible for 197
Allowed Charges Over The Deductible. (Medicare Pays 80%) ▶	210.65	168.52	IMPORTANT When Writing Please Refer To Both — HI # 574-01-9929A
Date DEC 11, 1973	Total Medicare Payment ▶	168.52	CO # 3283-80114 33

AETNA LIFE & CASUALTY
CROWN PLAZA BUILDING
1500 S.W. FIRST AVENUE
PORTLAND, OREGON 97201
TELEPHONE NO. 222-6831

Remarks: THE PART B MEDICARE INSURANCE PLAN DEDUCTIBLE HAS BEEN INCREASED FROM $50 TO $60 FOR ALL SERVICES PERFORMED AFTER DECEMBER 31, 1972.

06-33-6-150-38)

Beneficiary or Representative

DORA P LARSON
600 FAIRBANKS ST
ANCHORAGE AK

(MR-65392) THIS IS NOT A BILL — KEEP THIS COPY FOR YOUR RECORDS Printed In U.S.A

CENTRAL OFFICE COPY

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

06 | A1

15 | PROVIDER REF. | LARSEN

NO. 30005A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER: F4244D		NAME OF PROVIDER: THE ALASKA CLINIC
NAME OF PATIENT: DORA LARSON	RACE: W	DR. WEED
DATE OF BIRTH / SEX: M ☐ F ☐	ELIG. CODE: 20A	PROVIDER I.D. NO.: DIW392 / CATEGORY: 05
CASE NO.: 074636-01	RESOURCE: J	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): ALC 501

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
ASYMPTOMATIC ISCHEMIC HEART DISEASE	414
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☐ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
071973	DO	ELECTROLYTES	84290	26.65	7400	6	
071973	DO	BRIEF EXAM EVAL A/C TREATMENT	90040	12.30	1230	1	

* PLACE OF SERVICE
DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
EC EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL
2904		2904
MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL
726		726

TOTAL CHARGE		3630
LESS		2904
UNPAID BALANCE		726

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS

PROVIDER SIGNATURE _____ DATE _____

REMARKS:

RESUBMITTAL INDICATOR | MEDICAL REVIEW

CENTRAL OFFICE COPY ____

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

15 PROVIDER REF. MILLER

06 77

NO. 58826A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER: 7C49 813		NAME OF PROVIDER: THE ALASKA CLINIC DR. CATES
NAME OF PATIENT: Richard Miller	RACE: U	
DATE OF BIRTH: 8-4-44 M [X] F [ ]	ELIG. CODE: 20C	PROVIDER I.D. NO.: VAC 419 — CATEGORY: C5
CASE NO.: 5230801	RESOURCE: X	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): ALC 501

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST: Motor Neurone Disease	PRIMARY: 348
Headache	SECONDARY: 791
Migraine, Rule out.	R/O ~~Cat~~

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES [ ] NO [ ]

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
10 11 73	DO	OFFICE CALL RECHECK	90030	8.20	8 20	1	

* PLACE OF SERVICE
DO DOCTOR'S OFFICE
I INDEPENDENT LAB
H PATIENT'S HOME
IH INPATIENT HOSPITAL
O OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	50.50	41 35		
LESS		3 50		
UNPAID BALANCE		9 45		

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE [signature] DATE 10/11/73

REMARKS: J.J. Dr. 32-6-1 SI-30

RESUBMITTAL INDICATOR | MEDICAL REVIEW

86-1007
ADM-CDS-REVISED

AUTHORIZATION
ET

Auth. #127395

DEPARTMENT OF HEALTH AND WELFARE

SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH

AUTHORIZATION NO.
02764

POUCH H JUNEAU, ALASKA 99801

SECTION OF CHILD HEALTH
FAMILY

DATE November 6, 1973

*TO Alaska Orthopedics
Address 1087 W. 27th Avenue
Anchorage, Alaska 99503

Authorization is given to provide the following services, supplies, or equipment to:

Patient MAZE, Russell
Address Palmer

Birthdate: 06-26-72

06-P "W" #738

Code: SCRO-Appliance-Ortho

DATE(S) SERVICE RENDERED	DESCRIPTION OF SERVICE (ITEMIZE)	PRICE
1 11-73 ^	(23.50 Dennis Browne) bar and (15.50 pre-walker shoes) postage	$39.00 .65 #39.65

I certify that this is a just and proper bill and hereby authorize the Department Certifying Officer to effect payment of same.

[signature]
Date 12/20/73

06-31-1-687-470
3-Digit Account Code 3-Digit Object Code

Case or Med. Card No.

Please submit claims first to: Aetna Insurance--Group policy
Douglas MAZE--father

Remarks

This Department will assume only those charges not covered by the insurance. Crippled Children's Services will not be responsible for collecting benefits paid by the insurance company directly to the insured.

C-25564

Authorized by [signature]
PROGRAM REPRESENTATIVE CRIPPLED CHILDREN'S SERVICES

*IMPORTANT NOTICE TO VENDOR

All billing must be done on the last 3 sheets attached to this AUTHORIZATION immediately after fulfilling the order as stated above. If UNABLE to fill order, this authorization must be returned to DEPARTMENT OF HEALTH and WELFARE, DIVISION OF PUBLIC HEALTH, SECTION OF CHILD HEALTH.

We received this on:

CCS CENTRAL OFFICE COPY

AUTHORIZATION

DEPARTMENT OF HEALTH AND WELFARE SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH

POUCH H JUNEAU, ALASKA 99801

AUTHORIZATION NO. 01922

SECTION OF CHILD HEALTH FAMILY

*TO Alaska Orthopedics
1087 W. 27th Avenue
Address Anchorage, Alaska 99503

DATE July 5, 1973

#11596

Authorization is given to provide the following services, supplies, or equipment to:

Patient TALBOT, Yolanda Gail MA 1365, 11/1/73.
Anchorage
Address 06-P white

Birthdate: 72 11-11-~~73~~

Code: SCRO-Ortho-Appliance

DATE(S) SERVICE RENDERED	DESCRIPTION OF SERVICE (ITEMIZE)	PRICE
7/24/73 ~~7-13~~	Arm prosthesis Below elbow prosthesis, Right with passive unit	$359.00 207.00 151.50
	Acc. paid Bal due	

I certify that this is a just and proper bill and hereby authorize the Department Certifying Officer to effect payment of same

Signature

9/26/73
Date

Please submit claims first to: Traveler's thru Era Helicopters

06-31-1-627-470
~~GA 749-815-A~~ 3-Digit Object Code

Case or Med. Card No.

Remarks

This Department will assume only those charges not covered by the insurance. Crippled Children's Services will not be responsible for collecting benefits paid by the insurance company directly to the insured.

Authorized by

PROGRAM REPRESENTATIVE CRIPPLED CHILDREN'S SERVICES

* IMPORTANT NOTICE TO VENDOR

All billing must be done on the last 3 sheets attached to this AUTHORIZATION immediately after fulfilling the order as stated above. If UNABLE to fill order, this authorization must be returned to DEPARTMENT OF HEALTH and WELFARE, DIVISION OF PUBLIC HEALTH, SECTION OF CHILD HEALTH.

0042 4675

33004 ☐ PREPAID ☒ COLLECT

4100 INTERNATIONAL AIRPORT ROAD
ANCHORAGE, ALASKA 99502

FAI | VIA WC | TO BET | VIA WC | TO MOU | VIA WC | TO | VIA

Wien Consolidated Airlines, Inc.

2/ CONSIGNEE'S ACCOUNT NUMBER — CONSIGNEE

NAME: WELFARE OFFICE

STREET ADDRESS: DON PRICE

CITY / STATE / ZIP CODE: MOUNTAIN VILLAGE, AK

CHARGE CODES: PX - PREPAID CREDIT; PP - PREPAID CASH; CC - COLLECT; CG - COLLECT G.B.L.; CP - COLLECT CASH; CX - COLLECT CREDIT; MX - PART PREPAID, PARTIAL COLLECT CREDIT; MP - PART PREPAID, PARTIAL COLLECT - CASH; PG - PREPAID G.B.L. AND/OR OTR

CARRIER USE ONLY

DATE: 7 | CHECKED: 031

A. WEIGHT CHARGES: 465.00 (PAID)

B. PICK UP: 405.00

C. DELIVERY:

D. EXCESS VALUE:

3/ DEST ZONE — SPECIAL INSTRUCTIONS, INCLUDING CUSTOMER REFERENCE NUMBER: CHG TO STATE OF AK, DEPT HEALTH & SOCIAL SERVICES C/O BARNETT, FAI

4/ SHIPPER'S ACCOUNT NUMBER — SHIPPER

NAME: STATE OF ALASKA

STREET ADDRESS: DEPT OF HEALTH AND SOCIAL SERVICES

CITY / STATE / ZIP CODE: FORT YUKON, AK

PIECES / LENGTH / WIDTH / DEPTH / CUBIC FEET: 1 X X =

DIMENSIONAL WEIGHT / LBS:

C.O.D. SHIPMENT — IF AMOUNT ENTERED HERE BY SHIPPER, (9)

E. ADVANCES:

F. OTHER:

G. SHIPPER'S C.O.D.:

H. C.O.D. FEE: 23.25

5/ PICK UP TONS | ORIG. ADVANCE CHGS | DESCRIPTION OF ORIGIN ADVANCE CHARGES: ACCT. NO 06-26-3-100-520-13-0000 | DEST. ADVANCE CHGS | DESCRIPTION OF DESTINATION ADVANCE CHARGES

L. TAX: 23.25

6/ OTHER CHARGES | DESCRIPTION OF OTHER CHARGES | G.B.L. NUMBER

T. TOTAL CHARGES: 488.25

NO. PCS	WEIGHT	DESCRIPTION OF PIECES AND CONTENTS, PACKING, MARKS, NUMBER	CARRIER COMMODITY GROUP NO.	CARRIER COMMODITY GROUP NO.	CARRIER COMMODITY GROUP NO.
7/ 1	1500	SAFE			

8/ WEIGHT CHARGES: A 465.00 | PICK UP: B | DELIVERY: C | EXCESS VALUE: D | ADVANCES: E | OTHER: F | SHIPPER'S C.O.D.: G | C.O.D. FEE: H

TAX: I 23.25 | TOTAL CHARGES: T 488.25 | 1st RATE | 2nd RATE | 3rd RATE | ITEMS PREPAID | SHIPPER PAYS

EXECUTED AT: FAI/BAH | DATE: 10-31-72 | TIME: 2:30 p.m. | ITEMS COLLECT | CONSIGNEE PAYS

CARRIER ACCOUNTING COPY

CARRIER 212 | ORIGIN | SERIAL NUMBER 0042 4675

MADE IN U.S.A.

3108 REV 4-71

STATEMENT

Anchorage Times Publishing Co.

ALASKA'S LARGEST NEWSPAPER
POST OFFICE BOX 40
ANCHORAGE, ALASKA
June 24, 1971

ACCOUNT OF OFFICE OF THE ATTORNEY GENERAL
360 K ST. SUITE 105
ANCHORAGE, ALASKA 99501

TERMS: ALL ACCOUNTS DUE THE FIRST OF EACH MONTH

NOTICE TO ABSENT PARTY: MATTER OF NEAKOK CHILDREN, MINORS UNDER 18 YRS.....

June 2, 9, 16, 23

4x 56 lines $67.20

PROOF OF PUBLICATION ATTACHED.

I certify that the above bill is correct and just; that payment therefor has not been received; that all statutory requirements as to American production and labor standards, and all conditions of purchase applicable to the transactions have been complied with; and that state or local taxes are not included in the amounts billed.

ANCHORAGE TIMES PUBLISHING CO.

By Patti Gratt Clerk

6/21/75
Subject to Approval of next State legislature
(Invoice to remain open 2 years old)
Tom Nolan
Fiscal

Complete and return to Fiscal

- ☐ Authorized Signature
- ☐ Valid Account Code
- ☐ Certification Stamp

to be that been said th
6-25

IN THE SUPERIOR COURT
FOR THE STATE
OF ALASKA
THIRD JUDICIAL DISTRICT
AT ANCHORAGE
FAMILY DIVISION

In the Matter of:
NEAKOK CHILDREN — DONNA, EVA MARIE and THOMAS,
Minor Children under the Age of Eighteen (18) Years.
No. CP 1068, 1065 and 1840

NOTICE TO ABSENT PARTY

TO: Mrs. Frances Neakok

You a party in the above entitled children's proceeding, are hereby summoned and required to appear in the Superior Court, Family Division, at Anchorage, Alaska, on the 9th day of July, 1971, at the hour of 9:00 a.m., to answer to the petition filed in the above entitled children's proceeding in this Court.

If you fail to appear and answer, the Court will proceed to hearing of the above entitled case without further process.

The proceeding could result in the termination of parental rights in the above named children.

You may be represented at the hearing by an attorney of your desire. In the event you have no funds to employ an attorney and satisfy the Court in this regard, an attorney will be appointed to represent you. You may also waive the presence of an attorney in such proceeding.

DATED at Anchorage, Alaska, this 17 day of May, 1971.

A. M. Vokacek
Clerk of the
Superior Court
By: (s) M. Ryun
Deputy

PUB.: June 2, 9, 16, 23, 1971

Proof of Publication

ANCHORAGE DAILY TIMES

Janice Mays being duly sworn, according to law declares: That he is the Legal Advertising Dept. of The Anchorage Daily Times, a daily newspaper published in the town of Anchorage, in the Third Judicial Division, State of Alaska; that the notice of A Minor Under 18 a copy of which is hereto attached, was published June 2 9 16 23 in said Anchorage Daily Times, beginning with the issue of June 2, 19 71, and ending with the issue of June 23, 19 71.

Janice T Mays

Subscribed and sworn to before me this 22nd day of May, 19 75.

Rebecca M McKelvie
Notary Public for the State of Alaska.

My Commission Expires 12-14, 19 77.

ATZ

TRAVEL

BRANCH OFFICES

WASHINGTON:
SEATTLE
ANACORTES
MOUNT VERNON
OAK HARBOR

ALASKA:
JUNEAU
KENAI
KODIAK

HOME OFFICE
3853 WEST INTERNATIONAL AIRPORT ROAD
ANCHORAGE, ALASKA 99502
TELEPHONE (907) 279-5611

- ALWAYS OPEN
- TICKETS AND RESERVATIONS NO EXTRA CHARGE
- PARKING
- DRIVE-UP WINDOW SERVICE
- COURTESY LIMOUSINE SERVICE

Dept. of Health and Social Services
Fiscal Operations
Pouch H
Juneau, Alaska 99801

OCTOBER 24, 1975

Excursion rates must be used when ~~ava~~

STATE OF ALASKA
REQUEST FOR TRANSPORTATION

No. 331895

The DEPARTMENT OF HEALTH & SOCIAL SERVICES requests the
(Department or Office requesting transportation and address)

ATZ Company to furnish Transportation

for Dr. Frank P. Pauls. from Juneau
(Name of Traveler)

To Fairbanks & return. Juneau, Alaska. Aug. 27, 1973
(Place and Date of Issue)

Form No. 340763584b Ticket No.

Frank P. Pauls.
(Signature of Traveler)

Value $ 154.55 (No tax payable) Chief, Acct. & Reparations.
(Title)

Tourist class fare (See instruction #1 on reverse side) (To be inserted by carrier).

Carrier will forward this request to the Department or Office Requesting Transportation
(SEE INSTRUCTIONS ON REVERSE SIDE)

02-019

Account Code 06 31 1 870-211

54.55
40.64
13.00
08.19

Excursion rates must be used when available.

