

COMMITTEE REPORT

1/28/75

SENATE

Mr. President:

Date March 21, 1975

The Committee on FINANCE has had SB 70

special appropriation for payment of miscellaneous claims
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)
- recommends it BE REPLACED WITH CS FOR _____ AND THAT
CS FOR _____ DO PASS
- "and" recommends it BE REFERRED TO THE _____
COMMITTEE
- reports it back WITHOUT RECOMMENDATION
- "other"

Members signing the Majority report:

<u>[Signature]</u>	_____	_____
<u>[Signature]</u>	_____	_____
<u>[Signature]</u>	_____	_____
_____	_____	_____

Members NOT concurring in the Majority report:

_____ recommends:

_____ recommends:

_____ recommends:

_____ recommends:

_____ recommends:

[Signature] Chairman

A M E N D M E N T

Offered in the SENATE

By FINANCE

To: _____ SENATE BILL NO. 7

_____ HOUSE BILL NO. _____

AMENDMENT: Page 1 Line 22

Delete the figure "\$12,884.15", Insert the figure "\$12,975.57"

Page 1. Line 24

Delete the figure "\$45,310.65", Insert the figure "\$45,002.13"

18
January 28, 1975

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

Dear Mr. President:

Pursuant to the Uniform Rules of the Legislature, I am transmitting a bill making a special appropriation to the various departments of state government for payment of miscellaneous claims in the amount of \$45,910.06. The bill itself is self-explanatory as to the specific allocations to be made from the total appropriation.

Sincerely,

Jay S. Hammond
Governor

Introduced: 1/28/75
Referred: Finance

1 IN THE SENATE

BY THE RULES COMMITTEE BY
REQUEST OF THE GOVERNOR

2 SENATE BILL NO. 78

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 NINTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act making a special appropriation for the payment
7 of miscellaneous claims; and providing for an effective
8 date."

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

10 * Section 1. The sum of \$45,910.68 is appropriated from the general
11 fund for the fiscal year ending June 30, 1975 to be allocated as follows:

12 Department of Administration, final payment	
13 to beneficiaries and estates of deceased	
14 persons	\$2,712.37
15 Department of Administration, vendor claims	178.65
16 Department of Commerce, vendor claims	21.60
17 Department of Education, vendor claims	7,950.83
18 Department of Fish and Game, vendor claims	896.85
19 Department of Health and Social Services,	
20 vendor claims	9,302.51
21 Department of Law, assigned court costs	7,048.88
22 Department of Public Works, vendor claims	13,884.15
23 Department of Revenue, stale date warrants	<u>3,914.84</u>
24	\$45,910.68

25 * Sec. 2. This Act takes effect immediately in accordance with AS 01.-
26 10.070(c).

27

28

29

MEMORANDUM



TO: Richard Freer
Deputy Commissioner
Department of Administration

DATE : January

FROM: Edna Caldwell *ec*
State Payroll Supervisor
Department of Administration

SUBJECT: Request for special appropriation:

RE: Lance P. Deitelhoff
SS#391-40-8289
Terminated March 4, 1971
Date of Death March 5, 1971

Final salary has not been paid as Beneficiary was located in October 1973.
Amount needed to pay this unpaid Compensation is \$1,893.39.

RE: Mary E. Miles
SS#227-32-8925
Terminated March 24, 1972
Date of Death March 24, 1972

Final salary has not been paid as notice to release salary to the
Administrator of the estate was received in this office December 1973.
Amount needed to pay this unpaid Compensation is \$818.98.

STATE
of ALASKA

MEMORANDUM

#2

DEPARTMENT OF ADMINISTRATION

TO: M.R. Charney, Director
Division of Budget & Management
Department of Administration

DATE : January 30, 1974

FROM: Kellus N. Sewell *KNS*
Administrative Officer
Division of Administrative Services
Department of Administration

SUBJECT: Supplemental Claims Request

The Department of Administration has received copies of fifteen invoices from Capital Office Supply dated January through July 1971. We have been unable to find proof of previous payment; therefore, it is requested the total charge of \$178.65 be included in the Supplemental Claims Request to the Legislature in accordance with AS 37.25.010.

Copies of the invoices are attached.

KNS:MLH:cb
cc: William C. Mullin, Director
Division of Finance

Attachment

RECEIVED

JAN 30 1974

BUDGET & MANAGEMENT

PHONE: 586-2830

PHONE: 586-2830

OFFICE FURNITURE



MACHINE SERVICE

2032

Name: *Dept of Admin*
Address: *Data Processing*

Date: *3/26* 19 *71*
Customer's Order No.

I CERTIFY THAT THIS BILL IS CORRECT AND JUST, THAT PAYMENT THEREOF HAS NOT BEEN RECEIVED. CAPITAL OFFICE SUPPLY

Quantity	Description	Price	Amount
<i>1</i>	<i>... ..</i>	<i>27</i>	<i>5 00</i>
<i>1</i>	<i>... ..</i>		<i>3 00</i>
<i>6</i>	<i>... ..</i>	<i>80</i>	<i>4 80</i>
			<i>13 80</i>
			<i>12.49</i>

PHONE: 586-2830

PHONE: 586-2830

OFFICE FURNITURE



MACHINE SERVICE

3030

Name: *Dept of Admin*
Address: *...*

Date: *5/14* 19 *71*
Customer's Order No.

I CERTIFY THAT THIS BILL IS CORRECT AND JUST, THAT PAYMENT THEREOF HAS NOT BEEN RECEIVED. CAPITAL OFFICE SUPPLY

Quantity	Description	Price	Amount
<i>1</i>	<i>...</i>		<i>534</i>
<i>...</i>			<i>534</i>

OFFICE FURNITURE

Capital Office Supply

the "RED CARPET" store

MACHINE SERVICE

2389

Name

Dept of Admin. Services

Date

1-19-71

Address

Customer's Order No.

I CERTIFY THAT THIS BILL IS CORRECT AND JUST, THAT PAYMENT THEREFOR HAS NOT BEEN RECEIVED.
CAPITAL OFFICE SUPPLY

Quantity	Description	Price	Amount
<i>1</i>	<i>1000 Plate</i>		<i>10.00</i>
<i>1</i>	<i>1000 Plate</i>		<i>4.50</i>
<i>1</i>	<i>1000 Plate</i>		<i>1.00</i>
			<i>15.50</i>
			<i>1.50</i>
			<i>7.50</i>
			<i>14.36</i>

PHONE: 526-2630

OFFICE FURNITURE

Capital Office Supply

the "RED CARPET" store

MACHINE SERVICE

PHONE: 526-2630

2197

Name

Dept of Admin. Services

Date

1/15/71

Address

Customer's Order No.

I CERTIFY THAT THIS BILL IS CORRECT AND JUST, THAT PAYMENT THEREFOR HAS NOT BEEN RECEIVED.
CAPITAL OFFICE SUPPLY

Quantity	Description	Price	Amount
<i>12</i>	<i>1000 Plate</i>		<i>12.00</i>
<i>3</i>	<i>1000 Plate</i>		<i>3.30</i>
<i>1</i>	<i>1000 Plate</i>		<i>0.80</i>
			<i>16.10</i>
			<i>1003</i>

PHONE: 586-2830

PHONE: 586-2830

OFFICE FURNITURE

Capital Office Supply

MACHINE SERVICE

the "RED CARPET" store

Name

Alvin H. Huggell

Date

4/15

Address

Customer's Order No.

I CERTIFY THAT THIS BILL IS CORRECT AND JUST THAT PAYMENT THEREFOR HAS NOT BEEN RECEIVED.

CAPITAL OFFICE SUPPLY

Quantity	Description	Price	Amount
1	<i>2 1/2" x 13" ...</i>		<i>2.50</i>
10	<i>... 6</i>	<i>0.50</i>	<i>5.00</i>
1	<i>...</i>		<i>2.10</i>
1	<i>...</i>		<i>1.00</i>
2	<i>...</i>	<i>2.50</i>	<i>5.00</i>
5	<i>...</i>	<i>55</i>	<i>2.75</i>
			<i>24.75</i>
	<i>411400 2110.00</i>		<i>21.00</i>
			<i>21.00</i>

PHONE: 586-2830

PHONE: 586-2830

OFFICE FURNITURE

Capital Office Supply

MACHINE SERVICE

the "RED CARPET" store

Name

Dept. of Administration

Date

Apr 18

Address

Internal Order

Customer's Order No.

I CERTIFY THAT THIS BILL IS CORRECT AND JUST THAT PAYMENT THEREFOR HAS NOT BEEN RECEIVED.

CAPITAL OFFICE SUPPLY

Quantity	Description	Price	Amount
2	<i>Whisper ...</i>	<i>1.25</i>	<i>2.50</i>
	<i>...</i>	<i>1.25</i>	<i>3.00</i>
			<i>6.50</i>

PHONE: 566-2830

PHONE: 566-2830

OFFICE SUPPLIES

Capital Office Supply

MACHINE SERVICE

the "RED CARPET" store

Name *S. J. Williams*

Date *1/10* 19 *71*

Address _____

Customer's Order No. _____

I CERTIFY THAT THIS BILL IS CORRECT AND JUST, THAT PAYMENT THEREOF HAS NOT BEEN RECEIVED.

CAPITAL OFFICE SUPPLY

Quantity	Description	Price	Amount
10	<i>Yellow paper 11x14 100</i>	<i>135</i>	<i>13.50</i>
	<i>pen 10.</i>		
	<i>Finance</i>		
	<i>John</i>		
			<i>9.45</i>

PHONE: 566-2830

PHONE: 566-2830

OFFICE SUPPLIES

Capital Office Supply

MACHINE SERVICE

the "RED CARPET" store

Name *Administration*

Date *1/10* 19 *71*

Address _____

Customer's Order No. _____

I CERTIFY THAT THIS BILL IS CORRECT AND JUST, THAT PAYMENT THEREOF HAS NOT BEEN RECEIVED.

CAPITAL OFFICE SUPPLY

Quantity	Description	Price	Amount
1	<i>pen 10.</i>		<i>10.</i>
	<i>John</i>		

OFFICE FURNITURE **Capital Office Supply** MACHINE SERVICE
the "RED CARPET" store

2007

Name: Dept of Admin Aff Date: 1-20-71
Address: De France Customer's Order No.