STATE OF ALASKA
REQUEST FOR TRANSPORTATION

No. 339313

DEPARTMENT OF HEALTH & SOCIAL SERVICES

The requests the
(Department or Office requesting transportation and address)

ATZ Travel Company to furnish Transportation

for Rudolph Sunberg Jr from Kodiak Ak.
(Name of Traveler)

To Anchorage, Ak Kodiak Ak 8/27, 1973
(Place and Date of Issue)

Form No. 8103 Ticket No. 449101

Value $ 40.64 (No tax payable) Social Worker III
(Title)

Tourist class fare (See instruction #1 on reverse side) (To be inserted by carrier).

Carrier will forward this request to the Department or Office Requesting Transportation
(SEE INSTRUCTIONS ON REVERSE SIDE)

02-019

Sunberg, Rudolph
APD 09/9/75

Account Code 06 33 6-150 215 Hosk

442-3270 1

KOTZEBUE OCT 73 Billing No 442-3270 Page 1

Date of Call Mon	Day	From Place	To Place	Words or Minutes	Class	Type of Call	Calling Number	Called Number	Serial Number	Amount
09	06	OKLACY OK	KOTZEBUE ALAS	33	SN	4	947-5943	907-442-3K70	XR2672011	2.85
09	28	OKLACY OK	KOTZEBUE ALAS	12	SD	4	686-4447	907-442-3K70	XR2841340	1.70
10	08	NOME ALS	KOTZEBUE ALAS	3	SD	4	443-2922	907-442-3270	Q428214044	.80
10	10	NOME ALS	KOTZEBUE ALAS	3	SD	4	443-2922	907-442-3270	Q428515594	.80
							TELEPHONE CHARGES		****45.15	

45.15 unpaid

Codes: SD = Station Day; SE = Station Evening; SN = Station Night; SL = Station Late Night; PD = Person Day; PN = Person Night; DL = Day Letter; NL = Night Letter; Personal Opinion MSG; Type of Call: 1 = Non-Coin Paid; 2 = Third Number; 3 = Credit Card; 4 = Collect; 5 = Special Collect; 6 = Coin Paid; 7 = Collect to Coin; 8 = Special and Telegram Statement

Form F-6501-2

Amount

10 26 KTZEBUEALS COLD BAY ALAS 32 SN 3 442-3270 907-[illegible]

CURRENT CHARGES

TOTAL AMOUNT DUE

06-31-1-036-31

unpaid

RECEIVED
MAY 7 10 17 AM '75
FISCAL SERVICES
JUNEAU

Alaska Communications

For information regarding this bill please refer to [illegible] E Street, Anchorage, Alaska 99501, Telephone (907) 272-8411

ALASKA STATE PUBLIC HEALTH NURSE
P.O. BOX 170
KOTZEBUE, ALASKA 99752

Date 11/30/73

Account Number A8037

Page 1

All Bills Are Due When Rendered

Statement

Date	From Place	To Place	Words or Minutes	Class	Type of Call	Calling Number	Called Number	Serial Number	Amount
Description of other articles or credit							Sender		

PREVIOUS BALANCE 8.00

10 26 KTZEBUGALS COLD BAY ALAS 32 SN 2 442-3355 907-532-2481 0453020004

CURRENT CHARGES

TOTAL AMOUNT DUE

Paid
This has been submitted for Legislative approval

unpaid

RECEIVED
NOV 7 10 17 AM '73
FISCAL SERVICES
JUNEAU

KOTZEBUE NOV 73 442-3270 1

Billing No. Page

Day	From Place	To Place	Words or Minutes	Class	Type of Call	Calling Number	Called Number	Serial Number	Amount
21	BETHNY OK	KOTZEBUE ALAS	23	SE	4	787-7414	907-442-3270	XR29912871	2760
23	NOME ALS	KOTZEBUE ALAS	1	PD	4	443-2925	907-442-3270	G429715375	160
						TELEPHONE CHARGES		****29.20	

Hold
This has been
Submitted for
Legislative approval

$29.20 unpaid

Amount

Class Codes: SD = Station Day; SE = Station Evening; SN = Station Night; SL = Station Late Night; PD = Person Day; PN = Person Night; DL = Day Letter; NL = Night Letter; Type of Call: 1 = Non-Coin Paid; 2 = Third Number; 3 = Credit Card; 4 = Collect; 5 = Special Collect; 6 = Coin Paid; 7 = Collect to Coin; 8 = Special Personal Opinion MSG;

Long Distance and Telegram Statement Form F-0301-2

10 26 KTZEBUEALS COLD BAY ALAS 32 SN 3 442-3255 907-552-2481 G33

CURRENT CHARGES 8.00 Voided

TOTAL AMOUNT DUE

Hold
This has been
Submitted for
Legislative approval

Unpaid

RECEIVED
MAY 7 10 17 AM '73
FISCAL SERVICES
JUNEAU

PROVIDER COPY

06

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

15 PROVIDER REF.

NO. 81184A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER: Child Study Center		NAME OF PROVIDER: The Alaska Clinic, 825 L St., Anchorage, Alaska 99501
NAME OF PATIENT: McBryde, Robert	RACE	
DATE OF BIRTH: 12/27/50 SEX: M [X] F [ ]	ELIG. CODE	PROVIDER I.D. NO.: AOC 533 CATEGORY: 03
CASE NO.: 782-730	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): AOC 501

2/15 /75 Patient seen MD

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST: Routine health care screening.	PRIMARY
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES [ ] NO [ ]

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE):

REFERRING OR CONSULTING PHYSICIAN:

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
[illegible]		[illegible]					
[illegible]		[illegible]					

* PLACE OF SERVICE
DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	12.30				
LESS					
UNPAID BALANCE	12.30				

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE _____ DATE _____

REMARKS:
Rebilled 2/11/75
Info Dated
31-1-761-380

RESUBMITTAL INDICATOR | MEDICAL REVIEW

06-7014

PROVIDER

06

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 162628

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER	
NAME OF PATIENT	RACE		
DATE OF BIRTH ___/___/___ SEX M☒ F☐	ELIG. CODE	PROVIDER ID. NO.	CATEGORY
CASE NO. 694-380	RESOURCE	PAYEE ID NO. (if different from above)	

3/6/75 Patient Down

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? ☐ YES ☐ NO	SERVICE PRE-AUTHORIZATION NO. (if applicable)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:		

SERVICES RENDERED

11

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
1-16-75							

*PLACE OF SERVICE

DO DOCTOR'S OFFICE
IL INDEPENDENT LAB
H PATIENT'S HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATIONS
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL
MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL

TOTAL CHARGE				
LESS				
UNPAID BALANCE	25.42			

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."
TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE _____ DATE _____

REMARKS:

State Ordered

31-1-694-380

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

70196

REVISED (6/1/73) 09 7014

PROVIDER STATE OF ALASKA

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 182627

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT		RACE		
DATE OF BIRTH / /	SEX M ☐ F ☐	ELIG. CODE	PROVIDER ID. NO.	CATEGORY
CASE NO.		RESOURCE	PAYEE ID NO. (if different from above)	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? ☐ YES ☐ NO	SERVICE PRE-AUTHORIZATION NO. (if applicable)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:		

SERVICES RENDERED

11

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		

*PLACE OF SERVICE

DO DOCTOR'S OFFICE
IL INDEPENDENT LAB
H PATIENT'S HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATIONS
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL
MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL

TOTAL CHARGE					
LESS					
UNPAID BALANCE					

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN 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."
TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS

PROVIDER'S SIGNATURE _____ DATE _____

REMARKS:

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

20196 REVISED (6/1/73) 06 7014

PROVIDER

06

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 182631

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: Child's Children		NAME OF PROVIDER: Wrangell Alaska Public Health Clinic	
NAME OF PATIENT: [illegible]	RACE		
DATE OF BIRTH: 2 / 18 / 70 SEX: M ☒ F ☐	ELIG. CODE	PROVIDER ID. NO.: WRL 420	CATEGORY
CASE NO.: 694-380	RESOURCE	PAYEE ID NO. (if different from above): WRG 401	

3/4/75 Outpt Lab

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST: [illegible]	PRIMARY: 780
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? ☐ YES ☐ NO	SERVICE PRE-AUTHORIZATION NO. (if applicable)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:		

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
1-6-72	11	[illegible]	[illegible]	[illegible]			
11-6-72	11	[illegible]	[illegible]	11.30			
12-7-72	11	[illegible]	11 240	12.30			
12-7-72	11	[illegible]	[illegible]	12.50			
12-9-72	11	[illegible]	[illegible]	12.30			

*PLACE OF SERVICE

DO DOCTOR'S OFFICE
IL INDEPENDENT LAB
H PATIENT'S HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATIONS
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL

TOTAL CHARGE	121.60		
LESS	[illegible]		
UNPAID BALANCE	46.33		

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."
TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE [illegible] DATE [illegible]

REMARKS: Take Oded

RESUBMITTAL INDICATOR | MEDICAL REVIEW

76196 REVISED (6/1/73) 06 7014

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 182629

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER	
NAME OF PATIENT	RACE		
DATE OF BIRTH / / SEX M F	ELIG. CODE	PROVIDER ID. NO.	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above)	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES NO	SERVICE PRE-AUTHORIZATION NO. (if applicable)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:		

SERVICES RENDERED

11

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		

*PLACE OF SERVICE

- DO DOCTOR'S OFFICE
- IL INDEPENDENT LAB
- H PATIENT'S HOME
- IH INPATIENT HOSPITAL
- OL OTHER LOCATIONS
- NH NURSING HOME
- ECF EXTENDED CARE FACILITY
- OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL
MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL

TOTAL CHARGE				
LESS				
UNPAID BALANCE				

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."
TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE _____ DATE _____

REMARKS:

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

PROVIDER

06

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 182330

10. PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: Crippled Child.		NAME OF PROVIDER: [illegible]	
NAME OF PATIENT: Silas Steven	RACE		
DATE OF BIRTH: 7/12/70 SEX M ☒ F ☐	ELIG. CODE	PROVIDER ID. NO.	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above)	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? ☒ YES ☐ NO	SERVICE PRE-AUTHORIZATION NO. (if applicable)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:		

SERVICES RENDERED

11

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
12-3-72	IH	Dental visit	9021h	12.30			
12-4-72	IH	Dental visit	9021h	12.30			
12-4-72	IH	Dental visit	9021h	12.30			
12-5-72	IH	Dental visit	9021h	12.30			
12-6-72	IH	Dental visit	9021h	12.30			

*PLACE OF SERVICE

DO	DOCTOR'S OFFICE
IL	INDEPENDENT LAB.
H	PATIENT'S HOME
IH	INPATIENT HOSPITAL
OL	OTHER LOCATIONS
NH	NURSING HOME
ECF	EXTENDED CARE FACILITY
OH	OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL

	TOTAL CHARGE				
	LESS				
	UNPAID BALANCE				

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."
TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE _____ DATE _____

REMARKS:

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

70196 REVISED (6/1/71) 04 7014

CENTRAL OFFICE

06 P

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

15 PROVIDER REF.

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 210982 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER: Crippled Children's Services		NAME OF PROVIDER: Richard L. Day, D.D.S. M.S. 3606 Rhone Circle Anchorage, Alaska 99504
NAME OF PATIENT: FORBUSH, Douglas	RACE: W	
DATE OF BIRTH: 05 / 02 / 56 SEX M☒ F☐	ELIG. CODE: 30P	PROVIDER ID. NO. / CATEGORY: 10
CASE NO.: 694-380	RESOURCE: F	PAYEE ID NO. (if different from above)

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
Cleft Lip & Palate	749
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? ☒ YES ☐ NO

SERVICE PRE-AUTHORIZATION NO. (if applicable): 04971

REFERRING OR CONSULTING PHYSICIAN:

COMMENTS:

SERVICES RENDERED

11

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
Oct. 72		Debanding & Retainer fee		$200.00			

*PLACE OF SERVICE

DO DOCTOR'S OFFICE
IL INDEPENDENT LAB
H PATIENT'S HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATIONS
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL
	Champus	
MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL

TOTAL CHARGE	950.00
LESS	810.00
UNPAID BALANCE	140.00

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."
TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE: Richard L. Day DDS for DATE: 4-14-75

REMARKS: 4 of 4

31-1-694-380

RESUBMITTAL INDICATOR | MEDICAL REVIEW

77196 REVISED (6/1/73) 06 7014

CENTRAL OFFICE

06 P

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

15 PROVIDER REF.

NO. 210981

A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: Crippled Children's Services		NAME OF PROVIDER: Richard L. Day, D.D.S. M.S. 3606 Rhone Circle Anchorage, Alaska 99504	
NAME OF PATIENT: FORBUSH, Douglas	RACE: W		
DATE OF BIRTH: 05 / 02 / 56 SEX: M [x] F [ ]	ELIG. CODE: 30P	PROVIDER ID. NO.	CATEGORY: 10
CASE NO.: 694-380	RESOURCE: F	PAYEE ID NO. (if different from above)	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST Cleft Lip & Palate	PRIMARY: 749 SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? [X] YES [ ] NO	SERVICE PRE-AUTHORIZATION NO. (if applicable): 04971	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:		

SERVICES RENDERED

11

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
May 72		Treatment		$50.00			
June 72		"		$50-00			
July 72		"		$50.00			
August 72		"		$50.00			
Sept. 72		"		$50.00			

*PLACE OF SERVICE

DO DOCTOR'S OFFICE
IL INDEPENDENT LAB.
H PATIENT'S HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATIONS
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL

TOTAL CHARGE					
LESS					
UNPAID BALANCE					

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."
TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE _____ DATE _____

REMARKS: 3 of 4

RESUBMITTAL INDICATOR | MEDICAL REVIEW

70196

REVISED 6/1/72

CENTRAL OFFICE

06 P

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

15 PROVIDER REF.

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 210980 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER Crippled Children's Services		NAME OF PROVIDER Richard L. Day, D.D.S. M.S. #3606 Rhone Circle Anchorage, Alaska 99504	
NAME OF PATIENT FORBUSH, Douglas	RACE W		
DATE OF BIRTH 05 / 02 / 56 SEX M[X] F[ ]	ELIG. CODE 30P	PROVIDER ID. NO.	CATEGORY 10
CASE NO. 694-380	RESOURCE F	PAYEE ID NO. (if different from above)	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST Cleft Lip & Palate	PRIMARY 749 SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? [X] YES [ ] NO	SERVICE PRE-AUTHORIZATION NO. (if applicable)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:	04971	

SERVICES RENDERED

11

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
Dec. 71		Treatment		$50.00			
Jan. 72		"		$50.00			
Feb. 72		"		$50.00			
March 72		"		~~$50.00~~			
April 72		"		$50.00			

*PLACE OF SERVICE

DO DOCTOR'S OFFICE
IL INDEPENDENT LAB
H PATIENT'S HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATIONS
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL

TOTAL CHARGE					
LESS					
UNPAID BALANCE					

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."
TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE _____ DATE _____

REMARKS: 2 of 4

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

70196 REVISED (6/1/73) 08 7014

CENTRAL OFFICE

06 P

15 PROVIDER REF.

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 210979

A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER Crippled Children's Services		NAME OF PROVIDER Richard L. Day, D.D.S. M.S. 3606 Rhone Circle Anchorage, Alaska 99504	
NAME OF PATIENT FORBUSH, Douglas	RACE W		
DATE OF BIRTH 05 / 02 / 56 SEX M☒ F☐	ELIG. CODE 30P	PROVIDER ID. NO.	CATEGORY 10
CASE NO. 694-380	RESOURCE	PAYEE ID NO. (if different from above)	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST Cleft Lip & Palate	PRIMARY 749 SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? ☒ YES ☐ NO	SERVICE PRE-AUTHORIZATION NO. (If applicable)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:	04971	

SERVICES RENDERED

11

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
July 71		Treatment		$50.00			
Aug. 71		"		$50.00			
Sept. 71		"		$50.00			
Oct. 71		"		$50.00			
Nov. 71		"		$50.00			

*PLACE OF SERVICE

DO DOCTOR'S OFFICE
IL INDEPENDENT LAB
H PATIENT'S HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATIONS
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL

TOTAL CHARGE					
LESS					
UNPAID BALANCE					

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."
TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE _____ DATE _____

REMARKS:
1 of 4

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

HEALTH CARE FACILITY INVOICE NO. 335486

PATIENT INFORMATION

COUPON OR AUTHORIZATION NUMBER

STATE USE ONLY

NAME OF PATIENT

RACE

DATE OF BIRTH ___/___/___

SEX: M [ ] F [ ]

ELIG. CODE

CASE NUMBER

RESOURCE

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? [ ] YES [ ] NO

COMMENTS:

PROVIDER INFORMATION

NAME OF PROVIDER

PROVIDER ID NO.

CATEGORY

PAYEE ID NO. (if different from above)

ATTENDING PHYSICIAN

ID NO.

SERVICE PRIOR AUTHORIZATION NO. (if applicable)

DIAGNOSIS AND PROCEDURES

DATE OF ADMISSION ___/___/___

TOT. DAYS

SECONDARY DIAGNOSIS

CODE

PRIMARY DIAGNOSIS

CODE

DATE OF DISCHARGE ___/___/___

PRIMARY PROCEDURE PERFORMED

CODE

ID NO.

SECONDARY PROCEDURE PERFORMED

CODE

SERVICES RENDERED

CHARGE

OPERATING ROOM

ANESTHESIA

PHARMACY

RADIOLOGY

PHYSICAL THERAPY

SPEECH THERAPY

OTHER THERAPY

PROVIDER CERTIFICATION

PROVIDER'S SIGNATURE

DATE

REMARKS:

33-6-110-380

COORDINATION OF OTHER BENEFITS

OTHER BENEFITS

TOTAL

FAIRBANKS MEMORIAL HOSPITAL

Benjamin E. Bloch
14 Mile Steese Hwy
Fairbanks, Alaska 99701

ACCT. NO. 006-378

								64.00	01	02-02-73	64.00
								64.00	01	02-03-73	128.00
8.50	4.50	20.00	70.00			34.00	4	64.00	01	02-04-73	320.00
			159.00					64.00	01	02-05-73	544.00
			40.00	8.15							
				8.25						02-06-73	604.40
		873028FD								06-18-73	82.00

06-33-6-110-380

State File | Send white & canary copies for payment.

25 Provider Ref 009-934

06

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Health Care Facility Invoice

212 507685

20 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization Number DPH 0MA 32037		Name of Provider Fairbanks Memorial Hospital
Name of Patient ANDERSON, Peter A.	Race	
Date of Birth 06 / 22 / 02 Sex: M [ ] F [X]	Rlg. Code	Provider ID Number FMH 290 / Category 01
Case Number	Resource	Payee ID Number (if different from above)
		Attending Physician Raymond Evans, MD / ID Number
Have all other payment sources been exhausted? [X] Yes [ ] No		Service Pre-Authorization No. (if applicable)
Comments:		

21 DIAGNOSIS AND PROCEDURES

Date of Admission 04 / 13 / 71	Ref.Code 3	Svc.Unit 1	Primary Diagnosis Chronic Bronchiectasis	Code 518
Billing Period 04 / 13 / 71 thru 04 / 26 / 71		Tot.Days 13	Secondary Diagnosis	Code
Date of Discharge 04 / 26 / 71		Dis.Code 1	Primary Procedure Performed Non surg inpatient care	Code 90199
Consulting Physician	ID Number		Secondary Procedure Performed	Code

22 STATEMENT OF SERVICES RENDERED

	Blood: Pts. Furnished	Pints Replaced	Not Replaced	Charge Per Pint	Charge
1					
	Accommodation		Days	Rate	
2	1 Bed				
3	2 Beds		13	58.00	754.00
4	3 or More Beds				
5	Intensive Care				
6	Self Care				
7	Nursery				
8	Operating Room				
9	Anesthesia				
10	Outpatient Services				
11	Blood Administration				
12	Pharmacy				120.90
13	Radiology				30.00
14	Laboratory				71.00
15	Medical & Surgical Supplies				77.65
16	Physical Therapy				
17	Occupational Therapy				
18	Speech Therapy				
19	Inhalation Therapy				
20	Other (Specify)				
21					
22					
	Total Charge				1053.55

PROVIDER CERTIFICATION

"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the grounds of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any fals claims, statements or documents or concealment of a material fact, may be prosecuted under applicable Federal or State laws."

To the best of my knowledge no other resource exists.

Signature [signature] Date 10/24/73

Remarks:

see attached ledger copy

06-33-6-310-380

Resubmittal Indicator		Medical Review	

23 COORDINATION OF OTHER BENEFITS

Other Benefits		Medicare	
Medicare Paid	993.50	Co-Ins.	0
Ins. or Other Pd	0	Ded.	60.00
Total	993.5	Total	60.00
Less	993.5	Amount Billed	60.00

PROVIDER

06

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

HEALTH CARE FACILITY INVOICE NO. 527378

B

20 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: 44758 D		NAME OF PROVIDER: Providence Hospital	
NAME OF PATIENT: Pantages, John C. ADC	RACE		
DATE OF BIRTH: 12 / 06 / 71 SEX: M [X] F [ ]	ELIG. CODE	PROVIDER ID NO.: PRH 409	CATEGORY: 02
CASE NUMBER	RESOURCE	PAYEE ID NO. (if different from above)	
		ATTENDING PHYSICIAN: Dr. B. Hunter	ID NO.
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? [X] YES [ ] NO			
COMMENTS:		SERVICE PRE-AUTHORIZTION NO. (if applicable)	

21 DIAGNOSIS AND PROCEDURES

DATE OF ADMISSION: 12 / 28 / 72	REF. CODE: 3	SVC UNIT: 5	PRIMARY DIAGNOSIS: chest x-ray	CODE: 788
BILLING PERIOD: 12/28/72 — 12/28/72		TOT. DAYS: 1	SECONDARY DIGANOSIS	CODE
DATE OF DISCHARGE: 12/28/72		DIS. CODE: 1	PRIMARY PROCEDURE PERFORMED: non surgical outpatient care	CODE: 00290
CONSULTING PHYSICIAN	ID NO.		SECONDARY PROCEDURE PERFORMED	CODE

22 STATEMENT OF SERVICES RENDERED

		BLOOD PINTS FURNISHED	PINTS REPLACED	NOT REPLACED	CHARGE PER PINT	CHARGE		
1								
	ACCOMMODATION			DAYS	RATE			
2	1 BED							
3	2 BEDS							
4	3 OR MORE BEDS							
5	INTENSIVE CARE							
6	SELF CARE							
7	NURSERY							
8	OPERATING ROOM							
9	ANESTHESIA							
10	OUTPATIENT SERVICES							
11	BLOOD ADMINISTRATION							
12	PHARMACY							
13	RADIOLOGY					24.00	24.00	
14	LABORATORY							
15	MEDICAL & SURGICAL SUPPLIES							
16	PHYSICAL THERAPY							
17	OCCUPATIONAL THERAPY							
18	SPEECH THERAPY							
19	INHALATION THERAPY							
20	OTHER (SPECIFY)							
21								
22								

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."

TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE [signature]

DATE 7-1-74

REMARKS: Billed 7-1-74

93-6-150-380

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

23 COORDINATION OF OTHER BENEFITS

OTHER BENEFITS		MEDICARE	
MEDICARE PAID		CO-INS.	
INSURANCE OR OTHER PAY.		DED.	
TOTAL		TOTAL	

.80%

TOTAL CHARGE	24.00	24.00	LESS	0	AMOUNT BILLED	24.00		19.20

70196

REVISED (6/1/73) 06 7015

25 PROVIDER REF. Pantages, John C.

PROVIDER 06

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

B

HEALTH CARE FACILITY INVOICE NO. 527379

20 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: 44758 C		NAME OF PROVIDER: Providence Hospital	
NAME OF PATIENT: Pnatages, John C. ADC	RACE		
DATE OF BIRTH: 05/06/71 SEX: M ☒ F ☐	ELIG. CODE	PROVIDER ID NO.: PRH 409	CATEGORY: 02
CASE NUMBER:	RESOURCE	PAYEE ID NO. (if different from above)	
		ATTENDING PHYSICIAN: Dr. B. Hunter	ID NO.
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? ☒ YES ☐ NO			
COMMENTS:		SERVICE PRE-AUTHORIZTION NO. (if applicable)	

21 DIAGNOSIS AND PROCEDURES

DATE OF ADMISSION	REF. CODE	SVC UNIT	PRIMARY DIAGNOSIS	CODE
12/26/72	3	5	Chest x-ray	283
BILLING PERIOD: 12/26/72 12/26/72		TOT. DAYS: 1	SECONDARY DIGANOSIS	CODE
DATE OF DISCHARGE: 12/26/72		DIS. CODE: 1	PRIMARY PROCEDURE PERFORMED: non surgical outpatient care	CODE: 90290
CONSULTING PHYSICIAN	ID NO.		SECONDARY PROCEDURE PERFORMED	CODE

22 STATEMENT OF SERVICES RENDERED

		BLOOD PINTS FURNISHED	PINTS REPLACED	NOT REPLACED	CHARGE PER PINT	CHARGE		
1								
	ACCOMMODATION			DAYS	RATE			
2	1 BED							
3	2 BEDS							
4	3 OR MORE BEDS							
5	INTENSIVE CARE							
6	SELF CARE							
7	NURSERY							
8	OPERATING ROOM							
9	ANESTHESIA							
10	OUTPATIENT SERVICES							
11	BLOOD ADMINISTRATION							
12	PHARMACY							
13	RADIOLOGY					24.00	24.00	
14	LABORATORY							
15	MEDICAL & SURGICAL SUPPLIES							
16	PHYSICAL THERAPY							
17	OCCUPATIONAL THERAPY							
18	SPEECH THERAPY							
19	INHALATION THERAPY							
20	OTHER (SPECIFY)							
21								
22								

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."

TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE [signature]

DATE 7-1-74

REMARKS: Billed 7-1-74

38-6-130-380

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

23 COORDINATION OF OTHER BENEFITS

OTHER BENEFITS		MEDICARE	
MEDICARE PAID		CO-INS.	
INSURANCE OR OTHER PAY.		DED.	
TOTAL		TOTAL	

TOTAL CHARGE	24.00	24.00	LESS	0	AMOUNT BILLED	24.00		19.20

80%

70196 REVISED (6/1/73) 06 2013

25 PROVIDER REF. Mc Farland, Kerry

PROVIDER

06

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

HEALTH CARE FACILITY INVOICE NO. 527385

B

20 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER 44746 A		NAME OF PROVIDER Providence Hospital	
NAME OF PATIENT Mc Farland, Kerry S. AWC	RACE		
DATE OF BIRTH 07 / 03 / 63 SEX: M ☐ F ☐	ELIG. CODE	PROVIDER ID NO. PRH 409	CATEGORY 02
CASE NUMBER	RESOURCE	PAYEE ID NO. (if different from above)	
		ATTENDING PHYSICIAN Dr. D. Roberts	ID NO
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? ☑ YES ☐ NO			
COMMENTS:		SERVICE PRE-AUTHORIZTION NO. (if applicable)	

21 DIAGNOSIS AND PROCEDURES

DATE OF ADMISSION 12 / 30 / 72	REF. CODE 3	SVC UNIT 5	PRIMARY DIAGNOSIS outpatient labwork	CODE 788
BILLING PERIOD 12 / 30 / 72 12 / 30 / 72		TOT. DAYS 1	SECONDARY DIGANOSIS	CODE
DATE OF DISCHARGE 12 / 30 / 72		DIS. CODE 1	PRIMARY PROCEDURE PERFORMED non surgical outpatient care	CODE 90290
CONSULTING PHYSICIAN	ID NO.		SECONDARY PROCEDURE PERFORMED	CODE

22 STATEMENT OF SERVICES RENDERED

	BLOOD PINTS FURNISHED	PINTS REPLACED	NOT REPLACED	CHARGE PER PINT	CHARGE	
1						
	ACCOMMODATION		DAYS	RATE		
2	1 BED					
3	2 BEDS					
4	3 OR MORE BEDS					
5	INTENSIVE CARE					
6	SELF CARE					
7	NURSERY					
8	OPERATING ROOM					
9	ANESTHESIA					
10	OUTPATIENT SERVICES					
11	BLOOD ADMINISTRATION					
12	PHARMACY					
13	RADIOLOGY					
14	LABORATORY				10.00	10.00
15	MEDICAL & SURGICAL SUPPLIES					
16	PHYSICAL THERAPY					
17	OCCUPATIONAL THERAPY					
18	SPEECH THERAPY					
19	INHALATION THERAPY					
20	OTHER (SPECIFY)					
21						
22						

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."

TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS

PROVIDER'S SIGNATURE [signature]

DATE 7-1-74

REMARKS:

Billed 7-1-74

06-33-6-120-380

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

23 COORDINATION OF OTHER BENEFITS

OTHER BENEFITS		MEDICARE	
MEDICARE PAID		CO-INS.	
INSURANCE OR OTHER PAY.		DED.	
TOTAL		TOTAL	

.80

TOTAL CHARGE	10.00	10.00	LESS	0	AMOUNT BILLED	10.00	8.00

REVISED 10/72

25 PROVIDER REF. Tritt, Verlin W.

PROVIDER 06

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
HEALTH CARE FACILITY INVOICE NO. 527432

B

20 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: 45219 A		NAME OF PROVIDER: Providence Hospital	
NAME OF PATIENT: Tritt, Verlin W. JPC	RACE		
DATE OF BIRTH: 10 / 21 / 55 SEX: M ☐ F ☐	ELIG. CODE	PROVIDER ID NO.: PRH 409	CATEGORY: 02
CASE NUMBER	RESOURCE	PAYEE ID NO. (if different from above)	
		ATTENDING PHYSICIAN: L. Jones, M.D.	ID NO.
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? ☐ YES ☐ NO			
COMMENTS:		SERVICE PRE-AUTHORIZTION NO. (if applicable)	

21 DIAGNOSIS AND PROCEDURES

DATE OF ADMISSION: 11 / 10 / 72	REF. CODE: 3	SVC UNIT: 5	PRIMARY DIAGNOSIS: 1st lac puncture wound medial (R) foot	CODE: 891
BILLING PERIOD: 11 / 10 / 72 — 11 / 10 / 72		TOT. DAYS: 1	SECONDARY DIGANOSIS	CODE
DATE OF DISCHARGE: 11 / 10 / 72		DIS. CODE: 1	PRIMARY PROCEDURE PERFORMED: suture wound	CODE: 12120
CONSULTING PHYSICIAN	ID NO.		SECONDARY PROCEDURE PERFORMED	CODE

22 STATEMENT OF SERVICES RENDERED

	BLOOD PINTS FURNISHED	PINTS REPLACED	NOT REPLACED	CHARGE PER PINT	CHARGE		
1							
	ACCOMMODATION		DAYS	RATE			
2	1 BED						
3	2 BEDS						
4	3 OR MORE BEDS						
5	INTENSIVE CARE						
6	SELF CARE						
7	NURSERY						
8	OPERATING ROOM						
9	ANESTHESIA						
10	OUTPATIENT SERVICES				25.50	25.50	
11	BLOOD ADMINISTRATION						
12	PHARMACY						
13	RADIOLOGY						
14	LABORATORY						
15	MEDICAL & SURGICAL SUPPLIES						
16	PHYSICAL THERAPY						
17	OCCUPATIONAL THERAPY						
18	SPEECH THERAPY						
19	INHALATION THERAPY						
20	OTHER (SPECIFY)						
21							
22							

PROVIDER CERTIFICATION

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TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE _____

DATE 11

REMARKS:

336-120-380

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

23 COORDINATION OF OTHER BENEFITS

OTHER BENEFITS		MEDICARE	
MEDICARE PAID		CO-INS.	
INSURANCE OR OTHER PAY.		DED.	
TOTAL		TOTAL	

80 %

TOTAL CHARGE	25.50	25.50	LESS	0	AMOUNT BILLED	25.50	20.40

25 PROVIDER REF. Mueller, Judy

PROVIDER

06

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
HEALTH CARE FACILITY INVOICE

NO. 527450 B

20 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: 44756 A		NAME OF PROVIDER: Providence Hospital	
NAME OF PATIENT: Mueller, Judy (ADC)	RACE		
DATE OF BIRTH: 10 / 12 / 45 SEX: M ☐ FL ☒	ELIG. CODE	PROVIDER ID NO.: PRH 409	CATEGORY: 02
CASE NUMBER	RESOURCE	PAYEE ID NO. (if different from above)	
		ATTENDING PHYSICIAN: Brownsberger	ID NO.
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? ☒ YES ☐ NO		SERVICE PRE-AUTHORIZTION NO. (if applicable)	
COMMENTS:			

21 DIAGNOSIS AND PROCEDURES

DATE OF ADMISSION: 12 / 14 / 72	REF. CODE: 3	SVC UNIT: 5	PRIMARY DIAGNOSIS: misc. lab	CODE: 788
BILLING PERIOD: 12 / 14 / 72 — 12 / 14 / 72		TOT. DAYS: 1	SECONDARY DIGANOSIS	CODE
DATE OF DISCHARGE: 12 / 14 / 72		DIS. CODE: 1	PRIMARY PROCEDURE PERFORMED: Outpatient care	CODE: 90290
CONSULTING PHYSICIAN	ID NO.		SECONDARY PROCEDURE PERFORMED	CODE

22 STATEMENT OF SERVICES RENDERED

		BLOOD PINTS FURNISHED	PINTS REPLACED	NOT REPLACED	CHARGE PER PINT	CHARGE	
1							
	ACCOMMODATION			DAYS	RATE		
2	1 BED						
3	2 BEDS						
4	3 OR MORE BEDS						
5	INTENSIVE CARE						
6	SELF CARE						
7	NURSERY						
8	OPERATING ROOM						
9	ANESTHESIA						
10	OUTPATIENT SERVICES						
11	BLOOD ADMINISTRATION						
12	PHARMACY						
13	RADIOLOGY						
14	LABORATORY					25.00	25.00
15	MEDICAL & SURGICAL SUPPLIES						
16	PHYSICAL THERAPY						
17	OCCUPATIONAL THERAPY						
18	SPEECH THERAPY						
19	INHALATION THERAPY						
20	OTHER (SPECIFY)						
21							
22							

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."

TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE: Christine Hodge

DATE: 7/5/74

REMARKS: Billed 7-5-74

33-6-120-380

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

23 COORDINATION OF OTHER BENEFITS

OTHER BENEFITS		MEDICARE	
MEDICARE PAID		CO-INS.	
INSURANCE OR OTHER PAY.		DED.	
TOTAL		TOTAL	

80%

TOTAL CHARGE	25.00	25.00	LESS	.00	AMOUNT BILLED	25.00	20.00

Fairbanks Memorial Hospital

1650 Cowles
FAIRBANKS, ALASKA 99701

OPERATED BY
LUTHERAN HOSPITALS AND HOMES SOCIETY
FARGO, NORTH DAKOTA 58102

507685
STALE STS.

May 31, 1975

Dear Sir:

Patient: Anderson, Peter A.

ID# DPW OAA 32037

Group Name: MAID

Admission Date: April 13, 1971

On January 30, 1975 this hospital submitted a claim on the above named person. As of this date we have received no information regarding payment nor final disposition. Please advise as to the status of mentioned claim. Your immediate attention will be appreciated.

Sincerely,
Cathy Harris
for
Mrs. Rhonda Newman
Insurance

We have sent multiple requests for payment on this patient, and have recieved no responce from you. Your immediate attention to this past due account will be appreciated.

REPLY: NO

BASIC PLUS MAJOR MEDICAL PLAN
EXPLANATION OF BENEFIT PAYMENT 80 / 338000 / 10
Key / Control No. / Suf

1-2 Year 12 Sheet No. 11 Statistics Yes ☐ No ☒

Total Benefits Charged Against Maximum Prior To This Payment (On First Worksheet For Each Calendar Year Adjust For Automatic Restoration If Included In Plan). $154.23

Carr

M.P. Stevens Cert. No. 489329570 Dependent (First Name) William

CHARGES BY	DATES INCURRED	AMOUNT OF CHARGES	EXPENSES NOT COVERED	COVERED EXPENSES	BASIC BENEFITS
Jasba Clinic	10/24-11/20	$36.90	$	$36.90	$
Jasha Clinic	10/24-11/20	28.70	5.74	22.96	22.96
Rx	12/30-1/10	57.87	49.71	8.16	
TOTALS				Ⓐ 68.02	Ⓑ 22.96

BASIC BENEFIT PAYMENT

Excess 80% XRC

Duplicate charges processed on worksheet dated 12/4/72

See Comment No. ☐ (This box completed only if actual payment differs from "B" above)

MADE TO:

$ 54.01
$
$ 45.66 Rec'd 12/1
$

S. S. Suf.	State	Clmt	Code
	54	2	001

DCI	Amount	Special	Ⓐ Class	DCI	Amount	Special
			084	03	22.05	
DCI	Amount	Special	Ⓐ Class	DCI	Amount	Special
	$				$	

This Section Completed Only If Major Medical Deductible Has Not Been Satisfied.

EXPENSES APPLIED TO MEET YOUR MAJOR MEDICAL DEDUCTIBLE FOR _____ YEAR

Ⓐ COVERED EXPENSES Less Ⓑ BASIC BENEFITS

This Worksheet $
Previous Worksheets TOTAL FOR YEAR $
TO DATE $

Note: Major Medical Benefits will be payable when this amount exceeds your deductible.

Processor [illegible] Date 12/2/3

Clmt	Age	Salary
Diss	**Type Claim**	**Ded**
c/over	**Days Confined**	**Days Pvt Rm**

MAJOR MEDICAL BENEFITS

1.	Misc Fees	
	Total Hosp.	
	K Allow / Inv	
	Surg Fees	
2.	Phys Fees	
3.	Nurses	
4.	Drugs	
5.	All Other	
6.	Total Covered	
Sum of 1 thru 6 =	Basic Ben	less

Ⓐ COVERED EXPENSES Less Ⓑ BASIC BENEFITS $45.66 PLUS

See Comment No.

☐ Prior Expenses to be Applied Against This Year's Deductible $

equals

TOTAL EXPENSE ELIGIBLE UNDER MAJOR MEDICAL $45.66

LESS

☐ DEDUCTIBLE

Benefit Calculation $45.66 @ 50 % = $22.83

MAJOR MEDICAL BENEFIT PAYMENT

☐ (This box completed only if actual payment differs from above)

TOTAL CHARGED AGAINST MAXIMUM (PLAN LIMIT OF $50000) $190.88

19

JCM-65520 (8-71)

BASIC PLUS MAJOR MEDICAL PLAN
EXPLANATION OF BENEFIT PAYMENT 80 (Key) 338000 (Control No.) 10 (Suf) 1-2 Year 24 Sheet No. 11 Statistics Yes ☐ No ☒

Total Benefits Charged Against Maximum Prior To This Payment (On First Worksheet For Each Calendar Year Adjust For Automatic Restoration If Included In Plan). $154.23

Circo

M-f Stevens Cert. No. 489 32 9570 Dependent (First Name) William

CHARGES BY	DATES INCURRED	AMOUNT OF CHARGES	EXPENSES NOT COVERED	COVERED EXPENSES	BASIC BENEFITS
Iaska Clinic	10/24-11/20	$~~36.90~~	$	$36.90	$
Iaska Clinic	10/24-11/20	28.70	5.74	22.96	22.96
X	12/30-1/10	57.87	49.71	8.16	
TOTALS				Ⓐ 68.02	Ⓑ 22.96

BASIC BENEFIT PAYMENT →

Clmt	Age	Salary
Disa	**Type Claim**	**Ded**
c/over	**Days Confined**	**Days Pvt Rm**

1. Misc Fees	
Total Hosp	
K Allow / Inv	
2. Surg Fees	
3. Phys Fees	
4. Nurses	
Drugs	
5. All Other	
6. Total Covered	
Basic Ben	

MAJOR MEDICAL BENEFITS Sum of 1 thru 6 = → less

Ⓐ COVERED EXPENSES Less Ⓑ BASIC BENEFITS $45.06 PLUS

See Comment No.

☐ Prior Expenses to be Applied Against This Year's Deductible $

TOTAL EXPENSE ELIGIBLE UNDER MAJOR MEDICAL $45.06 equals

LESS

☐ DEDUCTIBLE

Benefit Calculation $45.06 @ 80 % = $36.05

MAJOR MEDICAL BENEFIT PAYMENT

☐ (This box completed only if actual payment differs from above) →

TOTAL CHARGED AGAINST MAXIMUM (PLAN LIMIT OF $50000) $190.88

Process 58% XRL

Duplicate charges processed on
Worksheet dated 12/4/22

See Comment No. ☐ (This box completed only if actual payment differs from "B" above) →

MADE TO:

~~Insig~~ 1 Cir. Anchorage Ak 99510-75 $ 59.01

$

$ 50.48 Rec'd 12/21

$

This Section Completed Only If Major Medical Deductible Has Not Been Satisfied.

EXPENSES APPLIED TO MEET YOUR MAJOR MEDICAL DEDUCTIBLE FOR _____ YEAR

Ⓐ COVERED EXPENSES	Less	Ⓑ BASIC BENEFITS
This Worksheet		$
Previous Worksheets TOTAL FOR YEAR TO DATE		$

Note: Major Medical Benefits will be payable when this amount exceeds your deductible.

S. S. Suf.	State	Clmt	Code
	54	2	001

DCI	Amount	Special	Ⓘ Class	DCI	Amount	Special
			1870	002	22.05	
	Amount	Special	Ⓘ Class	DCI	Amount	Special
	$				$	

Processor _____ Date 2/2/23

HOME OFFICE COPY

Cat. 238333
Printed in U.S.A.

19-1

(GRD-65501) 8-71

3 – 4

MEDICAL INSURANCE PLAN
EXPLANATION OF BENEFIT PAYMENT

AtlanticRichfieldCompany

& CASUALTY

Employee's Name [illegible] Certificate No. 4893295570 Year 73 Sheet No. 5 Key 80

CONTROL NO.	SUF.	SCD	S.S. SUF.	STATE	CLM'T.	CODE	IF DEPENDENT (FIRST NAME)	RELATIONSHIP
338000	10	92		54	02	001	[illegible]	[illegible]

CHARGES BY	DATES INCURRED	AMOUNT OF CHARGES	*SEE COMMENT NO.	EXPENSES NOT COVERED	*SEE COMMENT NO.	COVERED EXPENSES	BASIC BENEFITS	BASIC CO-INS.	*SEE COMMENT NO.	ELIGIBLE MAJOR MEDICAL EXPENSES
[illegible]	11/23/73	$ 28.70	☐	$	☐	$ 28.70	$ 13.12	$ 3.28	1	$ 12.30
" "	11/30-12/15	231.65	☐		☐	231.65	185.32	46.33	1	—
			☐		☐				1	
			☐		☐				1	
			☐		☐				1	
			☐		☐				1	
TOTAL		$ 260.35	☐	$	☐	$ 260.35	$ 198.44	$ 49.61	1	$ 12.30

PAYMENTS MADE TO:	AMOUNT
4 [illegible]	198.44
3 [illegible]	49.61
• pd $185.32 on 231.65 (adjd amt to charge)	
• pd 13.12 + 9.84 = 22.96 on 28.70 claim.	

☐ (This box completed only if actual payment differs from above) →

Including the expenses on this form, you have accumulated $ _____ toward your 19____ deductible of $100. When this amount is met, Major Medical payments will be payable.

TOTAL AMOUNT CHARGED AGAINST YOUR MAJOR MEDICAL LIFETIME MAXIMUM: $ _____

Prior Expenses toward This Yr's Deductible $

TOTAL EXPENSE ELIGIBLE UNDER MAJOR MEDICAL $ 12.30

LESS DEDUCTIBLE $

NET ELIGIBLE EXPENSE $ 12.30

X 80 %

MAJOR MEDICAL BENEFIT PAYMENT → $ 9.84

☐ (This box completed only if actual payment differs from above) →

COMMENTS: _____

PROCESSOR: [illegible] DATE 12/27/73

Comments are listed on the reverse side of this form.

NOTE:
This form may be useful to you in the preparation of your Federal Income Tax Return.

(C-5632-1) Ed. 3-73 EMPLOYEE COPY Printed in U.S.A.

Aetna LIFE & CASUALTY

BASIC PLUS MAJOR MEDICAL PLAN
EXPLANATION OF BENEFIT PAYMENT

80 Key | 338000 Control No. | 2-72 Suf | Year 23 | Sheet No. ____ | Statistics Yes ☐

Total Benefits Charged Against Maximum Prior To This Payment (On First Worksheet For Each Calendar Year Adjust For Automatic Restoration If Included In Plan). $ ~

Policyholder Arco

Employee M L Stevens Cert. No. 489329570 Dependent (First Name) William

See Comment No.	CHARGES BY	DATES INCURRED	AMOUNT OF CHARGES	EXPENSES NOT COVERED	COVERED EXPENSES	BASIC BENEFITS
☐	RX	1/5	$ 7.20	$	$ 7.20	$ —
☐	Alaska Clinic	1/16	12.30	0	12.30	
☐						
☐						
☐						
☐						
	TOTALS		Ⓐ 19.50			Ⓑ

Clmt	Age	Salary
Disa	**Type Claim**	**Ded**
c/over	**Days Confined**	**Days Pvt Rm**

MAJOR MEDICAL BENEFITS

1. Misc Fees	
Total Hosp.	
K Allow / Inv.	
2. Surg Fees	
3. Phys Fees	
4. Nurses	
Drugs	
5. All Other	
6. Total Covered	
Basic Ben	

Sum of 1 thru 6 = — less

Ⓐ COVERED EXPENSES Less Ⓑ BASIC BENEFITS $ ____ PLUS

See Comment No. ☐ Prior Expenses to be Applied Against This Year's Deductible $ ____ equals

TOTAL EXPENSE ELIGIBLE UNDER MAJOR MEDICAL $ ____ LESS

☐ DEDUCTIBLE ____

Benefit Calculation $ ____ @ ____ % = $ ____

MAJOR MEDICAL BENEFIT PAYMENT

☐ (This box completed only if actual payment differs from above) ____

TOTAL CHARGED AGAINST MAXIMUM (PLAN LIMIT OF $ ____) $ ____

COMMENTS

Orthotics Harvard Recreational Activity

BASIC BENEFIT PAYMENT ——

See Comment No. ☐ (This box completed only if actual payment differs from "B" above) ——

PAYMENTS MADE TO:

$ ____
$ ____
$ ____
$ ____

This Section Completed Only If Major Medical Deductible Has Not Been Satisfied.