I CERTIFY THAT THIS BILL IS CORRECT AND JUST THAT PAYMENT THEREOF HAS NOT BEEN RECEIVED.
CAPITAL OFFICE SUPPLY

Quantity	Description	Price	Amount
10	Red P. 525 Post Mt. Disc	1.25	12.50
			12.50

By: *[Signature]*

PHONE: 505-2000

PHONE: 505-2000

OFFICE FURNITURE **Capital Office Supply** MACHINE SERVICE
the "RED CARPET" store

815

Name: Admin Refinement Date: 1-20-71
Address: _____ Customer's Order No.

I CERTIFY THAT THIS BILL IS CORRECT AND JUST THAT PAYMENT THEREOF HAS NOT BEEN RECEIVED.
CAPITAL OFFICE SUPPLY

Quantity	Description	Price	Amount
1	De la Balle	1.50	1.50
1	Post Mt. Disc	1.25	1.25
1	Stapler	1.00	1.00
			3.75
			12.75
			16.50

By: *[Signature]*

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF BUDGET & MANAGEMENT

JAY S. HAMMOND, Governor

POUCH C — JUNEAU 99801

-FILE-
COPY SEN. HOHMAN

February 20, 1975

The Honorable Bill Ray
Chairman
Senate Finance Committee
Pouch V
Juneau, Alaska 99811

Attention: Senator George Hohman

Dear Senator Ray:

This is in response to a question raised by Senator Hohman at this morning's Senate Finance hearing concerning the Governor's requested supplemental appropriation for miscellaneous claims (SB 78).

After reviewing AS 37.25.010 (b) it is our interpretation that the claims associated with SB 78 are not legally payable with current year authorization. This is due to the fact that the provisions (1) and (2) of subsection (b) preclude such payment.

A copy of the proposed change to the SB 78 appropriated amount which I mentioned this morning is also attached. This alteration has the following effect:

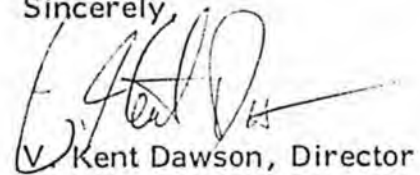
Remove:	N.C. Machinery Claim	(\$935.58)
Add:	Spenard Builders	
	(in. no. R27639)	18.04
Add:	Spenard Builders	
	(in. no. C5972)	<u>8.96</u>
	Net effect of revision	(\$908.58)

We accordingly recommend that SB 78 be amended to reduce the appropriated amount from \$45,900 to \$44,992; a reduction of \$908.00. Within the bill the amount appropriated to the Department of Public Works should be reduced by a like amount: \$908.58.

February 20, 1975

To avoid miscellaneous claim supplemental appropriations in future fiscal years we have proposed that the General Appropriation Bill be footnoted to include the provision that it be allowable for the Governor's Contingency Fund to be used to pay obligations for any agency for any time period. HB 70 now includes that provision. We solicit your support in having such a provision included in the Senate's version of the budget bill this session!

Sincerely,



V Kent Dawson, Director

cc: Jay Hogan, Director, Legislative Finance
Attachment:
VKD/bc

File → Senate Bill 78

MEMORANDUM

State of Alaska
DEPARTMENT OF PUBLIC WORKS

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

DATE: January 29, 1975

FILE NO: 131-1-03K & 131-1-03L

TELEPHONE NO:

FROM: *WAR*
William H. Race, P.E.
Director
Division of Buildings

SUBJECT: Miscellaneous Claims

The Division of Buildings, Department of Public Works requests the following listed attached invoices be included in the supplemental claims request.

<u>Vendor</u>	<u>Invoice Number</u>	<u>Date</u>	<u>Amount</u>
Spenard Builders	R27639	1/26/71	\$18.04
Spenard Builders	C5972	1/08/71	\$ 8.96

This Division also requests that the claims by N.C. Machinery turned in on a memo dated November 27, 1974 be taken from the supplemental claims request. N.C. Machinery has cancelled the balance they claimed was owing them. ^{935.58}

RECEIVED
JAN 30 1975
BUDGET & MANAGEMENT

MEMORANDUM

State of Alaska

TO: Mr. George Porter,
Chief of Maintenance
Division of Buildings
Juneau

DATE: January 21, 1975

FILE NO:

TELEPHONE NO:

FROM: Mr. Jesse R. Boyer, *JRB*
Building Management Supervisor
Division of Buildings
Anchorage

SUBJECT: N. C. Machinery Co.,
Past Due Balance

Attached are a statement and a credit memo on an account which has been in question for the past couple years. The account was, as admitted by N. C. Machinery Co.'s credit manager, in a terrible mess. There were double billings, unposted credits, mismatched invoices to purchase orders, etc.

It is my firm belief that all charges due N. C. Machinery Co. were paid by the State and that poor bookkeeping was the only reason for the balance which was claimed to be unpaid. N. C. Machinery Co. has now agreed and have cancelled the balance which has been carried for the past couple years.

JRB/rg

Attachments: as stated

Jan 27 1975

DIVISION

1975

MEMORANDUM

State of Alaska

TO: Mr. William Gillespie,
Cost Accountant
Division of Buildings
Juneau

DATE: January 23, 1975

FILE NO:

TELEPHONE NO:

FROM: Mr. Jesse R. Boyer, *JRB*
Building Management Supervisor
Division of Buildings
Anchorage

SUBJECT: Spenard Builders, Supply Account

By: Mr. Harold Henderson, *HH*
Supply Officer

We have worked on our account with Spenard Builder's Supply for some time and now have it down to only two old invoices which are reflected as unpaid. Information on these two invoices is as follows:

Invoice No.	Date	Amount	Remarks
R27639	1/26/71	\$18.04	Material was purchased for Ursa Minor School, Ft. Richardson on base schools. Purchase order 13-BA-5966 dated 1/26/71. Invoice was sent in for payment 3/8/71. Copies of PO and invoice are attached.
C5972	1/8/71	8.96	Material was purchased for Pitkas Point School on SR 5463 dated 1/8/71 and shipped to Pitkas Point. Via Wien Consolidated on air bill number 212-273845. Invoice and air bill were sent in for payment 3/9/71. Copies attached.

We hope to get this account straight once and for all.

JRB/HH/rg

Attachments: as stated.

Jan 27
DIVISION



TELEPHONE 279-8611

penard builders supply

4412 LOIS DRIVE • ANCHORAGE, ALASKA 99503

CUSTOMER'S ORDER NO.

SOLD TO

ADDRESS

DELIVER TO

PA 5463
DATE 1971
DID OF Bldg
D.H. 14
WEIN Com.

PAID BY	CASH	CHECK	COD	W/DSE	REC'D	PAID OUT
		✓				

STATEMENT COPY

1	CONCRETE GUN	1	2.15	1.94
12	SHOES ASPHALT CONCRETE	12	.65	7.02

RECEIVED
DIVISION OF
ANCHORAGE
FEB 7 1971
MAINTENANCE OFFICE

TERMS: ALL ACCOUNTS DUE 10TH OF MO. FOLLOWING PURCHASE IS PER MO CHARGED ON PAST DUE ACCOUNTS. ALL RETURNED GOODS MUST BE ACCOMPANIED BY THIS BILL

MAR 9 1971

TOTAL 7.96

DELIVERED BY _____ REC'D BY X

No. 5972


X(1)S(1)G
SIGNATURE OF SHIPPER OR SHIPPER'S AGENT

INTERNATIONAL AIRFREIGHT - EST. 1960 ANCHOR CO. ALABAMA 36612 AIRMAILS 212-273845 SUSJECT TO CONDITIONS OF CONTRACT ON THE BACK OF THE AIRBILL		KAPID AIRCELL		212 - 273845		s		D's		COR.					
SHIPPER SPENARD BUILDERS				CONSIGNEE DIV OF BLDGS				PREPAID TAX 30		OTHER 6.00		LTD VALUE			
STREET ADDRESS				STREET ADDRESS											
CITY ANG		STATE		ZIP CODE		CITY PITKAS PT		STATE		ZIP CODE		INSURANCE PREMIUM			
ROUTING FROM		VIA WE TO		VIA TO		VIA TO (DESTINATION)		PREPAID CASH		COLLECT CHARGE		CARRIER'S ADVANCES			
PIECES 1	DESCRIPTION (INCLUDING METHOD OF PACKING, MARKS & NUMBERS) GTN FLAMMABLES				WEIGHT 15	UNIT SHEG	RATE MIN	6.00		6.00					
PA#5163 CITE DIV OF BLDGS				APPROVED FOR PAYMENT Pitke's Peing silual											
INSTRUCTIONS TO CARRIER 2				M PA 5163											
DIMENSIONAL WEIGHT INFORMATION				EXECUTED AT BY ANG KARMUN 1/3/77				DATE TIME		6.30		6.30			

STATE OF ALASKA
DEPARTMENT OF PUBLIC WORKS

THIS NUMBER
MUST APPEAR
ON ALL PACKAGES
AND PAPERS

DEPARTMENTAL

CONSIGNEE 

PURCHASE
ORDER

RELATING
TO THIS
ORDER

DATE
FUND AND PROGRAM

REPORT OF BIRTH

TO

CONSIGNEE AND DESTINATION

S
H
I
P
T.
O.

CONTRACT NO.

DATE DELIVERY REQUIRED

SHIP VIA

REQUISITION NO.

IMPORTANT PREPAY SHIPMENT AND LIST CHARGES AS A SEPARATE ITEM ON INVOICE. SUBMIT COPY OF B/L WITH THE SHIPMENT.

ITEM NO.	QUANTITY	UNIT	ARTICLES OR SERVICE	UNIT PRICE	TOTAL
			<p>3/12/53</p> <p>3/12/53</p>		
<p><i>Received - [Signature]</i></p>					
				TOTAL	

MEMORANDUM

State of Alaska

DEPARTMENT OF PUBLIC WORKS

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

DATE: November 27, 1974

FILE NO: 131-1-03 K & 131-1-03 L

TELEPHONE NO:

FROM: John E. Benson, Director
Division of Buildings

SUBJECT: Miscellaneous Claims
FY 70-71 & FY 71-72

The Division of Buildings, Department of Public Works requests the following listed attached invoices be included in your supplemental claims request:

<u>Vendor</u>	<u>Item Number</u>	<u>Date</u>	<u>Amount</u>
Wien Airlines	09334231	Mar 3 '72	\$37.80
" "	00428321	Jul 28 '72	6.30
" "	00428325	Jul 28 '72	8.00
" "	00396210	Jul 7 '72	6.30
H. C. Machinery			
" "	08630	Feb 3 '70	[5.00]
" "	09030	Feb 16, '70	112.96
" "	08640	Feb 16 '70	15.18
" "	08627	Feb 20 '70	33.42
" "	12765	May 5 '70	87.50
" "	12264	May 8 '70	23.96
" "	12994	May 22 '70	6.62
" "	21423	Nov 9 '70	302.00
" "	25390	Feb 22 '71	33.22
" "	27355	Apr 16 '71	323.72
Wien Office Supply	63892	Aug 6 '71	1,662.50
Alaska Light & Power	Museum	Nov 8 '71	1,082.20

OK

Cancel

935,58.

A search of our records does not reveal that the attached bills have been paid.

MEMORANDUM

State of Alaska

TO: Mike Whitehead, Special Assistant
Office of the Governor

DATE: May 5, 1975

THROUGH: James W. Brooks, Commissioner
Department of Fish and Game

FILE NO:

TELEPHONE NO:

FROM: Vern Roberts, Director
Division of Administration
Department of Fish and Game

SUBJECT:

Claim of Wilson Potterville

In accordance with your request of April 28, 1975 I am forwarding my recommendation for settlement of the above referenced claim.

I have contacted two different private claims adjusters for their advice on appropriate procedures and rationale used in settling claims resulting from fire losses. The recommendations I have made incorporate to the greatest degree possible the advice of the professional adjusters. In those categories where no advice was available, every attempt has been made to deal fairly for both Mr. Potterville and the state.

The total amount recommended for settlement of this claim is \$10,175.55.

Mr. Potterville did not include with his claim information on either the age or condition of individual items. Therefore, I am required to use the adjusters procedure of applying percentages to various categories of items. The percentages used are shown below.

I have attached a copy of the claim with percentages applied for your information in reviewing this matter.

Attachment

1. Kitchen Appliances	75%
2. Kitchen Utensils, dishes, pots, pans, etc.	75%
3. Groceries & Prescriptions	100%
4. Supplies - various	75%
5. Disallow any charge that is not specifically identified	
6. Furniture	70%
7. Bedding	70%
8. Clothing, shoes, boots	60%
9. Books	50%
10. Electrical Appliances, radios, stereo, etc.	75%
11. Carpets, furnishings, luggage, pictures, plaques	70%
12. Optical Equipment	75%
13. Toys	50%
14. Guns, scopes, knives, sporting goods	60%
15. Furs, skins, trophies	50%
16. Jewelry	75%
17. Hobby items	75%
18. Cosmetics, beauty aids	50%
19. All categories not covered above	50%

Kitchen

Appliances (All new - Many wedding gifts priced at McKay's Hardware)

Hamilton Beach Blender	75% 50.00	
Sunbeam waffle iron	40.00	
12 C. Cory Stainless Steel coffee pot	35.00	
Hamilton Beach corn popper	19.00	
Dominion electric skillet	35.00	
Sunbeam handmixer	23.00	
Sunbeam steam N sprav iron	25.00	
<hr/>		
Canister set and cookie jar	75% 25.00	
Electric toothbrush (Sears)	15.00	
TV trays	12.00	
Utensil trays	5.00	
Coleman water jug 2 1/2 gal.	12.00	
5 gal. Jerry jug	7.00	
Lunchbox	3.00	
Stanley Thermos	25.00	
Cup rack (2 sets)	3.00	
Turntable spice rack	5.00	
Walnut spice rack	22.00	
Accompanying spices	100% 8.00	8.00
Rubbermaid turntable & trays	75% 5.00	
Rubbermaid dishpan	3.00	
Place mats		
...1 set plastic	6.00	
1 set Sydney Lawrence	6.00	
1 set Calico padded cotton	8.00	
2 tablecloths and napkin sets	24.00	
Dishtowels and hot pad holders	15.00	
Triple sifter	4.00	
Plastic measuring cups & spoons	2.50	
Wooden spoon set	1.50	
3 Bread pans	6.50	
1 Bundt pan	7.00	
2 Teflon Cake pans square & oblong	7.50	
1 Stainless Steel Cookie sheet	5.50	
2 muffin pans	2.50	
2 Sizzler steak servers	15.00	
1 salt box - salt & pepper sets	10.00	
2 one gal. plastic pitchers	4.00	
	<hr/>	
	\$502.00	378.5

Dishes

Ducks Unlimited glass set	75% 6.00	
Corningware 2 qt.	8.50	
Corningware lid	2.50	
Cake platter (cut glass)	12.00	
Apothecary jars (4)	8.00	
Wine decanter & goblet set	25.00	
Dessert dishes and glass set	12.00	
1 set 8 tumblers	8.00	
1 cup set and stand	15.00	
1 set flowered tea cups	11.00	
1 wrought iron cup rack	4.50	
Assorted stainless steel cooking utensils & aids	25.00	
	<hr/>	
	421.6	103

1 set pots & Pans	75%	30.00	
Assorted tupperware	✓	49.00	
6 12 oz. tumblers			} 97.91
ice cream container			
canister set			
cake box			
salad bowl			
storage set			
popsicle set			
Roaster pan	75%	4.50	
Canner (Hot Bath)	✓	9.50	
1 large Butcher Block with handle		15.00	
1 small Butcher Block		7.50	
Steak Knife set in Walnut cast		15.00	
Cookbooks - Woman's Day Encyclopedia Set & Recipe file box	50%	50.00	} 30.00
Cake Decorating Book	50%	10.00	
Papertowel rack	75%	1.50	1.13
Laundry & cleaning supplies	75%	34.00	25.50
Book Ends (White Onyx)	70%	25.00	17.50
Gerber Steel	75%	12.50	9.38
		<u>\$401.00</u>	

Groceries (including - staples, spices, canned goods, paper goods, etc.) 100% 500.00 500.00

Freezer bags & wrap, tape	75%	18.00	13.50
Home canned foods - jellies, etc. canning jars	100%	25.00	} 200.00
Frozen foods	✓	175.00	
liquor	50%	65.00	32.50
Prescription	100%	150.00	} 216.00
Vitamin & Mineral Supplements	✓	21.00	
Medicine supplies - First aid Materials	✓	45.00	

Accessories

1 Personalized Rose Maul Decorator Breadboard of 100 year old Walnut	70%	75.00	} 105.00
Hanging plants, pots vases, trivats, plaques	✓	75.00	
		<u>\$1.149.00</u>	

1,248.39

Bedroom

Furniture

Bed frame	70%	30.00	21.0
Mattress	50%	145.00	
Box springs	35%	145.00	145.0
Walnut headboard - built in bookcase	70%	125.00	
Walnut dresser		75.00	

Bedding

3 Blankets	70%	45.00	547.1
2 Mattress pads (twin & ful)		22.00	
Wool quilt queen size		75.00	
Wool afghan queen size		125.00	
Courduroy quilt full size		75.00	
Goose down pillow Eddie Bauer		38.50	
Duck down pillow Eddie Bauer		29.50	
Bedspread		45.00	
Sheets & pillow cases 5 sets separate		125.00	
Pillow protective cover (2)		4.50	
Shoe bag	60%	5.00	10.20
Garnet bags		12.00	

Cosmetics

Make-up purse	50%	35.00	30.00
Make-up mirror			
Perfumes, tales, colognes	50%	25.00	
Eye glasses - gold rims	75%	90.00	
Jewelry			
Ladies wrist watch	75%	65.00	
Pearl sterling silver ring		42.00	
Earrings			
Necklace	75%	175.00	485.2
Bracelets			
Jewelry box			
Diamond engagement ring & wedding band	75%	175.00	
Butch Timex watch		25.00	
Sterling silver ring		75.00	
Photo Albums	50%	125.00	87.50
Wedding pictures		50.00	

Personal Effects

Oster table model hairdryer	50%	50.00	
Electric curler set-Clairol		42.00	
Baby Benn alarm clock		12.00	68.00
Halcraft vaporizer	50%	17.00	
Barber set		15.00	

\$2139.50

1396.10

Boxes of Educational/Teaching materials
Reference - resource books & supplies
Teaching games, aids
AM-FM - Craig Cassette
Unrecorded tapes
Cassette tape collection

50%	125.00)
(95.00) 142.5
2	65.00)
75%	169.00)
(35.00) 245.7
1	125.00)
	<u>\$614.00</u>	
		<u>389.25</u>

Living Room

Household Furnishings

Hanging Brass Lamp	\$ 85.00	
Floor Lamp with Marble stand	70% 65.00	150.50
Alaskan scenery shade	15.00	
Two vanity lamps	50.00	
Curtains and drapes	70% 80.00 & 35.00	
Carpet (pile 5 x 8)	40.00	
Shag carpets		
6 x 9	70% 145.00	619.50
5 x 8 (two) @ 75.00	150.00	
3 x 5 (two) @ 45.00	90.00	
2 x 3	35.00	
Wool Braided rug (5 x 8)	150.00	
Vinyl upholstered captains chair	75% 75.00	
Walnut desk	85.00	
Sewing machine (Kenmore zig zag)	75% 90.00	67.50
Colonial sewing cabinet	70% 45.00	31.50
Console Humidifier	75% 120.00	90.00
Mediterranean style metal shelf unit	70% 40.00	73.50
Luggage (2 pieces)	65.00	
Pioneer stereo speaker	75% 75.00	56.25
Antique frame mirror 3 1/2 x 4 1/2	70% 75.00	
Framed pictures collection	125.00	
Linen hand painted bird mural	21.00	
Slide carousel (empty)	5.50	
Slide stack loader	13.00	
Decorator wall plaques	45.00	
Spanish carved book ends	25.00	319.50
Brass candlestick holder	15.00	
<u>Accessories</u>		
Rocking planter	70% 15.00	
Posters	12.00	
Decorator pillows: 1 wool hand embroidered	85.00	
3 corduroy hand stitched		
1 needlepoint:		
6' x 6' felt wall hanging	70% 20.00	
Vivitar 35mm zoom lens & adapter	75% 53.00	39.75
Desk Items - stationary & gift wrap, etc.	20.00	
Wastebasket	70% 8.00	5.60
Ivory collection		
Biliken	75% 22.00	49.50
Ivory fork	14.00	
Dog key chain	12.00	
Cake server	18.00	
Straw flower arrangements	70% 15.00	28.00
Decorator plaques	25.00	
Butch's reference & resource books		
Biology & Natural Resources	50% 125.00	77.00
3 flight manuals	50% 29.00	
Black mahogany piano bench	70% 35.00	24.50
	\$2367.50	