EXPENSES APPLIED TO MEET YOUR MAJOR MEDICAL DEDUCTIBLE FOR 73 YEAR

Ⓐ COVERED EXPENSES	Less	Ⓑ BASIC BENEFITS
This Worksheet		$ 19.50
Previous Worksheets TOTAL FOR YEAR		$ ____
TO DATE		$ 19.50

Note: Major Medical Benefits will be payable when this amount exceeds your deductible.

SCD	S. S. Suf.	State	Clmt	Code
92		37	2	00

① Class	DCI	Amount	Special	② Class	DCI	Amount	Special
		$				$	
③ Class	DCI	Amount	Special	① Class	DCI	Amount	Special
		$				$	

REMARKS:

Processor (illegible) Date 2/6/73

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Cat. 238333

	U • T
	12 • 30 +
	25 • 42 +
	16 • 33 +
	140 • 00 +
	92 • 00 +
	60 • 00 +
	19 • 20 +
	19 • 20 +
	8 • 00 +
	20 • 40 +
	20 • 00 +
	15 • 00 +
	69 • 00 +
	214 • 00 +
	52 • 00 +
	24 • 00 +
	72 • 00 +
	135 • 70 +
	226 • 30 +
	10 • 50 +
	20 • 00 +
	513 • 90 +
	14 • 00 +
	12 • 00 +
	12 • 00 +
	30 • 25 +
	22 • 40 +
	159 • 10 +
	249 • 30 +
	26 • 50 +
	129 • 25 +
	171 • 00 +
	3,973 • 15 T

ADC

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DEPARTMENT OF HEALTH & SOCIAL SERVICES

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06

15 PROVIDER REF. Smith

NO. 74500 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER: 00836 BZ		NAME OF PROVIDER: The Alaska Clinic
NAME OF PATIENT: Billy Smith	RACE	Dr Bosveld
DATE OF BIRTH: 4/23/41 SEX: M [X] F [ ]	ELIG. CODE	PROVIDER I.D. NO.: ROB 389 — CATEGORY
CASE NO.: 38100-01	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): ALC501

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST: *Gunshot Wound	PRIMARY
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☐ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
3/7/73	OH	Em Rm Brief eval Hist ex treat	90500	32..80	

* PLACE OF SERVICE
DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	32.80	1500	
LESS			
UNPAID BALANCE			

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE: P Bosveld DATE: 6-17-75

REMARKS: State Dated From Hospital Emergency Room 33-6-150-380

RESUBMITTAL INDICATOR | MEDICAL REVIEW

06-7014

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15 PROVIDER REF. Penn

06

NO. 74731 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER: The Alaska Clinic	
NAME OF PATIENT: Elmore Penn	RACE	Dr. DePalatis	
DATE OF BIRTH: 6-1923 SEX M [X] F [ ]	ELIG. CODE	PROVIDER I.D. NO.: SAD 417	CATEGORY
CASE NO.	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): ALC 501	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST: Sprains & Strains of back - History of enlarged heart R/O Ventral Hernia Status - Post Appendectomy Post Pancreatitis.	PRIMARY
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES [X] NO [ ]

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
5/29/72	DO	~~Brief Exam Eval A/O Treat~~ CBC	85010	8.00			
5/9/72	DO	AMylase	82150	12.00			
5/9/72	DO	Chest 2 Views	71020	24.00			
6/6/72	DO	Brief Exam Eval A/O Treatment	90040	12.00			
10/25/73	DO	Brief Exam Eval A/O Treatment	90040	12.00			
			TOTAL CHARGE	68.00			
			LESS				
			UNPAID BALANCE				

* PLACE OF SERVICE

DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

PROVIDER CERTIFICATION

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PROVIDER SIGNATURE: L DePalatis MD DATE: 6-19-75

REMARKS: unable to obtain coupon for back charges 33-6-350-380

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

06-7014

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15 PROVIDER REF. Penn

NO. 74732 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER: The Alaska Clinic Dr. [illegible] Palatis
NAME OF PATIENT: Elmore Penn	RACE	
DATE OF BIRTH: 6-19-23 SEX: M [X] F [ ]	ELIG. CODE	PROVIDER I.D. NO.: SAD 417 — CATEGORY
CASE NO.	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): ALC 501

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST: Probable Early Acute Pancreatitis Possible Posterior Perforation Of Duodenal Ulcer w/o Lesser Sac	PRIMARY
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES [X] NO [ ]

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
[redacted]					
2/15/72	DO	V Pressure Cath Place Percutan	36480	32.00	
2/15/72	IH	Appendectomy	44950	380.00	
2/15/72	IH	ABD Drain Pancreatitis	48000	520.00	
5/9/72	DO	Brief Exam Eval A.O Treatment	90040	12.00	
			TOTAL CHARGE	944.00	
			LESS		
			UNPAID BALANCE		

* PLACE OF SERVICE

DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

PROVIDER CERTIFICATION

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PROVIDER SIGNATURE: [signature] DATE: 6-19-75

REMARKS: Unable to obtain coupon for each charges

53-6-350-380

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15 PROVIDER REF. Penn

06

NO. 74733 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER: The Alaska Clinic Dr. Cates
NAME OF PATIENT: Elmore Penn	RACE	
DATE OF BIRTH: 6-19-75 SEX: M [X] F [ ]	ELIG. CODE	PROVIDER I.D. NO.: VAC 419 CATEGORY
CASE NO.	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): AIC 501

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST: Possible Pancreatitis; Possible Posterior Perforation of Duodenal ulcer into Lesser Sac Probably Early Acute Pancreatitis	PRIMARY
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES [X] NO [ ]

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

COMMENTS:

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
2/15/72	DO	ABD Comp Inc Decub-Erect	74020	32.00			
2/15/72	DO	UA	81000	4.00			
2/15/72	DO	CBC	85010	8/00			
2/15/72	DO	Sed Rate	85650	6.00			
2/15/72	SO	Amulase	82150	12.00			
			TOTAL CHARGE	62.00			
			LESS				
			UNPAID BALANCE				

* PLACE OF SERVICE

DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE: R Cates MD DATE: 6-19-75

REMARKS: Unable to obtain coupon for back charges

33-6-350-380

RESUBMITTAL INDICATOR

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06 | | 15 PROVIDER REF. Penn

NO. 74734 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER: The Alaska Clinic, Dr. Townes
NAME OF PATIENT: Elmore Penn	RACE	
DATE OF BIRTH: 6-19-25 SEX: M [X] F [ ]	ELIG. CODE	PROVIDER I.D. NO.: PJT 189 — CATEGORY
CASE NO.	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): AIC 501

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS — DIAGNOSIS CODE (OPT.)

LIST PRIMARY DIAGNOSIS FIRST — PRIMARY

Probably early Acute Pancreatitis
Possible Posterior Perforation of Duodenal ulcer into Lesser Sac.

SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES [X] NO [ ]

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
2/19/72	IH	Hosp Vis W Brief Exam	90240	12.00			
2/20/72	IH	Hosp Vis W Brief Exam	90240	12.00			

* PLACE OF SERVICE

DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE 24.00

LESS

UNPAID BALANCE

PROVIDER CERTIFICATION

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PROVIDER SIGNATURE D. Townes MD DATE 6-19-75

REMARKS: Unable to obtain coupon for back charges 33-6-250-880

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15 PROVIDER REF. 2-908740-1

NO. 96616A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER: Dr. Robert W. Taylor
NAME OF PATIENT: Topper, Charles	RACE	
DATE OF BIRTH: 12/05/16 SEX: M [X] F [ ]	ELIG. CODE: APD	PROVIDER I.D. NO.: RWT 424 CATEGORY:
CASE NO.: 76825	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
ARTERIAL EMBOLISM AND THROMBOSIS	444
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES [ ] NO [ ]

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
10/22/73	IH	SURGERY	32900	164.00	7200		

* PLACE OF SERVICE
DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	164.00	7200			
LESS					
UNPAID BALANCE					

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE: R Arneyl DATE: 11/1/74

REMARKS: 11/73 Coupon # 30375 E X
33-6-150-380

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15 PROVIDER REF. 2-730290-1

06

NO. 96637 A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT		RACE	Dr. Joseph K. Johnson	
Pyers, Alice C.				
DATE OF BIRTH	SEX	ELIG. CODE	PROVIDER I.D. NO.	CATEGORY
03/01/34	M ☐ F XX	ABL	JKJ 309	
CASE NO.		RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE)	
77671			FMS 881	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
ACUTE AND SUBACUTE NECROSIS OF LIVER	570
FRACTURE OF VAULT OF SKULL	800
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☐ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
01/21/73	IH	E R BRIEF EET-NEW	90500	34.00	1770		
01/21/73	IH	BRIEF EET-5 @ 12.00	90240	60.00	6000		
01/21/73	IH	COMPR HE EV	90620	70.00	5900		

* PLACE OF SERVICE

DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	164.00	13670		
LESS				
UNPAID BALANCE				

PROVIDER CERTIFICATION

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PROVIDER SIGNATURE P. Mayr DATE 11/1/74

REMARKS:

2/73 - coupon # 12744 E

33-6-150-380

RESUBMITTAL INDICATOR		MEDICAL REVIEW	

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15 PROVIDER REF. 2-886058-2

06

NO. 96652 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER: 72-262-41-461		NAME OF PROVIDER: Dr. Charles W. Townsend
NAME OF PATIENT: Thomas, Lottie	RACE	
DATE OF BIRTH: 04/16/26 SEX: M ☐ F XX	ELIG. CODE	PROVIDER I.D. NO.: CWT 308 — CATEGORY
CASE NO.	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☐ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
09/25/72	DO	T-3 OR T-4 UPTAKE	83440	8.60	860		
09/25/72	DO	SGOT, COLORIMETRIC OR FLUO	84455	8.60	860		
09/25/72	DO	CHEST	71010	17.20	1720		
09/25/72	DO	POTASSIUM, BLOOD	84140	10.30	1030		
09/25/72	DO	SGPT, COLORIMETRIC OR FLUO	84465	8.60	860		
09/25/72	DO	ABDOMEN, SINGLE VIEW-KUB	74000	17.20	1700		
09/28/72	DO	BRIEF ET-EST	90040	12.00	1200		
09/28/72	DO	EKG	93000	30.00	3000		
09/28/72	DO	CYTOPATH, SMEARS, GENITAL	88100	12.90	600		
09/28/72	DO	UPPER GASTROINTESTINAL TR	74240	60.00	6000		
			TOTAL CHARGE	271.40	26430		
			LESS				
			UNPAID BALANCE				

* PLACE OF SERVICE
DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

PROVIDER CERTIFICATION

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PROVIDER SIGNATURE: P. Mayr DATE: 11-8-74

REMARKS: 53-6-150-380

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STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

06

15 PROVIDER REF. 2-805983-3

NO. 96655 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER: 72-334-41-934		NAME OF PROVIDER: Dr. Nicholas F. Deely
NAME OF PATIENT: Sheakley, Baby Boy	RACE	
DATE OF BIRTH: 11/18/72 SEX: M [XX] F [ ]	ELIG. CODE: ADC	PROVIDER I.D. NO.: NFD 312 CATEGORY:
CASE NO.: 59043	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST OTHER DISEASES OF BLOOD AND BLOOD-FORMING ORGANS	PRIMARY @*(SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☐ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
LL?L*?&(11-15-72	IH	NEWBORN EXAM & CARE	90285	60.00	4850		

* PLACE OF SERVICE
DO DOCTORS OFFICE
IL INDEPENDENT LAB.
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

	CHARGE				
TOTAL CHARGE	60.00	4850			
LESS					
UNPAID BALANCE					

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE J. Mays DATE 11-8-72

REMARKS:

33-6-150-380

Cannot confirm eligibility

RESUBMITTAL INDICATOR | MEDICAL REVIEW

06-7014

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DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

15 PROVIDER REF. 2-668637-1

06

NO. 96682 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER
NAME OF PATIENT: O'Brian, Geraldine L.	RACE	Dr. Edwin Lindig
DATE OF BIRTH: 12/12/43 SEX: M ☐ F ☒ XX	ELIG. CODE: ADC	PROVIDER I.D. NO.: ELM 831 CATEGORY:
CASE NO.: 32395	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
CHRONIC SINUSITIS	503
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☐ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
01/26/73	IH	E R INTER EFT-EST	90560	30.00	2000		

* PLACE OF SERVICE
DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	30.00	2000		
LESS				
UNPAID BALANCE				

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE E. Lindig DATE 11/1/73

REMARKS:
2/73 - Coupon # 41835-C
150
33-6-~~350~~-380

RESUBMITTAL INDICATOR

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15 PROVIDER REF. 2-603060-1

NO. 96690 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER: Dr. George B. Murphy
NAME OF PATIENT: Mead, Emma I.	RACE	
DATE OF BIRTH: 06-26-40 SEX: M ☐ F XX	ELIG. CODE: ADC	PROVIDER I.D. NO.: GBM 311 — CATEGORY
CASE NO.: 54201	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
VARICOSE VEINS OF LOWER EXTREMITIES	454
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☐ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
07/24/73	IH	SURGERY	37721	564.00	54380		

* PLACE OF SERVICE

DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	564.00	54380			
LESS					
UNPAID BALANCE					

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE: F. Mayr DATE: 11/1/74

REMARKS:
7/3 for Dr. Worrall
Coupon #1 58027 B
33-6-150-380

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DEPARTMENT OF HEALTH & SOCIAL SERVICES

15 PROVIDER REF. 2-777570-1

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 96701 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: 72-301-41-923		NAME OF PROVIDER: Dr. Charles W. Townsend	
NAME OF PATIENT: Rynearson, Bert	RACE		
DATE OF BIRTH: 11/11/17 SEX: M [X] F [ ]	ELIG. CODE: APD	PROVIDER I.D. NO.: CWT 308	CATEGORY
CASE NO.: 33029	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
BOIL AND CARBUNCLE	680
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES [ ] NO [ ]

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
10/30/72	DO	PT-WHIRLPOOL	97004	12.00	1200		
10/30/72	DO	SUPPLIES AND MATERIAL	99070	2.00	200		

* PLACE OF SERVICE
DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	14.00	1400		
LESS				
UNPAID BALANCE				

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE Phyllis Mayr DATE 11-8-74

REMARKS: AUTH ABOVE
Care not confirm
33-6-156-380
Disability

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15 PROVIDER REF. 2-925599-1

NO. 96708A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: 72-262-41-462		NAME OF PROVIDER: Dr. Glen Straatsma	
NAME OF PATIENT: Wagar, Robert J.	RACE		
DATE OF BIRTH: 11/22/13 SEX: M [XX] F [ ]	ELIG. CODE: APD	PROVIDER I.D. NO.: GWS 318	CATEGORY
CASE NO.: 71547-79	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
DISEASES OF ESOPHAGUS, STOMACH AND DUODENUM	530
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES [ ] NO [ ]