1607.65

Alaskan Trophies

Trophy Grayling
Cinnamon Black Bear Rug
Seal skin (pup)
Fox picture
3 Rabbit furs
Reel to reel tape collection
Pioneer head phones
Bausch & Lomb Sunglasses
Bausch & Lomb Quiet Ears
Gun Rack
Buck folding hunting knife

50%	\$	525.00	}	765.5
		750.00		
		150.00		
		100.00		
		6.00		
75%		150.00	}	153.7
		40.00		
75%		15.00	}	28.9
60%		15.00		
		13.00	}	20.00
		20.00		
		<u>\$1784.00</u>		

943.00

Clothing Butch

Leather Jacket	60% 120.00
Browning Chucka boots	30.00
Stearn Flotation jacket	56.00
Raichle boots	75.00
Dress shoes	45.00
Red wing shoes	40.00
Bas cross country ski boots	45.00
3 Woolrich shirts	75.00
7 Pendleton shirts	175.00
4 White Stag knit tops	40.00
3 Turtleneck sweaters	60.00
3 Levis	39.00
3 Dress slacks (Double knit)	66.00
2 Vests	32.00
1 Cardigan sweater	18.00
3 Dress shirts	50.00
Brushed Corduroy Sport Coat	80.00
5 ski sweaters	250.00
White Stag 3/4 down vest	45.00
3 belts	18.00
1 knit scarf (wool hand knit)	9.50
1 wool suit	18.00
9 T-shirts	19.50
10 Jockey Briefs	17.00
8 pairs wool socks	11.00
6 pair dress socks	11.50
1 pair of Sorel boot packs	18.00

\$1463.50

878.10

Bathroom

Bathroom set rug & seat cover
Bathroom scales
Hot water bottle
Heating pad
Storage rack for towels
Towel rack
Shower handy hanging tray
Towel sets (1 doz.)
Separate washcloths
Bath mat
Toilet soap
Toilet tissue
Facial tissue
Shampoo - rinse

70%
10.00
14.00
6.00
8.00
9.00
3.00
5.00
112.00
7.50
4.00

50%
5.00
3.50
\$187.00

129.21

Clothing Carol

Clothes for teaching

Trench coat - Misty Harbor	-60%	75.00
Wool coat & dress outfit (Wedding outfit)		150.00
5 dresses 25.00 up		170.00
4 pantsuits (33.00, 49.00, 60.00, 55.00,)		197.00
Shoes, Boots & Purses		
White Sandles		22.00
Black Pantent .		25.00
Beige pumps		24.00
Red high top boots		11.00
Black leather boots high tops		35.00
Black leather purse		22.00
Brown leather and suede purse		16.00
White hand crochedted purse		19.00
Belts (4)		20.00
Blouses 16.00 @ x 8		128.00
2 Maxi dresses		54.00
2 robes - 29.00 & 22.00		51.00
Slippers		9.50
Lingerie		40.00
Pajamas & Gowns		48.00
5 Nylons		15.00
4 Slips		32.00
10 panties		10.50
7 bras		36.00
5 turtlenecks		45.00
5 cardigan sweaters		85.00
3 ski sweaters		90.00
3 ski pants		105.00
Slacks 15.00 @ 4 pairs		60.00
Raichle hiking boots		75.00
Refigiware Suite		65.00
Gold wool coat		55.00
Snowmobile boots		17.50
knit scarf & 2 pair of mittens		22.00
Janoy X country ski boots		45.00

Personal Effects

Artists supplies	25.00
*Needlework	
Sewing materials	75% 50.00
knitting bag and large bag of yarn	65.00 } 86.2
	\$2014.50

1,247.

1210.95

Guns

1.	Remington Mod. 700 7MM Magnum	60%	184.95
	3-9 Bushnell Scopechief Scope		110.00
	Weaver Mounts		12.50
	Mounting Fee		10.00
			<u>317.45</u>
2.	Remington Mod. 760 30-06		199.95
	Bushnell Banner 4 Power Multi x Scope		49.95
	Weaver Mounts		12.50
	Mounting fee		10.00
	Spare Clip		7.95
			<u>280.35</u>
3.	ITHACA Mod. 37 Shotgun		154.95
4.	Winchester 22 Cal. Single Automatic		50.00
5.	Remington 22 Target Master		49.95
	Weaver Scope		19.95
	Mounting Fee		10.00
			<u>79.90</u>
6.	Ruger Super Black Hawk 44 Magnum Revolver		149.50
	Holster		9.95
			<u>159.45</u>
7.	Ruger Single Six Convertable 22 Cal Magnum Revolver		92.50
	Holster		9.95
			<u>102.45</u>
			<u>\$1144.55</u>

696.73

John's Bedroom

Oak chest of drawers	70%	125.00	
Quilt - handmade child's		55.00	} 187.1
Pillow - Duck down		29.50	
Mattress Pad		10.00	
Sheets , pillow case & cover		13.50	
Extra large Needlepoint handmade pillow		35.00	} 45.00
3' handmade Raggedy Andy doll	50%	45.00	
rifle rack - toy rifle		12.00	} 106.5
Ed'l games, including puzzles, toys, Magnetic letters etc.		75.00	
Library collection of children's books		85.00	} 25.00
Record player (G.E.)	75%	25.00	
Record collection		35.00	} 45.00
Hand crocheted living room ball	50%	25.00	
Viewmaster and viewmaster picture sets		14.00	19.50

Toys

Fisher Price playhouse	50%	15.00	} 118.50
Putt Putt set		15.00	
Tinker toys		8.00	
Hot wheels		9.00	
Puppets 5.00 x 2		10.00	
Boxing gloves		4.50	
Johnny West. & clothes		12.00	
Stuffed Bear and clothes		10.50	
Tonka cars & trucks		75.00	
Fisher Price telephone		4.50	
Sno Machine & People		6.00	
Model tank, airplane, sub		36.00	
Water color painting		23.50	

Clothes

Sorrells	60%	15.00	} 246.3
Blue suede shoes		18.00	
Black leather dress shoes		16.00	
Tennis shoes		9.00	
Underwear		42.00	
Leather vest		23.00	
Slippers		4.50	
2 Sweaters		19.00	
2 vests		12.00	
4 Pajamas		24.00	
10 knit tops		49.00	
7 pants		49.00	
3 belts		12.00	
sport coat		12.00	
Wool C.O. Jacket		15.00	
Pile winter parka		22.00	
Snowmobile suit		39.00	
Break-up boots		12.00	
Bathrobe		9.00	
Oshkosh pants		9.00	

\$1223.50

721.4

Suede cowboy hat (1)
6 Dress shirts
3 ties
2 Wool hats
3 pairs mittens
10 pairs socks

60% 11.00
/ 36.00
6.00
12.00
15.00
8.50

\$88.50

53.00

Removed From Fire (Estimated Damage)

Typewriter (portable Smith/Corona)		75.00
Wolf hide	to clean	50.00
Projector		100.00
Slide collection		500.00
File box with Documents, photo albums, tapes, personal effects		75.00
		<u>\$800.00</u> ^{400.}

Total \$15,878.55

10,175.55

Wilson Potterville
P.O. Box 231
Glennallen, Ak. 99588
April 18, 1975

Mr. Bob Palmer
Executive Assistant
Office of the Governor
Pouch A

Juneau, Ak. 99811

Dear Mr. Palmer:

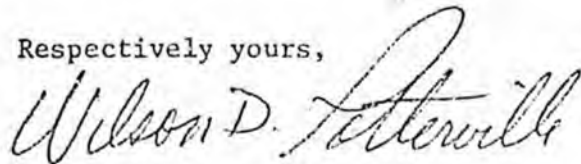
I am writing in regard to the Crooked Creek Fire loss on August 12, 1974. While an employee of Alaska Department of Fish and Game, Division of Fisheries Rehabilitation Enhancement and Development, at Kasilof Gravel Incubation Facility, my family and I resided on site in the small house provided by the state. We resided here in order that I might fulfill job responsibilities of a routine nature and attend emergency situations. Living here was not so much a choice as a necessity. As there were no provisions for running water in the house, it was equipped with a propane toilet which caught fire on August 12, 1974 and completely burned the inside of the house. The majority of the furnishings in the house were our own personal belongings. We lost our furniture, kitchen appliances, professional libraries and materials, winter clothing, bedding, wedding gifts, and many many personal effects. My wife's teaching career required a professional wardrobe and many specialized books and supplies. My work in the biological field led to the acquisition of many useful reference and textbooks in related areas of science. My association with the outdoors through work experience or personal endeavors resulted in my fine Alaskan trophies. These trophies are not replaceable.

Immediately following the fire we were instructed to submit a list of everything we had in the fire. Stan Swanson, Robert Libida, Rupert Andrews, and Russ Redick were some who requested this. As I was transferring to Sport Fish Division soon after August 13 or 14, the Division of Fisheries Rehabilitation Enhancement and Development agreed to have Sport Fish Division assist us in presenting our fire loss paper to legislature for consideration and passing a special bill for reimbursement to us. We compiled a list of items to the best of our recollection and researched widely for today's replacement values; submitted a paper briefly describing the situation and listing our loss ... one which amounted to over \$15,000. Rupert Andrews apparently made every effort to introduce this paper to legislature for the consideration of reimbursement and found all avenues blocked at the administrative level for reasons unbeknownst to us. We are aware of prior incidents in which the state has at least partially reimbursed employees for losses incurred at state's responsibility. For the past nine months we have waited with optimism that the state might offer whole or partial compensation. We have recently learned that Fish and Game Department has

April 18, 1975

done all in its' power to assist us and can not get past the administrative level. For this reason we see no recourse but to either file suit against the state, for providing substandard housing where on-site residence was required for the job, - or procuring the interest and cooperation of an influential political figure. We implore your attention in reviewing our case and humbly request your assistance in legislating or budgeting monies for a fair compensation for our incurred loss. Having presented this limited amount of information to you, I would welcome any further discussion you might desire by phone or letter. Because we find ourselves in a financial crisis, we find it most urgent to expedite matters. I will await your reply and hope to be hearing from you in the very near future.