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
09/14/72	DO	LIMITED EET-EST	90050	16.00	1600		

* PLACE OF SERVICE
DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	16.00	1600		
LESS				
UNPAID BALANCE				

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE R. Mayr DATE 11-8-74

REMARKS: 33-6-150-380

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06

15 PROVIDER REF. 2-886058-2

NO. 96651 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER: 72-262-41-461		NAME OF PROVIDER: Dr. Charles W. Townsend
NAME OF PATIENT: Thomas, Lottie	RACE	
DATE OF BIRTH: 04/16/26 SEX: M ☐ F XX	ELIG. CODE: APD	PROVIDER I.D. NO.: CWT 308 — CATEGORY
CASE NO.: 42407	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
MALIGNANT HYPERTENSION	400
INFLUENZA, UNQUALIFIED	470
ACUTE ARTHRITIS DUE TO PYOGENIC ORGANISMS	710
DISEASES OF ESOPHAGUS	530
	SECONDARY
CONGENITAL DISORDERS OF AMINO-ACID METABOLISM	270

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☐ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
09/25/72	DO	CREATININE, BLOOD	82565	8.60	860
09/25/72	DO	LATEX, FIX, RHEUMATOIC FACT	86360	8.60	860
09/25/72	DO	BLOOD COUNT, COMPLETE	85010	10.30	1030
09/25/72	DO	T-3 OR T-4 UPTAKE	83440	8.60	860
09/25/72	DO	SEDIMENTATION RATE	85650	6.00	600
09/25/72	DO	LDH	83615	8.60	860
09/25/72	DO	UREA NITROGEN, BLOOD	84520	9.50	950
09/25/72	DO	BRIEF ET-EST	90040	12.00	1200
09/25/72	DO	URINALYSIS, ROUTINE, COMPLE	81000	5.20	520
09/25/72	DO	URIC ACID, BLOOD, CHEMICAL	84550	8.60	860

* PLACE OF SERVICE

DO DOCTOR'S OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE

LESS

UNPAID BALANCE

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE: P. Mauk DATE: 11-8-74

REMARKS:

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DEPARTMENT OF HEALTH & SOCIAL SERVICES

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06

15 PROVIDER REF. 2-183125

NO. 96717 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER: Dr. Raymond D. Evans
NAME OF PATIENT: Corey, Richard A.	RACE	
DATE OF BIRTH: 05/04/52 SEX: M [XX] F [ ]	ELIG. CODE: APD	PROVIDER I.D. NO.: RDE 3.9 CATEGORY:
CASE NO.: 77934	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
GASTRITIS AND DUODENITIS	535
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☐ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
03/01/73	DO	BRIEF ET-EST	90040	12.00	1200		

* PLACE OF SERVICE

DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	12.00	1200		
LESS				
UNPAID BALANCE				

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE: D. Mayr DATE: 11/1/74

REMARKS:

2/73- Coupon # 41-0 12776 X

33-6-150-380

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15 PROVIDER REF. 2-676145

06

NO. 96683 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: 72-336-41-984		NAME OF PROVIDER: Dr. Raymond D. Evans	
NAME OF PATIENT: Olson, Janet R.	RACE		
DATE OF BIRTH: 02/05/51 SEX: M ☐ F XX	ELIG. CODE: GDM	PROVIDER I.D. NO.: RDE 319	CATEGORY
CASE NO.: 59988	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
OTHER DISEASES OF LIVER	573
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☐ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
11/21/72	DO	BILIRUBIN, BLOOD, TOTAL	82250	10.30	1030		
11/21/72	DO	SGOT, COLORIMETRIC OR FLUO	84455	8.60	855		
11/21/72	DO	BRIEF ER-EST	90040	12.00	1200		

* PLACE OF SERVICE

DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	30.90	3085		
LESS				
UNPAID BALANCE				

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE Phyllis Mayer DATE 11-8-74

REMARKS:

~~Can not confirm~~
~~eligibility~~
33-6-350-388

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15 PROVIDER REF. 2-623090-3

06

NO. 96693 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER	
NAME OF PATIENT: Mitchell, Nicholas	RACE: Juven.	Dr. James H. Jordon	
DATE OF BIRTH: 10-10-71 M XX F	ELIG. CODE: Ote 6PM	PROVIDER I.D. NO.: HJJ 467	CATEGORY
CASE NO.: 52700	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
OTHER AND UNSPECIFIED LACERATION OF HEAD	873
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☐ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
07/21/73	DO	SURGERY	12120	37.60	2240		

* PLACE OF SERVICE

DO DOCTORS OFFICE
IL INDEPENDENT LAB.
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	37.60	2240		
LESS				
UNPAID BALANCE				

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE P. Mayo DATE 11/1/74

REMARKS: 336-350-380

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15 PROVIDER REF. 2-995250-1

06

NO. 96696 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: See attached		NAME OF PROVIDER: Dr. Charles W. Townsend	
NAME OF PATIENT: Zdanovec, Richard G.	RACE		
DATE OF BIRTH / SEX: M XX F	ELIG. CODE	PROVIDER I.D. NO.: CWT 308	CATEGORY
CASE NO.	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST: BUNION	PRIMARY: 730
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES ☐ NO ☐

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
02/21/72	IH	SURGERY	27332	158.00	
02/21/72	IH	DISCOUNT	1005	7.90-	

* PLACE OF SERVICE

DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	150.10			
LESS				
UNPAID BALANCE				

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE: P. Mayr DATE: 11-8-74

REMARKS: 33-6-350-380

RESUBMITTAL INDICATOR | MEDICAL REVIEW

06-7014

CENTRAL OFFICE COPY

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

15 PROVIDER REF. 2-995250-1

06

NO. 96697 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER: see attached		NAME OF PROVIDER: Dr. Edwin Lindig
NAME OF PATIENT: Zdanovec, Richard G.	RACE	
DATE OF BIRTH / SEX: M [X] F [ ]	ELIG. CODE	PROVIDER I.D. NO.: ELM 831 / CATEGORY
CASE NO.	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST	PRIMARY
BUNION	730
SPRAINS AND STRAINS OF SHOULDER AND UPPER ARM	840
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES [ ] NO [ ]

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
02/21/72	DO	EKG	93000	30.00			
02/21/72	DO	DISCOUNT	01005	2.70-			
02/21/72	DO	DISCOUNT	01005	31.50-			
02/21/72	IH	SURGERY	27332	630.00			
02/21/72	DO	CHEST, 2 VIEWS	71020	24.00			
			TOTAL CHARGE	649.80			
			LESS				
			UNPAID BALANCE				

* PLACE OF SERVICE

DO DOCTORS OFFICE
IL INDEPENDENT LAB
PH PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

PROVIDER CERTIFICATION

"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. 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." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER SIGNATURE J. Mayo DATE 11-8-74

REMARKS: 33-6-350-380

RESUBMITTAL INDICATOR | MEDICAL REVIEW

06-7014

CENTRAL OFFICE COPY

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

15 PROVIDER REF. 2-995250-1

06

NO. 96711 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
COUPON OR AUTHORIZATION NUMBER: see attached		NAME OF PROVIDER: Dr. Edwin Lindig
NAME OF PATIENT: Zdanovec, Richard G.	RACE	
DATE OF BIRTH / SEX: M [X] F [ ]	ELIG. CODE	PROVIDER I.D. NO.: ELM 831 / CATEGORY
CASE NO.	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE): FMS 881

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST: SPRAINS AND STRAINS OF SHOULDER AND UPPER ARM	PRIMARY: 840
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES [ ] NO [ ]

COMMENTS:

SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF * SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
03/02/72	DO	PT-EXCERCISE & WHIRLPOOL	97050	13.00	
03/02/72	DO	BRIEF ET-EST	99040		
03/02/72	DO	DISCOUNT	01005	.75-	
03/02/72	DO	ACE BANDAGES	99071	2.00	
03/03/72	DO	DISCOUNT	01005	.65-	
03/03/72	DO	PT-EXCERCISE & WHIRLPOOL	97050	13.00	

* PLACE OF SERVICE

DO DOCTORS OFFICE
IL INDEPENDENT LAB
H PATIENTS HOME
IH INPATIENT HOSPITAL
OL OTHER LOCATION
NH NURSING HOME
ECF EXTENDED CARE FACILITY
OH OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL

TOTAL CHARGE	26.60
LESS	
UNPAID BALANCE	

PROVIDER CERTIFICATION

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PROVIDER SIGNATURE: J. Mauer DATE: 11-8-74

REMARKS: 33-6-350-380

RESUBMITTAL INDICATOR | MEDICAL REVIEW

06-7014

STATEMENT

HOME HEALTH CARE SERVICES
5700 1st Avenue South • Seattle, Wn. 98108 Phone:762-2156

DATE July 25, 1975

NAME John P. Friede
Dept. of Health & Social Services
Division of Family and Children

ADDRESS McKay Bldg.
Anchorage, Alaska
ADDRESS CHANGE REQUESTED

TOTAL AMOUNT DUE 129.25

PLEASE ENCLOSE STUB WITH REMITTANCE.

DATE OF SERVICE	EQUIPMENT RENTED	AMOUNT BILLED	AMOUNT PAID BY _____	BALANCE DUE
	Rental of Puritan Mask and regulator (4 months)	256.25		256.25
6/22/72	PAYMENT RECEIVED ON ACCOUNT STATE OF ALASKA		127.00	129.25
	33-6-410-370			

PLEASE REMIT LAST AMOUNT SHOWN IN THIS COLUMN

If you have any question regarding your statement, questions regarding equipment, or if your financial status changes, please contact this office immediately at 762-2156.

1% interest per month will be charged on all past due balances.

THANK YOU.

HOME HEALTH CARE SERVICE
5700 FIRST AVENUE SOUTH
SEATTLE, WASHINGTON 98108

75155

NAME AUNISKETTE, Alfred NO. 67
ADDRESS c/o Mr. Joe Cornell
CITY Route 1, Box 866
City
SPOUSE 1
FAMILY 2
3
4
5
6
PHONE NO.

NOTES	DATE	REFERENCE	CHARGES	CREDITS	BALANCE	PREVIOUS BALANCE PICKUP
		BALANCE FORWARDED				
7.0323	[illegible]	P SER E71	** 25.00			
	[illegible]	X-RAY E71	** 18.00		* 43.00	
	AUG 30	PAID E71		* * 43.00	* .00	
	SEP 1	P SER E71	** 40.00			
	[illegible]	X-RAY E71	** 37.50			
	[illegible]	X-RAY E71	** 27.00			
	[illegible]	X-RAY E71	** 13.00			
9-15-72 Lab Chgs	[illegible]	LAB E71	** 12.50			
Ltr to Pt	[illegible]	MS CHG E71	** 6.00		* 1,141.00	
1 OCT 5	SEP 18	LAB 71	** 20.00		* 161.00	
Dept Rules	[illegible]	MS CHG 71	** 10.00		* 171.00	
3. Not [illegible]						
[illegible] 0 (C7)						
[illegible] 5 1972						
[illegible] 7 1972						
[illegible] -6 1972						
[illegible]						
[illegible] Defenders						
[illegible] Department						
[illegible] Bobbie						
[illegible] Assistants						
[illegible] Diseases to						
[illegible] Physicians						
[illegible] Department						
[illegible] 1972						
[illegible] 1972	SEP 6 1972					
[illegible] Def. Parking						
Dept.						
9/15 Letter to Pauline						
Dept. of Corr.						
2nd [illegible]						

66-4-112-380

INS. CO. EMP. BY
COVERAGE ADDRESS
SOC. SEC. NO.

KETCHIKAN MEDICAL CLINIC
3612 TONGASS
KETCHIKAN, ALASKA 99901

PHONE
CREDIT BUREAU

TO: Fiscal Services
Dept of Health & Social Services
Div. of Correction
Pouch H
Juneau, Alaska 99801

FROM:

CREDIT BUREAU OF KETCHIKAN, INC.
320 BAWDEN #311 • KETCHIKAN, ALASKA 99901

SUBJECT:

DATE: May 6, 1975

MESSAGE

Dear Sirs,

Per instructions from the State Jail here in Ketchikan, we are sending this billing to your office to see if we can't obtain payment. Apprantely this patient is under state care and will be for a long time; and was at the time this doctor account was incurred. We have had several conversations with Mr. Andrews, at the state jail here; and he states that a voucher was sent into Juneau for payment of this account; but to date neither our client our ourselves have received payment.

We would appreciate any help you could furnish us in this matter.

Thank you.

SIGNED

REPLY

C. McMurchie, Collection Dept.

66-4-112-380

SIGNED DATE

THIS COPY FOR PERSON ADDRESSED

WHITE: State file
CANARY: State Suspense
PINK: Provider's Copy

Send white & canary copies for payment.

15 Provider Ref

06 P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

No 111698 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number: Crippled Children's Services		Name of Provider: Susan Clark, Visual Therapist	
Name of Patient: Lombard, Patrick	Race: W		
Date of Birth: 08 / 22 / 71 Sex: M [X] F [ ]	Bldg. Code: 30P	Provider ID No.: SUC 242	Category: 14
Case No.: 672-3210	Resource: X	Payee ID No. (if different from above): ATC 964	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First: Blindness	Primary: 379
	Secondary:

Have all other payment sources been exhausted? [X] Yes [ ] No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01388	Dr Manwiller

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
06/28/73	OL	Visual Therapy	92065	10.00	1080
07/05/73	OL	Visual Therapy	92065	12.50	1090
07/12/73	OL	Visual Therapy	92065	12.50	1090
07/19/73	OL	Visual Therapy	92065	12.50	1090
07/26/73	OL	Visual Therapy	92065	12.50	1090
			Total Charge	60.00	5520
			Less		
			Unpaid Balance	60.00	5510

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
EC Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

PROVIDER CERTIFICATION

"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. 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."

To the best of my knowledge no other resource exists.

Signature: Rita Abrajalon Date: 10-05-73

Remarks:

Resubmittal Indicator:

Medical Review:

Revised 6/1/73 06 7014

State File | Send White & canary copies for payment.
State Suspense
Provider's Copy

15 Provider Ref LOMBARD

06 D

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

No 111900 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization number: Crippled Children Services		Name of Provider: Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504
Name of Patient: Lombard, Patrick	Race: W	
Date of Birth: 08 / 22 / 71 Sex: M [X] F [ ]	Elig. Code: 30P	Provider ID No.: SUC 242 — Category: 14
Case No.: 682-780	Resource: X	Payee ID No. (if different from above): ATC 964

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First Blindness	Primary: 379 Secondary:

Have all other payment sources been exhausted? [X] Yes [ ] No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01388	Dr Manwiller

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
09/05/73	OL	Visual Therapy	92065	12.50	
09/10/73	OL	Visual Therapy	92065	12.50	
09/12/73	OL	Visual Therapy	92065	12.50	
09/14/73	OL	Visual Therapy	92065	12.50	
09/17/73	OL	Visual Therapy	92065	12.50	
			Total Charge	62.50	
			Less		
			Unpaid Balance	62.50	5450

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature: Play Rogers JA Date: 11-5-73

Remarks:

Resubmittal Indicator | Medical Review

Revised 6/1/73 OB 7014

WHITE: State File
CANARY: State Suspense
PINK: Provider's Copy

Send white & canary copies for payment.