Respectively yours,



Wilson D. Potterville
Fisheries Biologist
Glennallen

Copies sent to

Governor Hammond
Senator Bill Ray
Representative Keith Specking
Rupert Andrews

MEMORANDUM

State of Alaska

#8

DEPARTMENT OF PUBLIC WORKS

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

DATE: November 27, 1974

FILE NO: 131-1-03 K & 131-1-03 L

TELEPHONE NO:

FROM: John E. Benson, Director
 Division of Buildings

JB

SUBJECT: Miscellaneous Claims
 FY 70-71 & FY 71-72

RECEIVED
 DEC 2 1974
 BUDGET & MANAGEMENT

The Division of Buildings, Department of Public Works requests the following listed attached invoices be included in your supplemental claims request:

<u>Vender</u>	<u>Item Number</u>	<u>Date</u>	<u>Amount</u>
Wien Airlines	00334231	Mar 8 '72	\$37.80
" "	00428321	Jul 28 '72	6.30
" "	00428325	Jul 28 '72	8.09
" "	00396210	Jul 7 '72	6.30
N. C. Machinery			
" "	08830	Feb 3 '70	[5.00]
" "	09030	Feb 16 '70	112.96
" "	08640	Feb 16 '70	15.18
" "	08627	Feb 20 '70	33.42
" "	12165	May 5 '70	37.50
" "	12264	May 8 '70	23.96
" "	12994	May 22 '70	6.62
" "	21423	Nov 9 '70	302.00
" "	25890	Feb 22 '71	33.22
" "	27355	Apr 16 '71	323.72
Yukon Office Supply	63692	Aug 6 '71	1,662.50
Alaska Light & Power	Museum	Nov 8 '71	1,082.20

3746.77
 [5.65]
 3736.77

A search of our records does not reveal that the attached bills have been paid.

STATEMENT

Wien Consolidated Airlines, Inc.



4100 INTERNATIONAL AIRPORT RD.
ANCHORAGE, ALASKA 99502

Page 2 of 2

33-033
APR 1974

RECEIVED
DIVISION
ANCHORAGE

APR 1 1974
MAINTENANCE OFFICE

TO Division of Buildings
Touch P
Juneau, Alaska 99801

4-23-72

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

TERMS - NET CASH. NO DISCOUNT ALLOWED. INTEREST CHARGED ON OVERDUE ACCOUNTS.

MO.	DATE	YEAR	CODE	ITEMS	DEBITS	CREDITS	BALANCE
MO.	DAY	YEAR					
					BALANCE FORWARD		3780
MAR	08	72	A0334231				
APR	13	72	A0334893		2048		
APR	13	72	A0334893		630		
APR	13	72	A0334893		630		
APR	13	72	A0334893		630		
APR	02	72	A0337297		1300		
APR	02	72	A0337297		1300		
APR	24	72	A0338908		630		
APR	21	72	A0370312		3750		
APR	20	72	A0403131		630		
APR	25	72	A0401738		7927		
APR	25	72	A0401738		2315		
APR	13	72	A0401738		630		
APR	13	72	A0401738		630		
APR	14	72	A0335100		630		
APR	14	72	A0335100		630		
APR	14	72	A0335107		770		
APR	14	72	A0335107		2030		
APR	14	72	A0335110		630		
APR	14	72	A0335070		630		
APR	13	72	A0335207		1300		

Pd c/r 060806-602
Pd c/r 062915-608
Pd c/r 041201-604
Pd c/r 062915-608
Pd c/r 060804-602
Pd c/r 062915-608
Pd c/r 060806-602

CODE:
A - FREIGHT
B - TICKETS-PASSI
C - CASH RECEIPTS
D - DEBIT MEMOS
E - CREDIT MEMOS
F - TRANSFERS
G - JOURNAL VOUCHERS
H - INVOICE BILLINGS
J - EXCHANGE ORDERS

Our books close on the 25th of each month. All charges and credits received in this office after that date will appear on next month's statement.
Correspondence regarding this statement should be mailed to
Wien Consolidated Airlines, Inc., 4100 International Airport Rd., Anchorage, Alaska 99502

PAY LAST AMOUNT IN THIS COLUMN

FROM:

SUBJECT: THIS SHIPMENT IS SUBJECT TO THE FOLLOWING SPECIAL PROVISIONS:

CARRIER NO. 212.		OFFICE ORIGIN ANC		FLIGHT NO. 0033		FLIGHT DATE 4231		DATE 1972		TIME		TO		THRU		DATE		TIME		TO		THRU		DATE		TIME					
ROUTING AIRLINE ROUTING APPLIES UNLESS SHIPPER INSERTS SPECIFIC ROUTING HERE														COL PREPAID		CHG COLLECT		4100 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502													
CONSIGNEE'S ACCOUNT NUMBER														CONSIGNEE		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 GTR										CARRIER USE ONLY					
NAME: DIV OF BLDGS																										RATE					
STREET ADDRESS: HENRY CORBAN WHITE MTN SCHOOL																										WEIGHT CHARGES					
CITY: WHITE MTN STATE: NONE ZIP CODE:																										EXCESS VALUE					
SHIPPER'S ACCOUNT NUMBER														SHIPPER		PCS/PAGES LENGTH WIDTH DEPTH CUBE INCHES										ADVANCES					
NAME: SPENARD BUILDERS																DIMENSIONAL WGT - LBS.										OTHER					
STREET ADDRESS:																C.O.D. SHIPMENT IF AMOUNT ENTERED HERE BY SHIPPER										SHIPPER'S C.O.D.					
CITY: ANC STATE: ZIP CODE:																										C.O.D. FEE					
PICK UP ZONE														ORIG. ADVANCE CHGS		DESCRIPTION OF ORIGIN ADVANCE CHARGES										DEST. ADVANCE CHGS		DESCRIPTION OF DESTINATION ADVANCE CHARGES			
OTHER CHARGES																										TOTAL CHARGES					
NO PCS		WEIGHT		DESCRIPTION OF PIECES AND CONTENTS PACKING MARKS NUMBER										CARRIER COMM. BY GROUP NO.		CARRIER COMM. BY GROUP NO.		CARRIER COMM. BY GROUP NO.													
3 - 200		2 CTNS DOORS (SHIPPERS RISK)																													
		1 BDL METAL TRIM																													
		1 2 3 7																													
WEIGHT CHARGES		PICK UP		DELIVERY		EXCESS VALUE		ADVANCES		OTHER		SHIPPER'S C.O.D.		C.O.D. FEE																	
36.00																															
TAX		TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER PAYS																			
1.80		37.80		18																											
EXCISE TAX BY: ANC SKIP 03/08/72 9:15														DATE		TIME		ITEMS COLLECT		CONSIGNEE PAYS											

1AC 17) PRINTED IN U.S.A. 2278 REV. 4-71

CARRIER ACCOUNTING COPY

CARRIER 212 ORIGIN ANC SPECIAL REFERENCE 0033 4231

WEIGHT CHARGES		PICK UP		DELIVERY		EXCESS VALUE		ADVANCES		OTHER		SHIPPER'S C.O.D.		C.O.D. FEE											
36.00																									
TAX		TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER PAYS													
1.80		37.80		18																					
EXCISE TAX BY: ANC SKIP 03/08/72 9:15														DATE		TIME		ITEMS COLLECT		CONSIGNEE PAYS					
RECEIVED BY: Mike Skerman														DATE		TIME		PERSON CONTACTED		PHONE		CARRIER 212 ORIGIN ANC SPECIAL REFERENCE 0033 4231			

DELIVERY RECEIPT



TELEPHONE 279-8611

Penard builders supply

4412 LOIS DRIVE • ANCHORAGE, ALASKA 99503

CUSTOMER'S ORDER NO.

7775

DATE

3/8/72

SOLD TO

STATE OF ALASKA. DIV OF BLDG

ADDRESS

MAINT FOREMAN N.W. AREA

DELIVER TO

STATE OPERATED SCHOOLS

NOME ALASKA

SO	CASH	CC	C.D.D.	W.D.S.E. RECD	PAID OUT

QUANTITY	DESCRIPTION	UNIT PRICE	TOTAL PRICE	REMARKS
2	30 1/4 FIRE DOORS PERMANENT			Ken L. ...
	4 7/8 PINE LAMBS	102.04	204.08	
	MADE FOR: WHITE MOUNTAIN			
	VIA: WILSON COMPANY			
	PENARD - BILL STAFF			
	White Mountain School			
	Approved for payment			
	APR 14 1972			
	By <i>Donald R. ...</i>			
	M-10-13-3812			

STATEMENT COPY

TERMS: ALL ACCOUNTS DUE 10TH OF MO. FOLLOWING PURCHASE. 1% PER MO. CHARGED ON PAST DUE ACCOUNTS. ALL RETURNED GOODS MUST BE ACCOMPANIED BY THIS BILL.

670-13744

204.08

No. M10301

TO:
FROM:

F. H. Heston
SHIPPER'S SIGNATURE

UNIFORM AIRBILL

NON-NEGOTIABLE

SUBJECT TO CONDITIONS OF CONTRACT ON THE BACK OF THE AIRBILL

CARRIER 212	ORIGIN ANC	AIRBILL NUMBER 0033 4231	DATE DAY NO MM YY	IC	CHGS	FLIGHT/DATE	FLIGHT/DATE	DECLARED VALUE NVD	CUSC INCHES
----------------	---------------	-----------------------------	-------------------------------	----	------	-------------	-------------	-----------------------	-------------

ROUTING: AIRLINE ROUTING APPLIES UNLESS SHIPPER INSERTS SPECIFIC ROUTING HERE								<input type="checkbox"/> COL PREPAID <input type="checkbox"/> CHG COLLECT		4100 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502	
TO	VIA	TO	VIA	TO	VIA	TO	VIA	<i>Wen Consolidated Airlines, Inc.</i>			
1/											

CONSIGNEE'S ACCOUNT NUMBER				CONSIGNEE				CARRIER USE ONLY							
NAME DIV OF BLDGS				CHARGE CODES PK - PREPAID CREDIT PP - PREPAID CASH CC - COLLECT CG - COLLECT G.B.L. CP - COLLECT CASH CX - COLLECT CREDIT MX - PARTIAL PREPAID, PARTIAL COLLECT CREDIT MP - PARTIAL PREPAID, PARTIAL COLLECT - CASH PG - PREPAID G.B.L. AND/OR GTR				RATE				CHARGES			
STREET ADDRESS HENRY CORBA WHITE MTH SCHOOL				DIMENSIONAL WGT. - LBS.				A				WEIGHT CHARGES			
CITY WHITE MTH NONE				C.O.D. SHIPMENT IF AMOUNT ENTERED HERE BY SHIPPER				B				PICK UP			
DEL. ZONE				SPECIAL INSTRUCTIONS, INCLUDING CUSTOMER REFERENCE NUMBER				C				DELIVERY			

SHIPPER'S ACCOUNT NUMBER				SHIPPER				ADVANCES							
NAME SPENARD BUILDERS				DIMENSIONAL WGT. - LBS.				E				OTHER			
STREET ADDRESS				C.O.D. SHIPMENT IF AMOUNT ENTERED HERE BY SHIPPER				F				SHIPPER'S C.O.D.			
CITY ANC				IF AMOUNT ENTERED HERE BY SHIPPER				G				C.O.D. FEE			
DEL. ZONE				SPECIAL INSTRUCTIONS, INCLUDING CUSTOMER REFERENCE NUMBER				H				EXCESS VALUE			

PICK UP ZONE	ORIG. ADVANCE CHGS.	DESCRIPTION OF ORIGIN ADVANCE CHARGES	DEST. ADVANCE CHGS.	DESCRIPTION OF DESTINATION ADVANCE CHARGES	TAX
OTHER CHARGES	DESCRIPTION OF OTHER CHARGES			G.B.L. NUMBER	TOTAL CHARGES

NO. PCS.	WEIGHT	DESCRIPTION OF PIECES AND CONTENTS PACKING, MARKS, NUMBER	CARRIER COMMUNITY GROUP NO.	CARRIER COMMUNITY GROUP NO.	EXPIRES COMMUNITY GROUP NO.
3	200	2 CTNS DOORS (SHIPPERS RISK)			
-	-	1 BDL METAL TRIM			
		2 3 7			

WEIGHT CHARGES	PICK UP	DELIVERY	EXCESS VALUE	ADVANCES	OTHER	SHIPPER'S C.O.D.	C.O.D. FEE
36.00							
TAX	TOTAL CHARGES	1st RATE	2nd RATE	3rd RATE	ITEMS PREPAID	SHIPPER PAYS	
1.80	37.80	18					
TRACKED BY	DATE	TIME	ITEMS COLLECT	CONSIGNEE PAYS			
ANC SKIP	03/08/72	9:15					

(AC 17) PRINTED IN U.S.A.

2208 REV. 4-71

ORIGINAL INVOICE

CARRIER	ORIGIN	AIRBILL NUMBER
212	ANC	0033 4231

24V
952984

670-131744

527775

noted
2-16-72
picks

STATEMENT

Wien Consolidated Airlines, Inc.
ANCHORAGE, ALASKA



4100 INTERNATIONAL AIRPORT RD.
ANCHORAGE, ALASKA 99502

AUG 1 1974

Page 4 of 4

TO
Division of Buildings
Anchorage
Juneau, Ak. 99801

MAINTENANCE OFFICE

33-30

9-22-72

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

TERMS - NET CASH. NO DISCOUNT ALLOWED. INTEREST CHARGED ON OVERDUE ACCOUNTS.

MO.	DATE		CODE	ITEMS	DEBITS	CREDITS	BALANCE
	DAY	YEAR					
JUL	28	72	A	2(42)8321	630		

CODE:
A - FLIGHT
B - TICKETS (PASS)
C - CASH RECEIPTS
D - DEBIT ITEMS
E - CREDIT MEMOS
F - TRANSFERS
G - JOURNAL VOUCHERS
H - INSURANCE BILLINGS
J - EXCHANGE ORDERS

Our books close on the 25th of each month. All charges and credits received in this office after that date will appear on next month's statement. Correspondence regarding this statement should be mailed to Wien Consolidated Airlines, Inc., 4100 International Airport Rd., Anchorage, Alaska 99502

PAY LAST AMOUNT IN THIS COLUMN

TO:
FROM:

John Adams
SHIPPER'S SIGNATURE

UNIFORM AIRBILL
NOT NEGOTIABLE
SUBJECT TO CONDITIONS OF CONTRACT ON THE BACK OF THE AIRBILL

ARRIER	AIRBILL NUMBER	DATE	TC	CHGS	FLIGHT/DATE	FLIGHT/DATE	DECLARED VALUE	CUBIC INCHES
212	0042 8321			PX			NVD	

ROUTING AIRLINE ROUTING APPLIES UNLESS SHIPPER INSERTS SPECIFIC ROUTING HERE						4100 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502	
33.002						<input checked="" type="checkbox"/> PREPAID <input type="checkbox"/> COLLECT	
New Consolidated Airlines, Inc.							

CONSIGNEE'S ACCOUNT NUMBER	CONSIGNEE	CHARGE CODES	CARRIER USE ONLY	
		PA - 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 GTR	RATE	
NAME	BETHEL SCHOOL		MF	WEIGHT CHARGES
STREET ADDRESS				A 6.00
CITY	BET			B DELIVERY
STATE				C EXCESS VALUE
ZIP CODE				D ADVANCES

DLL ZONE	SPECIAL INSTRUCTIONS, INCLUDING CUSTOMER REFERENCE NUMBER						EXCESS VALUE
SHIPPER'S ACCOUNT NUMBER	SHIPPER	PCS/PROG	LENGTH	WIDTH	DEPTH	CUBIC INCHES	ADVANCES
		/	X	X	=		E OTHER
NAME	DIV OF AVIATION						F SHIPPER'S COD
STREET ADDRESS	PO 1283						G COD FEE
CITY	ANC	C.O.D. SHIPMENT IF AMOUNT ENTERED HERE BY SHIPPER					H TAX
STATE							T 50
ZIP CODE							T 6.30

PICK UP ZONE	ORIG. ADVANCE CHGS	DESCRIPTION OF ORIGIN ADVANCE CHARGES	DEST. ADVANCE CHGS	DESCRIPTION OF DESTINATION ADVANCE CHARGES	TAX
					50
OTHER CHARGES	DESCRIPTION OF OTHER CHARGES				G.B.L. NUMBER
					PA 6.30

NO. PCS	WEIGHT	DESCRIPTION OF PIECES AND CONTENTS PACKING, MARKS, NUMBER	CARRIER COMM BY GROUP NO	CARRIER COMM BY GROUP NO	CARRIER FEE BY GROUP NO
1	20	CTNS	/	/	/
-	-		/	/	/
-	-	2 7 24	/	/	/
-	-		/	/	/

WEIGHT CHARGES	PICK UP	DELIVERY	EXCESS VALUE	ADVANCES	OTHER	SHIPPER'S COD	COD FEE
A	B	C	D	E	F	G	H
TAX	TOTAL CHARGES	1st RATE	2nd RATE	3rd RATE	ITEMS PREPAID	SHIPPER PAYS	
					ITEMS COLLECT	CONSIGNEE PAYS	
EXECUTED AT/BY		DATE	TIME				
ANC SKIP 07/28/72		11:16					

CARRIER ACCOUNTING COPY
CARRIER 212 ORIGIN 0042 8321

TAX	TOTAL CHARGES	1st RATE	2nd RATE	3rd RATE	ITEMS PREPAID	SHIPPER PAYS
					ITEMS COLLECT	CONSIGNEE PAYS
EXECUTED AT/BY		DATE	TIME			
ANC SKIP 07/28/72		11:15				

RECEIVED BY	DATE	TIME	CARRIER	ORIGIN	SERIAL NUMBER
<i>John Adams</i>			212	0042 8321	
PERSON CONTACTED	PHONE	DATE	TIME	PERSON CONTACTED	PHONE

DELIVERY RECEIPT

052004

TO: *Alvin C. [unclear]*
FROM: *[unclear]*

UNIFORM AIRBILL NON-NEGOTIABLE
SUBJECT TO CONDITIONS OF CONTRACT ON THE BACK OF THE AIRBILL

212	0042 8321	PX	NVD
-----	-----------	----	-----

<input checked="" type="checkbox"/> PREPAID <input type="checkbox"/> COLLECT		4100 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502	
Western Consolidated Airlines, Inc.			