15 Provider Ref.

KK

06 P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

d161223

A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number: Crippled Children Services		Name of Provider: Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504	
Name of Patient: Lombard, Patrick	Race: W		
Date of Birth: 08 / 22 / 71 Sex: M [XX] F [ ]	Elig. Code: 30P	Provider ID No.: SUC 242	Category: 14
Case No.: 42-320	Resource:	Payee ID No. (if different from above): ATC 964	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First Blindness	Primary: 379
	Secondary:

Have all other payment sources been exhausted? [XX] Yes [ ] No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01388	Dr Manwiller

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
10-17-73	OL	Group Visual Therapy	92080	9.00	900
10-19-73	OL	Visual Therapy	92080	12.50	1250
10-22-73	OL	Group Visual Therapy	92080	9.00	900
10-24-73	OL	Group Visual Therapy	92080	9.00	900
10-26-73	OL	Visual Therapy	92080	12.50	1250

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	52.00	
Less		
Unpaid Balance	52.00	5200

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature J. Allen Date 1-4-74

Remarks:

Resubmittal Indicator

Medical Review

Revised 6/1/73 06 7014

WHITE: State File
CANARY: State Suspense
PINK: Provider's Copy

Send white & canary copies for payment.

15 Provider Ref. RR

06 P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

4161229 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number: Crippled Children Services		Name of Provider: Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504	
Name of Patient: Lombard, Patrick	Race: W		
Date of Birth: 08 / 22 / 71 Sex: M [XX] F [ ]	Elig. Code: 30P	Provider ID No.: SUC 242	Category: 14
Case No.: [illegible]	Resource: X	Payee ID No. (if different from above): ATC 964	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First: Blindness	Primary: 379
	Secondary:

Have all other payment sources been exhausted? [XX] Yes [ ] No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01388	Dr Manwiller

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
10-29-73	OL	Group Visual Therapy	92080	9.00	
10-31-73	OL	Group Visual Therapy	92080	9.00	

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

17 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	18.00
Less	
Unpaid Balance	18.00

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature: J. Allen Date: 1-4-74

Remarks:

Resubmittal Indicator | Medical Review

Revised 6/1/73 06 7014

WHITE: State File
CANARY: State Suspense
PINK: Provider's Copy

Send white & canary copies for payment.

15 Provider Ref. RR

06

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

4161342 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization Number: Crippled Children Services		Name of Provider: Alaska Treatment Center, 3710 E 20th Avenue, Anch Ak 99504
Name of Patient: Lombard, Patrick	Race: W	
Date of Birth: 8 / 22 / 71 Sex: M ☐ F ☐	Elig. Code: 30P	Provider ID No.: SUC 242 Category: 14
Case No.: 671-380	Resource: X	Payee ID No. (if different from above): ATC 964

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First: Blindness	Primary: 379
	Secondary:

Have all other payment sources been exhausted? XXXYes ☐ No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01388	Dr Manwiller

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
Nov 28 73	OL	Group Visual Therapy	92080	9.00	
Nov 30 73	OL	Visual Therapy	92080	12.50	
Dec 3 73	OL	Group Visual Therapy	92080	9.00	
Dec 5 73	OL	Group Visual Therapy	92080	9.00	
Dec 12 73	OL	Group Visual Therapy	92080	9.00	
			Total Charge	48.50	
			Less		
			Unpaid Balance	48.50	

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature: [signature] Date: 2-1-74

Remarks:

Resubmittal Indicator | Medical Review

Revised 6/1/73 06 7014

WHITE: State File
CANARY: State Suspense
PINK: Provider's Copy
Send white & canary copies for payment.

KK

15 Provider Ref.

06 P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

161343 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number Crippled Children Services		Name of Provider Akaka Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504	
Name of Patient Lombard, Patrick	Race W		
Date of Birth 8 / 22 / 71 Sex M XX F ☐	Elig. Code 20P	Provider ID No. SUC 242	Category 14
Case No. 62-320	Resource X	Payee ID No. (if different from above) ATC 2964	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First BLINDNESS	Primary 379
	Secondary

Have all other payment sources been exhausted? XX Yes ☐ No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01388	Dr Manwiller

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
Dec 17 73	OL	Group Visual Therapy	92080	9.00	
Dec 19 73	OL	Group Visual Therapy	92080	9.00	

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
N. Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	18.00	
Less		
Unpaid Balance	18.00	

PROVIDER CERTIFICATION

"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. 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."

To the best of my knowledge no other resource exists.

Signature J Adlon Date 2-1-74

Remarks:

Resubmittal Indicator

Medical Review

Revised 6/1/73 06 7014

WHITE: State File
CANARY: State Suspense
PINK: Provider's Copy

Send white & canary copies for payment.

15 Provider Ref.

KK

06 P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice 161353

A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization Number: Crippled Children Services		Name of Provider: Alaska S Treatment Center, 3710 E 20th Avenue, Anch Ak 99504
Name of Patient: Lombard, Patrick	Race: W	
Date of Birth: 8 / 22 / 71 Sex: M [xx] F [ ]	Elig. Code: 30P	Provider ID No.: SUC 242 / Category: 14
Case No.: 622-280	Resource: X	Payee ID No. (if different from above): ATC 964

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First: Blindness	Primary: 379
	Secondary:

Have all other payment sources been exhausted? [xx] Yes [ ] No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01388	Dr Manwiller

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
LL-02-73	OL	Visual Therapy	92080	12.50	
11-05-73	OL	Group Visual Therapy	92080	9.00	
11-09-73	OL	Visual Therapy	92080	12.50	
11-21-73	OL	Group Visual Therapy	92080	9.00	

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	43.00	
Less		
Unpaid Balance	43.00	

PROVIDER CERTIFICATION

"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. 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."

To the best of my knowledge no other resource exists.

Signature: J Allen Date: 1-21-74

Remarks:

Resubmittal Indicator | Medical Review

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15 Provider Ref.

RR

06 P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

4161479 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number: Crippled Children Services		Name of Provider: Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504	
Name of Patient: Lombard, Patrick	Race: W		
Date of Birth: 08 / 22 / 71 Sex: M [XX] F [ ]	Elig. Code: 30P	Provider ID No.: SUC 242	Category: 14
Case No.: 1,52-370	Resource: X	Payee ID No. (if different from above): ATC 964	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First: Blindness	Primary: 379
	Secondary:

Have all other payment sources been exhausted? [XX] Yes [ ] No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01388	Dr Manwiller

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
09-24-73	OL	Visual Therapy	92080	12.50	
09-26-73	OL	Visual Therapy	92080	12.50	
10-01-73	OL	Visual Therapy	92080	12.50	
10-03-73	OL	Visual Therapy	92080	12.50	
10-05-73	OL	Visual Therapy	92080	12.50	

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	62.50	
Less		
Unpaid Balance	62.50	5/4/73

PROVIDER CERTIFICATION

"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. 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."

To the best of my knowledge no other resource exists.

Signature: Phyllis Rogers Jr. Date: 11-24-73

Remarks:

Resubmittal Indicator | Medical Review

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15 Provider Ref.

06 P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

4161480 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization Number: Crippled Children Services		Name of Provider: Alaska Treatment Center, 3710 E 20th Avenue, Anch Ak 99504
Name of Patient: Lombard, Patrick	Race: W	
Date of Birth: 08 / 22 / 71 Sex: M [XX] F [ ]	Elig. Code: 30P	Provider ID No.: SUC 242 — Category: 14
Case No.: 672-3870	Resource: X	Payee ID No. (if different from above): ATC 964

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First: Blindness	Primary: 379
	Secondary:

Have all other payment sources been exhausted? [XX] Yes [ ] No

Comments:

Service Preauthorization No. (if applicable): 01388

Referring or Consulting Physician: Dr Manwiller

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
10-08-73	OL	Group Visual Therapy	92080	9.00	
10-10-73	OL	Group Visual Therapy	92080	9.00	

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	18.00	
Less		
Unpaid Balance	18.00	1900

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature: Phil Riggs Jr Date: 11-20-73

Remarks:

Resubmittal Indicator | Medical Review

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15 Provider Ref. LOMBARD

06 P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

161627 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number: Crippled Children Services		Name of Provider: Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504	
Name of Patient: Lombard, Patrick	Race: W		
Date of Birth: 08 / 22 / 71 Sex: M [X] F [ ]	Elig. Code: 30P	Provider ID No.: SUC 242	Category: 14
Case No.: 192-370	Resource: X	Payee ID No. (if different from above): ATC 964	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First Blindness	Primary: 379
	Secondary:

Have all other payment sources been exhausted? [X] Yes [ ] No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01388	Dr Manwiller

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
09/19/73	OL	Visual Therapy	92065	12.50	1090
09/21/73	OL	Visual Therapy	92065	12.50	1090

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
EOF Extended Care Fac.
OH Outpatient Hosp.

17 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	25.00	2180
Less		
Unpaid Balance	25.00	2180

PROVIDER CERTIFICATION

"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. 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."

To the best of my knowledge no other resource exists.

Signature: Ploy Rogers Jr Ploy Rogers Sr Date: 11-5-73

Remarks:

Resubmittal Indicator | Medical Review

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15 Provider Ref.

06 P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

161209 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization Number: Crippled Children Services		Name of Provider: Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504
Name of Patient: Evans, Margaret (Missy)	Race: W	
Date of Birth: 02/19/69 Sex: M ☐ F ☒	Elig. Code: 30P	Provider ID No.: SMM 560 Category: 14
Case No.: 126-321	Resource: EC	Payee ID No. (if different from above): ATC 964

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (cpt.)
List Primary Diagnosis First Cerebral Palsy	Primary: 343 Secondary:

Have all other payment sources been exhausted? ☒ Yes ☐ No

Comments:

Service Preauthorization No. (if applicable): 01867

Referring or Consulting Physician: Dr Brown

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
10-16-73	OL	Physical Therapy	97100	14.40	Paid
10-18-73	OL	Group Hydro Conditioning	97240	3.00	300
10-18-73	OL	Physical Therapy 1 HR	97100	28.80	2880
10-23-73	OL	Physical Therapy 1 HR	97100	28.80	2880
10-25-73	OL	Physical Therapy 1 HR	97100	28.80	2880

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
N. Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	103.80	10260
Less		
Unpaid Balance	103.80	10260

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature: [signature] Date: 1-4-74

Remarks:

Resubmittal Indicator: | Medical Review:

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15 Provider Ref. 161211

06 P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization Number: Crippled Children Services		Name of Provider: Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504
Name of Patient: Evans, Margaret (Missy)	Race: W	
Date of Birth: 02 / 19 / 69 Sex: M ☐ F ☒	Elig. Code: 30P	Provider ID No.: SMM 560 — Category: 14
Case No.: 676-320	Resource: C	Payee ID No. (if different from above): ATC 964

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First: Cerebral Palsy	Primary: 343
	Secondary:

Have all other payment sources been exhausted? ☒ Yes ☐ No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01867	Dr Brown

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
10-30-73	OI	Physical Therapy	97100	14.40	

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	14.40	
Less		
Unpaid Balance	14.40	14.40

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature: J Allen Date: 1-4-74

Remarks:

Resubmittal Indicator		Medical Review	

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15 Provider Ref.

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ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

161275 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization Number Crippled Children Services		Name of Provider Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504
Name of Patient Evans, Margaret (Missy)	Race W	
Date of Birth 2 / 19 / 69 Sex M☐ F☒	Elig. Code 30P	Provider ID No. SMM 560 — Category 14
Case No. 686-327	Resource C	Payee ID No. (if different from above) ATC 964

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First Cerebral Palsy	Primary 343 Secondary

Have all other payment sources been exhausted? ☒Yes ☐ No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01867	Dr Brown

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
Nov 29 73	OL	Physical Therapy 1 HR	97100	28.80	2440
Dec 4 73	OL	Physical Therapy 1 HR	97100	28.80	2440
Dec 6 73	OL	Physical Therapy 1 HR	97100	28.80	2440
Dec 6 73	OL	Pool Therapy	97240	3.00	300
Dec 13 73	OL	Physical Therapy 1 HR	97100	28.80	2440

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OP Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	118.20	1660
Less		
Unpaid Balance	118.20	1660

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature J Allen Date 2-1-74

Remarks:

Resubmittal Indicator | Medical Review

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15 Provider Ref.

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ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

161276 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization Number Crippled Children Services		Name of Provider Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504
Name of Patient Evans, Margaret (Missy)	Race W	
Date of Birth 2 / 19 / 69 Sex M ☐ F ☒	Elig. Code 30P	Provider ID No. SMM 560 — Category 14
Case No. [illegible]	Resource	Payee ID No. (if different from above) ATC 964

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First Cerebral Palsy	Primary 343 Secondary

Have all other payment sources been exhausted? ☒ Yes ☐ No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	018678	Dr Brown

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
Dec 18 73	OI	Physical Therapy 1 HR	97100	28.80	[illegible]

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OI Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	28.80	
Less		
Unpaid Balance	28.80	[illegible]

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature [signature] Date 2-1-74

Remarks:

Resubmittal Indicator

Medical Review

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15 Provider Ref. 161360

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ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number Crippled Children Services		Name of Provider Alaska Treatment Cetner 3710 E 20th Avenue Anch Ak 99504	
Name of Patient Evans, Margaret (Missy)	Race W		
Date of Birth 2 / 19 / 609 Sex M☐ F☒	Elig. Code 30P	Provider ID No. SMM 560	Category 14
Case No. 476-3750	Resource C ☐	Payee ID No. (if different from above) ATC 964	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First Cerebral Pasly	Primary 343
	Secondary

Have all other payment sources been exhausted? Yes ☐ No ☐	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01867	Dr Brown

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
11-01-73	OL	Group Hydro Conditioning Therapy	97240	3.00	
11-01-73	OL	Physical Therapy	97100	14.40	
11-02-73	OL	Physical Therapy	97100	14.40	
11-06-73	OL	Physical Therapy 1 HR	97100	28.80	
11-08-73	OL	Group Hydro Conditioning Therapy	97240	3.00	

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	63.60	
Less		
Unpaid Balance	63.60	

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature [signature] Date 12-4-74

Remarks:

Resubmittal Indicator ☐ Medical Review ☐

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ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

161361 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization Number Crippled Children Services		Name of Provider Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504
Name of Patient Evans, Margaret (Missy)	Race W	
Date of Birth 2 / 19 / 69 Sex M ☐ F ☒	Elig. Code 30P	Provider ID No. SMM 560 — Category 1A
Case No. [illegible]	Resource 0 X	Payee ID No. (if different from above) ATC 964

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First Cerebral Palsy	Primary 343
	Secondary

Have all other payment sources been exhausted? ☒ Yes ☐ No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01867	Dr Brown

SERVICES RENDERED

31

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
11-13-73	OL	Physical Therapy	97100	14.40	

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

32 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	14.40	
Less		
Unpaid Balance	14.40	[illegible]

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature J Allen Date 1-21-74

Remarks:

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15 Provider Ref.

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ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

4161462 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization Number: Crippled Children Services		Name of Provider: Alaska Treatment Center, 3710 E 20th Avenue, Anch Ak 99504
Name of Patient: Evans, Margaret (Missy)	Race: W	
Date of Birth: 02 / 19 / 609 Sex: M ☐ F ☒	Elig. Code: 30P	Provider ID No.: SMM 560 — Category: 14
Case No.: [illegible]	Resource: 3C	Payee ID No. (if different from above): ATC 964

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First: Cerebral Palsy	Primary: 343
	Secondary:

Have all other payment sources been exhausted? ☒ Yes ☐ No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01867	Dr Brown

SERVICES RENDERED

31

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
09-27-73	OL	Group Hydro Conditioning	97240	3.00	
09-27-73	OL	Physical Therapy	97100	14.40	
10-04-73	OL	Physical Therapy	97100	28.80	43.20
10-04-73	OL	Group Hydro Conditioning	97240	3.00	
10-11-73	OL	Group Hydro Conditioning	97240	3.00	

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

32 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	52.20	
Less		
Unpaid Balance	52.20	43.20

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature [signature] Date 11-30-73

Remarks:

Resubmittal Indicator | Medical Review

Revised 6/1/73 06 7014

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CANARY: State Suspense
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15 Provider Ref. MME

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ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

4161696 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization Number: Crippled Children Services		Name of Provider: Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504
Name of Patient: Evans, Margaret (Missy)	Race: W	
Date of Birth: 02 / 19 / 69 Sex: M ☐ F ☒	Elig. Code: 30P	Provider ID No.: * Category: 14
Case No.: [illegible]	Resource: X	Payee ID No. (if different from above): ATC 964

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First cerebral palsy	Primary: 343 Secondary:

Have all other payment sources been exhausted? ☒ Yes ☐ No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01867	Dr Brown

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
12-27-73	OL	Physical Therapy	97100	28.80	
01-08-74	OL	Physical Therapy	97100	28.80	
01-10-74	OL	Physical Therapy	97100	28.80	
01-15-74	OL	Physical Therapy	97100	28.80	
01-17-74	OL	Physical Therapy	97100	28.80	

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OF Other Location
Nh Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	144.00
Less	[illegible]
Unpaid Balance	144.00

PROVIDER CERTIFICATION

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To the best of my knowledge no other resource exists.

Signature [signature] Date 3-19-74

Remarks:

*Number has been requested

Resubmittal Indicator

Medical Review

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15 Provider Ref. MME

06 | 9

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital · Practitioner · Home Health Agency Invoice

4161697 A

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization Number: Crippled Children Services		Name of Provider: Alaska Treatment Center, 3710 E 20th Avenue, Anch Ak 99504
Name of Patient: Evans, Margaret (Missy)	Race: W	
Date of Birth: 02 / 19 / 69 Sex: M ☐ XXXX	Elig. Code: 30P	Provider ID No.: * Category: 74
Case No.: 676-380	Resource: X	Payee ID No. (if different from above): ATC 964

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	Diagnosis Code (opt.)
List Primary Diagnosis First: cerebral palsy	Primary: 343
	Secondary:

Have all other payment sources been exhausted? ☒ Yes ☐ No	Service Preauthorization No. (if applicable)	Referring or Consulting Physician
Comments:	01895 67	Dr Brown

SERVICES RENDERED

11

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
01-22-74	OL	Physical Therapy	97100	28.80	28.80
01-24-74	OL	Physical Therapy	97100	14.40	14.40
01-29-74	OL	Physical Therapy	97100	14.40	14.40
01-31-74	OL	Physical Therapy	97100	28.80	28.80

*Place of Service
DO Doctor's Office
IL Independent Lab
H Patient's Home
IH Inpatient Hospital
OL Other Location
NH Nursing Home
ECF Extended Care Fac.
OH Outpatient Hosp.

12 Coordination of Other Benefits

M/Care Pd.	Other Paid	Total

M/Care CoIn	M/Care Ded.	Total

Total Charge	86.40	86.40
Less		
Unpaid Balance	86.40	86.40

PROVIDER CERTIFICATION

"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. 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."

To the best of my knowledge no other resource exists.

Signature [signature] Date 3-19-74

Remarks: *Number has been requested

Resubmittal Indicator | Medical Review

Revised 6/1/73 06 701"

Rec. coupon Aug. 75

Cascade

CENTRAL OFFICE

06

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

15 PROVIDER REF.

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 195558

10 PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER: 660794		NAME OF PROVIDER: SPENCER P. FALCONMD	
NAME OF PATIENT: Michael Naumoff	RACE		
DATE OF BIRTH: 03/07/67 SEX: M ☒ F ☐	ELIG. CODE	PROVIDER ID. NO.: SPS-4734	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above)	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES	DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST: Shigella	PRIMARY
	SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? ☒ YES ☐ NO	SERVICE PRE-AUTHORIZATION NO. (if applicable)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:		

SERVICES RENDERED

11

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
2/16/1973	DO	Office Care	90000	10.00	1000	1	
✓	✓	Injection (Ampicillin)	90030	5.00	500	1	
✓	✓	White Blood Cell Count	85030	7.50	400	6	

*PLACE OF SERVICE
DOCTOR'S OFFICE
INDEPENDENT LAB
PATIENT'S HOME
INPATIENT HOSPITAL
OTHER LOCATIONS
NURSING HOME
EXTENDED CARE FACILITY
OUTPATIENT HOSPITAL

12 COORDINATION OF OTHER BENEFITS

MEDICARE PAID	OTHER INS.	TOTAL

MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL

TOTAL CHARGE	22.50			
LESS				
UNPAID BALANCE	22.50	1900		

PROVIDER CERTIFICATION

THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. 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."

REMARKS:

Introduced: 1/19/76
Referred: Finance

IN THE SENATE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

SENATE BILL NO. 530

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Health and Social Services and the Department of Commerce and Economic Development for vendor claims; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. The sum of $5,669.32 is appropriated from the general fund to the Department of Health and Social Services and the Department of Commerce and Economic Development, for the purpose of paying miscellaneous vendor claims, to be allocated as follows:

Department of Health and Social Services	$5,638.24
Department of Commerce and Economic Development	31.08
	$5,669.32

* Sec. 2. This Act takes effect immediately in accordance with AS 01.-10.070(c).

Return this amend. to Fairbanks (Fin. 415)
SB 530

JAN 16 1976

The Honorable Chancy Croft
President of the Senate
Alaska State Legislature
Juneau, Alaska 99811

Dear Mr. President:

In accordance with AS 24.30.060(b) and the Uniform Rules of the Alaska State Legislature, I am transmitting a bill making a special appropriation to the Department of Health and Social Services and the Department of Commerce and Economic Devlelopment for miscellaneous vendor claims.

Sincerely,

Jay S. Hammond
Governor

MISCELLANEOUS CLAIMS
FOR
LEGLISLATIVE APPROVAL
FOR
FISCAL YEAR 1975

SB 550

ubmitted November 17, 1975

IVISION	INVOICE #	DATE OF SERVICE	AMOUNT	DATE RECEIVED	CODE	REASON FOR DELAY
Social Svcs.						
Wien Airlines	0042-4675	10-31-~~75~~ 72	488.25	7-17-75	06-21-3-409-350	Invoice not recvd.
					06-21-3-509-350	" " "
					06-21-3-618-350	" " "
Anchorage Times	Neakok Children	06-24-~~75~~ 71	67.20	6-09-75	06-21-3-212-325	" " "
Public Health						
ATZ Travel	STR 331895	08-27-73	154.55	10-27-75	06-31-1-870-211	" " "
RCA	A8037	10-10-73	45.15	11-07-75	06-31-1-036-311	" " "
RCA	A8037	11-11-73	37.20	11-07-75	06-31-1-036-311	" " "
Public Assistance						
ATZ Travel	STR 339313	08-27-~~75~~ 73	40.64	10-27-75	06-33-6-180-215	" " "
TOTAL General Bills (held in fiscal)			832.99			
TOTAL Medical Bills (detail attached)			4,805.25			
TOTAL Department of Health & Social Svcs.			5,638.24			

RECEIVED
NOV 20 1975
Administrative Services
Comptroller's Office

LEGISLATIVE BILLINGS FOR YEAR 1975-76

Submitted November 17, 1975

DIVISION	INVOICE #	DATE OF SERVICE	AMOUNT	DATE RECEIVED	CODE	DELAY REASON
Public Health						
Alaska Clinic	61184	07/13/73	12.30	07/15/75	06-31-1-761-380	Invoice not rcv
Alaska Clinic	182628	11/20/72	25.42	03/06/75	06-31-1-694-380	" " "
Alaska Clinic	182631	12/06/72	46.33	03/06/75	06-31-1-694-380	" " "
Richard L Day DDS	210982	7/71-10/72	140.00	04/17/75	06-31-1-694-380	" " "
Medical Assistance						
Fairbanks Mem Hosp	535486	02/02/73	82.00	06/12/75	06-33-6-110-380	Invoice not rcv
Fairbanks Mem Hosp	507685	04/13/71	60.00	01/30/75	06-33-6-310-380	" " "
Providence Hosp	527378	12/28/72	19.20	04/12/75	06-33-6-120-380	" " "
Providence Hosp	527379	12/26/72	19.20	04/12/75	06-33-6-120-380	" " "
Providence Hosp	527385	12/30/72	8.00	04/12/75	06-33-6-120-380	" " "
Providence Hosp	527432	11/10/72	20.40	06/12/75	06-33-6-120-380	" " "
Providence Hosp	527450	12/14/72	20.00	04/12/75	06-33-6-120-380	" " "
Alaska Clinic	74500	03/07/73	15.00	06/30/75	06-33-6-150-380	" " "
Alaska Clinic	74731	05/09/72	68.00	07/18/75	06-33-6-350-380	" " "
Alaska Clinic	74732	02/15/72	944.00	07/18/75	06-33-6-350-380	" " "
Alaska Clinic	74733	02/15/72	62.00	07/18/75	06-33-6-350-380	" " "
Alaska Clinic	74734	02/19/72	24.00	07/18/75	06-33-6-350-380	" " "
Fairbanks Med-Surg	96616	10/22/73	72.00	11/28/74	06-33-6-150-380	Eligibility & Au
Fairbanks Med-Surg	96637	01/21/73	136.70	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96652	09/25/72	264.30	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96655	11/18/72	48.50	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96682	01/26/73	20.00	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96690	07/24/73	543.80	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96701	10/30/72	14.00	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96708	09/14/72	16.00	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96717	03/01/73	12.00	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96683	11/21/72	30.85	11/28/74	06-33-6-350-380	" "
Fairbanks Med-Surg	96693	07/21/73	22.40	11/28/74	06-33-6-350-380	" "
Fairbanks Med-Surg	96696	02/21/72	150.10	11/28/74	06-33-6-350-380	" "
Fairbanks Med-Surg	96697	02/21/72	649.80	11/28/74	06-33-6-350-380	" "
Fairbanks Med-Surg	96711	03/02/72	26.60	11/28/74	06-33-6-350-380	" "
Home Health Care Svc	-	06/22/72	129.25	07/31/75	06-33-6-410-380	Invoice not rcv
Corrections						
Ketchikan Med Clinic	-	09/14/71	171.00	11/14/75	06-66-4-112-380	Invoice not r

(continued)

LEGISLATIVE BILLINGS FOR YEAR 1975-76

Submitted DIVISION	INVOICE #	DATE OF SERVICE	AMOUNT	DATE RCVD.	CODE	DELAY REASON
Public Health						
Alaska Treatment Ctr.	111698	06/28/73	53.60	11/19/75	06-31-1-682-380	Invoice not rcvd.
Alaska Treatment Ctr.	111900	09/05/73	54.50	11/19/75	06-31-1-682-380	" " "
Alaska Treatment Ctr.	161228	10/17/73	48.80	11/19/75	06-31-1-682-380	" " "
Alaska TReatment Ctr.	161229	10/29/73	18.00	11/19/75	06-31-1-682-380	" " "
Alaska Treatment Ctr.	161342	11/28/73	46.90	11/19/75	06-31-1-682-380	" " "
Alaska TReatment Ctr.	161343	12/17/73	18.00	11/19/75	06-31-1-682-380	" " "
Alaska TReatment Ctr.	161353	11/02/73	39.80	11/19/75	06-31-1-682-380	" " "
Alaska Treatment Ctr.	161479	09/24/73	54.50	11/19/75	06-31-1-682-380	" " "
Alaska Treatment Ctr.	161480	10/08/73	18.00	11/19/75	06-31-1-682-380	" " "
Alaska Treatment Ctr.	161627	09/19/73	21.80	11/19/75	06-31-1-682-380	" " "
Alaska Treatment Ctr.	161209	10/16/73	102.60	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161211	10/30/73	14.40	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161275	11/29/73	116.60	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161276	12/18/73	28.40	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161360	11/01/73	63.20	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161361	11/13/73	14.40	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161462	09/27/73	41.80	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161696	12/27/73	92.00	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161697	01/22/74	65.80	11/19/75	06-31-1-686-380	" " "
Medical Assistance						
Spencer Falcon, MD	195558	04/18/73	19.00	09/05/75	06-33-6-150-380	" " "
TOTAL			4,805.25			

SB530

MISCELLANEOUS CLAIMS FOR LEGLISLATIVE APPROVAL FOR FISCAL YEAR 1975

Submitted November 17, 1975

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RCA	A8037	11-11-73	37.20	11-07-75	06-31-1-036-311	" " "
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Providence Hosp	527378	12/28/72	19.20	04/12/75	06-33-6-120-380	" " "
Providence Hosp	527379	12/26/72	19.20	04/12/75	06-33-6-120-380	" " "
Providence Hosp	527385	12/30/72	8.00	04/12/75	06-33-6-120-380	" " "
Providence Hosp	527432	11/10/72	20.40	06/12/75	06-33-6-120-380	" " "
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Fairbanks Med-Surg	96652	09/25/72	264.30	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96655	11/18/72	48.50	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96682	01/26/73	20.00	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96690	07/24/73	543.80	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96701	10/30/72	14.00	11/28/74	06-33-6-150-380	" "
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Fairbanks Med-Surg	96717	03/01/73	12.00	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96683	11/21/72	30.85	11/28/74	06-33-6-350-380	" "
Fairbanks Med-Surg	96693	07/21/73	22.40	11/28/74	06-33-6-350-380	" "
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Corrections						
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(continued)

LEGISLATIVE BILLINGS FOR YEAR 1975-76

Submitted DIVISION	INVOICE #	DATE OF SERVICE	AMOUNT	DATE RCVD.	CODE	DELAY REASON
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Alaska Treatment Ctr.	111900	09/05/73	54.50	11/19/75	06-31-1-682-380	" " "
Alaska Treatment Ctr.	161228	10/17/73	48.80	11/19/75	06-31-1-682-380	" " "
Alaska TReatment Ctr.	161229	10/29/73	18.00	11/19/75	06-31-1-682-380	" " "
Alaska Treatment Ctr.	161342	11/28/73	46.90	11/19/75	06-31-1-682-380	" " "
Alaska TReatment Ctr.	161343	12/17/73	18.00	11/19/75	06-31-1-682-380	" " "
Alaska TReatment Ctr.	161353	11/02/73	39.80	11/19/75	06-31-1-682-380	" " "
Alaska Treatment Ctr.	161479	09/24/73	54.50	11/19/75	06-31-1-682-380	" " "
Alaska Treatment Ctr.	161480	10/08/73	18.00	11/19/75	06-31-1-682-380	" " "
Alaska Treatment Ctr.	161627	09/19/73	21.80	11/19/75	06-31-1-682-380	" " "
Alaska Treatment Ctr.	161209	10/16/73	102.60	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161211	10/30/73	14.40	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161275	11/29/73	116.60	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161276	12/18/73	28.40	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161360	11/01/73	63.20	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161361	11/13/73	14.40	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161462	09/27/73	41.80	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161696	12/27/73	92.00	11/19/75	06-31-1-686-380	" " "
Alaska Treatment Ctr.	161697	01/22/74	65.80	11/19/75	06-31-1-686-380	" " "
Medical Assistance						
Spencer Falcon, MD	195558	04/18/73	19.00	09/05/75	06-33-6-150-380	" " "
TOTAL			4,805.25			