2/	CONSIGNEE'S ACCOUNT NUMBER	CONSIGNEE	CHARGE CODES PK - PREPAID CREDIT PC - PREPAID CASH CC - COLLECT CG - COLLECT G.B. CP - COLLECT CASH CA - COLLECT CASH MK - PARTIAL PREPAID PARTIAL COLLECT - CASH MP - PARTIAL PREPAID PARTIAL COLLECT - CASH PG - PREPAID G.P.L. AND/OR STR	CARRIER USE ONLY	
NAME BETHEL SCHOOL		CITY BET		RATE	
STREET ADDRESS		STATE		WEIGHT CHARGES	
CITY		ZIP CODE		A 6.00 B C	

3/	SPECIAL INSTRUCTIONS, INCLUDING CUSTOMER REFERENCE NUMBER	EXCESS VALUE							
4/	SHIPPER'S ACCOUNT NUMBER	SHIPPER	PCS/PKGS	LENGTH	WIDTH	DEPTH	CUBIC INCHES	D	ADVANCES
NAME DIV OF <i>Buildings</i>		CITY ANC		STATE		ZIP CODE		E	
STREET ADDRESS PO 1283		CITY		STATE		ZIP CODE		F	

5/	PREPAID ADVANCE CHGS	DESCRIPTION OF PREPAID ADVANCE CHARGES	POST ADVANCE CHGS	DESCRIPTION OF DEFERRED ADVANCE CHARGES	I	SALES TAX
6/	OTHER CHARGES	DESCRIPTION OF OTHER CHARGES	<i>Bethel School</i>		J	TOTAL CHARGES 6.30

7/	NO. PCS	WEIGHT	DESCRIPTION OF PIECES AND CONTENTS PACKING, MARKS, NUMBER	CARRIER'S COMMUNITY CALL NO.	CARRIER'S COMMUNITY PHONE NO.	CARRIER'S PHONE TO CALL IN CASE
1- 20		CTNS		Approved for payment SEP 14 1972 By <i>[Signature]</i>		

8/	TAX	TOTAL CHARGES	EXCESS VALUE	1st RATE	2nd RATE	3rd RATE	ITEMS PREPAID	SHIPPER'S CODE	CARRIER'S CODE
ANC SKIP 07/28/72		11.16					4629	4629	
DATE		TIME	DATE	TIME	DATE	TIME	ITEMS COLLECT	CONSIGNEE'S CODE	
SHIPPER'S RECEIPT		CARRIER	ORIGIN	DESTINATION	SHIPPER'S CODE	CONSIGNEE'S CODE			
212		0042	8321						

STATEMENT

Wien Consolidated Airlines, Inc.
 DIVISION OF BUILDINGS
 ANCHORAGE, ALASKA



4100 INTERNATIONAL AIRPORT RD.
 ANCHORAGE, ALASKA 99502

AUG. 1 1974

Page 3 of 4

TO **S.M. MAINTENANCE OFFICE**
 Division of Buildings
 Anchorage, Ak. 99501

33-35

8-27-72

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

TERMS - NET CASH. NO DISCOUNT ALLOWED. INTEREST CHARGED ON OVERDUE ACCOUNTS.

NO.	DATE		CODE	ITEMS	DEBITS	CREDITS	BALANCE
	DAY	YEAR					
					BALANCE FORWARD		
JUL	20	72	A	2426610	0.50		
JUL	20	72	A	2426848	8.87		
JUL	20	72	A	2426849	5.08		
JUL	21	72	A	2427019	0.50		
JUL	21	72	A	2427107	0.50		
JUL	24	72	A	2427388	10.36		
JUL	25	72	A	2427661	0.50		
JUL	27	72	A	2428074	0.50		
JUL	28	72	A	2428325	8.09		
JUL	28	72	A	2428345	8.67		
JUL	28	72	A	2428387	10.07		
JUL	28	72	A	2428530	10.07		
AUG	02	72	A	0420774	10.00		
AUG	02	72	A	0420775	10.00		
AUG	02	72	A	0420776	9.07		
AUG	02	72	A	0420777	30.00		
AUG	03	72	A	0420936	6.10		
AUG	03	72	A	0420937	1.00		
AUG	03	72	A	0420938	0.00		
AUG	04	72	A	0420939	2.00		
AUG	04	72	A	0420940	10.00		
AUG	04	72	A	0420941	7.00		
AUG	04	72	A	0420942	7.00		

Pa c/r 122109-626

Pa c/r 122109-626

Pa c/r 122109-626

CODE:
 A - FREIGHT
 B - TICKETS/PASS
 C - CASH RECEIPTS
 D - DEBIT MEMOS
 E - CREDIT MEMOS
 F - TRANSFERS
 G - JOURNAL VOUCHERS
 H - INVOICE BILLINGS
 J - EXCHANGE ORDERS

Our books close on the 25th of each month. All charges and credits received in this office after that date will appear on next month's statement.
 Correspondence regarding this statement should be mailed to
 Wien Consolidated Airlines, Inc., 4100 International Airport Rd., Anchorage, Alaska 99502

PAY LAST AMOUNT IN THIS COLUMN

RECEIVED

AUG 8 1974

Alaska State-Operated Schools
 Voucher Audit

TO:
FROM:

John P. Wilson
SHIPPER'S SIGNATURE

UNIFORM AIRBILL

NON-NEGOTIABLE

SUBJECT TO CONDITIONS OF CONTRACT ON THE REVERSE OF THIS AIRBILL

CARRIER 212	AIRBILL NUMBER 0042 8325	DATE DAY MO YR 23 03 72	TC PX	FLIGHT/DATE	FLIGHT/DATE	DECLARED VALUE NVD	CUBIC INCHES
----------------	-----------------------------	-------------------------------	----------	-------------	-------------	-----------------------	--------------

ROUTING AIRLINE ROUTING APP. IS UNLESS SHIPPER INSERTS SPECIFIC ROUTING HERE						4100 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502	
TO VIA TO VIA TO VIA TO VIA						33.030 <input checked="" type="checkbox"/> PREPAID <input type="checkbox"/> COLLECT	
1/						<i>Alaska State-Operated Airlines, Inc.</i>	

2/ CONSIGNEE'S ACCOUNT NUMBER				CONSIGNEE		CARRIER USE ONLY	
NAME ANLAK SCHOOL				CHARGE CODES PK - PREPAID CREDIT PF - 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 GTR		RATE 11	
STREET ADDRESS				CITY ANI		WEIGHT CHARGES A 7.70	
STATE				ZIP CODE		PICK UP B	
3/ SPECIAL INSTRUCTIONS, INCLUDING CUSTOMER REFERENCE NUMBER				SHIPPER'S ACCOUNT NUMBER		DELIVERY C	
SHIPPER'S ACCOUNT NUMBER				SHIPPER		EXCESS VALUE D	

4/ SHIPPER'S ACCOUNT NUMBER				SHIPPER		DIMENSIONAL WGT. - LBS.	
NAME DIV OF BLDGS				PC'S/PKG'S		LENGTH	
STREET ADDRESS PO 1284				WIDTH		DEPTH	
CITY ANC				STATE		ZIP CODE	
5/ PICK UP ZONE				DESCRIPTION OF ORIGIN ADVANCE CHARGES		DESCRIPTION OF DESTINATION ADVANCE CHARGES	
6/ OTHER CHARGES				DESCRIPTION OF OTHER CHARGES		G.B.L. NUMBER	
7/ NO. PCS				WEIGHT		DESCRIPTION OF PIECES AND CONTENTS PACKING, MARKS, NUMBER	
2 -				70		CTNS	
8/ TAX				TOTAL CHARGES		1st RATE	
9/ TAX				TOTAL CHARGES		2nd RATE	
10/ TAX				TOTAL CHARGES		3rd RATE	
11/ TAX				TOTAL CHARGES		ITEMS PREPAID	
12/ TAX				TOTAL CHARGES		SHIPPER'S PAYS	
13/ TAX				TOTAL CHARGES		ITEMS COLLECT	
14/ TAX				TOTAL CHARGES		CONSIGNEE'S PAYS	

15/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER'S PAYS	
16/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS COLLECT		CONSIGNEE'S PAYS	
17/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER'S PAYS	
18/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS COLLECT		CONSIGNEE'S PAYS	

19/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER'S PAYS	
20/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS COLLECT		CONSIGNEE'S PAYS	
21/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER'S PAYS	
22/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS COLLECT		CONSIGNEE'S PAYS	

23/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER'S PAYS	
24/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS COLLECT		CONSIGNEE'S PAYS	
25/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER'S PAYS	
26/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS COLLECT		CONSIGNEE'S PAYS	

27/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER'S PAYS	
28/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS COLLECT		CONSIGNEE'S PAYS	

29/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER'S PAYS	
30/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS COLLECT		CONSIGNEE'S PAYS	
31/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER'S PAYS	
32/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS COLLECT		CONSIGNEE'S PAYS	

33/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER'S PAYS	
34/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS COLLECT		CONSIGNEE'S PAYS	

35/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS PREPAID		SHIPPER'S PAYS	
36/ TAX				TOTAL CHARGES		1st RATE		2nd RATE		3rd RATE		ITEMS COLLECT		CONSIGNEE'S PAYS	

CARRIER ACCOUNTING COPY

CARRIER	ORIGIN	SERIAL NUMBER
212		0042 8325

J.P. Wilson
ANC SKIP 07/28/72 11:15

J.P. Wilson
ANC SKIP 07/28/72 11:15

RECEIVED BY	DATE	TIME	CARRIER	ORIGIN	SERIAL NUMBER
<i>J.P. Wilson</i>	07/28/72	11:15	212		0042 8325

DELIVERY RECEIPT

RECEIVED

AUG 8 1974

Alaska State-Operated Schools

6 74 131517

SHIPPER'S NAME

212

0042 8325

5-ANC SKIP

07/28/72

11:5

4-476-257-00

NO. PCS.	2	NO. OF CONTAINERS	2
WEIGHT	70	WEIGHT	70
CONTENTS	CTNS		
DATE	AUG 27 1972		

SHIPPER'S ACCOUNT NUMBER: SHIPPER

CONSIGNEE'S ACCOUNT NUMBER: CONSIGNEE

SHIPMENT TYPE: SHIPMENT

SHIPMENT ADDRESS: DIV OF B DSS

SHIPMENT DATE: 09 1987

SHIPMENT TO: ANO

SHIPMENT FROM: ANO

SHIPMENT TYPE: SHIPMENT

SHIPMENT ADDRESS: ANI

SHIPMENT DATE: 09 1987

SHIPMENT TO: ANI

SHIPMENT FROM: ANI

SHIPMENT TYPE: SHIPMENT

SHIPMENT ADDRESS: ANI

SHIPMENT DATE: 09 1987

SHIPMENT TO: ANI

SHIPMENT FROM: ANI

SHIPMENT TYPE: SHIPMENT

SHIPMENT ADDRESS: ANI

SHIPMENT DATE: 09 1987

SHIPMENT TO: ANI

SHIPMENT FROM: ANI

STATEMENT

RECEIVED
DIVISION OF BUILDINGS
ANCHORAGE, ALASKA
Wien Consolidated Airlines, Inc.



4100 INTERNATIONAL AIRPORT RD.
ANCHORAGE, ALASKA 99502

AUG 1 1974

MAINTENANCE OFFICE

TO DIV OF BUILDINGS
PO BOX 1
JUNEAU AK 99801

33030

7-25-72

PLEASE DETACH AND
RETURN THIS PORTION
WITH YOUR REMITTANCE

TERMS - NET CASH. NO DISCOUNT ALLOWED. INTEREST CHARGED ON OVERDUE ACCOUNTS.

MO	DATE		CODE	ITEMS	DEBITS	CREDITS	BALANCE
	DAY	YEAR					
					BALANCE FORWARD		
MAY	12	72	B1270020		4400		
MAY	23	72	B1202000		1700		
MAY	25	72	B1510000		2700		
MAY	19	72	B0007307		3200		
JUN	10	72	B0002000		577		
JUN	12	72	B2250914		2000		
JUN	25	72	B0005593		1400		
JUN	25	72	B0310000		0000		
JUN	06	72	B0001075		2000		
JUN	06	72	B0003122		7400		
JUN	10	72	B0110100		5007		
JUN	10	72	A0305000		1000		
JUN	10	72	A0305000		4200		
JUN	10	72	A0304601		630		
JUN	12	72	A0304050		7000		
JUN	20	72	A0307001		2000		
JUN	20	72	A0310000		1000		
JUN	07	72	A0396210		630		
JUN	20	72	B0300000		0000		
JUN	20	72	B0300000		2000		
JUN	20	72	B0300000		2000		
JUN	20	72	B0300000		2000		
JUN	20	72	B0300000		2000		
JUN	20	72	B0300000		2000		

Pa CR 091910 - 617
Pa CR 082104 - 614
Pa CR 082104 - 614
Pa CR 082104 - 614
Pa CR 122904 - 628
Pa CR 082104 - 614

CODE:
A - FREIGHT
B - TICKETS/PASSI
C - CASH RECEIPTS
D - DEBIT MEMOS
E - CREDIT MEMOS
F - TRANSFERS
G - JOURNAL VOUCHERS
H - INVOICE BILLINGS
J - EXCHANGE ORDERS

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Wien Consolidated Airlines, Inc., 4100 International Airport Rd., Anchorage, Alaska 99502

PAY LAST
AMOUNT
IN THIS
COLUMN

212 AKN 0039 6210 COLLECT GAB H

4100 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502

33.030

PREPAID COLLECT

When Consolidated Air Lines Inc.

2/ CONSIGNEE'S ACCOUNT NUMBER		↓ CONSIGNEE ↓		CHARGE CODES PK - PREPAID CREDIT PP - PREPAID CASH CC - COLLECT CO - COLLECT G.R.L. CP - COLLECT CASH CX - COLLECT CREDIT MX - PART PREPAID, PARTIAL COLLECT-CREDIT MP - PART PREPAID, PARTIAL COLLECT - CASH PG - PREPAID G.R.L. AND/OR CTR		CARRIER USE ONLY	
NAME DIVISION OF BLDG.		CITY ANCHORAGE		STATE ALASKA		RATE	
STREET ADDRESS 3507 SPAR AVE.		CITY ANCHORAGE		STATE ALASKA		CHARGES WEIGHT CHARGES A EXCESS VALUE D ADVANCES E OTHER F SHIPPER'S C.O.D. G C.O.D. FEE H TAX T TOTAL CHARGES T	

3/ SPECIAL INSTRUCTIONS, INCLUDING CUSTOMER REFERENCE NUMBER		SHIPPER'S ACCOUNT NUMBER		PCS/PKGS. LENGTH		WIDTH		DEPTH		CUBIC INCHES		CHARGES	
		↓ SHIPPER ↓		/		X		X		=		A	
NAME JERRY HILL		CITY KING SALMON		STATE ALASKA		CITY KING SALMON		STATE ALASKA		CITY KING SALMON		STATE ALASKA	
STREET ADDRESS		CITY		STATE		CITY		STATE		CITY		STATE	

5/ OTHER CHARGES		DESCRIPTION OF OTHER CHARGES		G.R.L. NUMBER		TOTAL CHARGES	

NO.	PCS.	WEIGHT	DESCRIPTION OF PIECES AND CONTENTS PACKING, MARKS, NUMBER			CARRIER COMBY GROUP NO.	CARRIER CODE BY G.F.O.P. NO.	CARRIER CODE BY G.F.O.P. NO.
7/	3	2	WATER SAMPLE IN BIG BOX			/	/	/
			CALL ON ARR. DIVISION OF BLDG Q			/	/	/
			277-2667			/	/	/
			NOTED NOTED NOTED			/	/	/

WEIGHT CHARGES	TAX	TOTAL CHARGES	PICK UP	DELIVERY	EXCESS VALUE	ADVANCES	OTHER	SHIPPER'S C.O.D.	C.O.D. FEE
6.00		6.30							

7 JUNE 72 CARRIER ACCOUNTING COPY

212 0039 6210

WEIGHT CHARGES	TAX	TOTAL CHARGES	PICK UP	DELIVERY	EXCESS VALUE	ADVANCES	OTHER	SHIPPER'S C.O.D.	C.O.D. FEE
6.50		6.50							

STATE
of ALASKA

MEMORANDUM

TO: Ron Lind, Deputy Director
Division of Budget and Management
Department of Administration

DATE : December 13, 1973

FROM: John Benson, Director
Division of Buildings
Department of Public Works

SUBJECT: Miscellaneous claims
FY 70-71
131-1-03 K

The Division of Buildings, Department of Public Works, requests the attached invoices be included in your supplemental claims request in accordance with AS 37. 25. 010.

It has been determined that these invoices are just charges and payment has not been made. Your continued prompt attention to these matters is appreciated.

Attachments

N C MACHINERY CO.

A DIVISION OF NORTHERN COMMERCIAL COMPANY

Please REMIT TO:

6450 PACIFIC BLVD.
ANCHORAGE, ALASKA

P.O. BOX 611
ANCHORAGE, ALASKA

IN ACCOUNT WITH:

STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAR ROAD
ANCHORAGE, ALASKA 99501

RECEIVED
DIVISION OF BUILDINGS
ANCHORAGE, ALASKA

CUSTOMER NUMBER 9993112

OCT 9 1973

CLOSING DATE OF THIS BILLING CYCLE IS:

09-30-73

MAINTENANCE OFFICE

PAGE 1

PLEASE DETACH AND RETURN WITH YOUR REMITTANCE \$ _____

TERMS:	DATE	REFERENCE	CHARGES/CREDITS	PAYMENTS	BALANCE
PAYABLE BY 15TH OF MONTH FOLLOWING DATE OF PURCHASE. FINANCE CHARGE* WHICH IS COMPUTED BY A PERIODIC RATE OF 1% PER MONTH APPLIED TO THE PREVIOUS BALANCE, LESS CURRENT PAYMENTS AND CREDITS APPEARING ON THIS STATEMENT, IS CHARGED ON PAST DUE AMOUNTS. ANNUAL PERCENTAGE RATE IS 12%. TO AVOID ADDITIONAL FINANCE CHARGES PAY NEW BALANCE BEFORE 10 OF MONTH.				PREVIOUS BALANCE	933.58
			RECEIVED OCT 11 1973 DIVISION OF BUILDINGS ANCHORAGE, ALASKA		933.58
0 CURRENT	6 30 DAYS		9 60 DAYS	933.58 90 DAYS	933.58 NEW BALANCE

FORM NO. 1029 25M 3/72

N C MACHINERY CO.
CUSTOMER COPY

PRINTED IN U.S.A.

STATEMENT

N C MACHINERY CO.

A DIVISION OF NORTHERN COMMERCIAL COMPANY

Please REMIT TO:

6450 ARCTIC BLVD.
ANCHORAGE, ALASKA

BOX 6143 99502
ANCHORAGE, ALAS

IN ACCOUNT WITH:

STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAN ROAD
ANCHORAGE, ALASKA 99501

RECEIVED
DIVISION OF BUILDINGS
ANCHORAGE, ALASKA

CUSTOMER NUMBER 9993112

CLOSING DATE OF THIS
BILLING CYCLE IS.

07-31-83

AUG 6 1983

PAGE 1

PLEASE DETACH AND RETURN WITH YOUR REMITTANCE \$

TERMS:	DATE	REFERENCE	CHARGES/CREDITS	PAYMENTS	BALANCE
<p>1. PAYABLE BY 15TH OF MONTH FOLLOWING DATE OF CHASE.</p> <p>FINANCE CHARGE* WHICH IS COMPUTED BY A MONTHLY RATE OF 1% PER CENT APPLIED TO THE PREVIOUS BALANCE, LESS RECENT PAYMENTS AND CREDITS APPEARING ON STATEMENT, IS CHARGED ON PAST DUE AMOUNTS.</p> <p>ANNUAL PERCENTAGE RATE IS 12%.</p> <p>AVOID ADDITIONAL FINANCE CHARGES BY PAYING BALANCE BEFORE 15TH OF MONTH.</p>				PREVIOUS BALANCE	933.58
					933.58
			41.29	892.29	933.58
CURRENT	30 DAYS		60 DAYS	90 DAYS	NEW BALANCE

NO. 1029 25M 3/72

N C MACHINERY CO.
CUSTOMER COPY

PRINTED IN U.S.A.

STATEMENT

N C MACHINERY CO.

A DIVISION OF NORTHERN COMMERCIAL COMPANY

Please REMIT TO:

6450 ARCTIC BLVD.
ANCHORAGE, ALASKA

BOX 6148 99507
ANCHORAGE, ALASKA

IN ACCOUNT WITH:

STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAR ROAD
ANCHORAGE, ALASKA 99501

RECEIVED
DIVISION OF BUILDINGS
ANCHORAGE, ALASKA

JUL 12 1973

MAINTENANCE OFFICE

CUSTOMER NUMBER 9993112

CLOSING DATE OF THIS BILLING CYCLE IS 06-30-73

PAGE 1

PLEASE DETACH AND RETURN WITH YOUR REMITTANCE \$

TERMS:	DATE	REFERENCE	CHARGES/CREDITS	PAYMENTS	BALANCE	
NET PAYABLE BY 15TH OF MONTH FOLLOWING DATE OF PURCHASE. FINANCE CHARGE WHICH IS COMPUTED BY A PERIODIC RATE OF 1% PER MONTH APPLIED TO THE PREVIOUS BALANCE, LESS CURRENT PAYMENTS AND CREDITS APPEARING ON THIS STATEMENT, IS CHARGED ON PAST DUE AMOUNTS. ANNUAL PERCENTAGE RATE IS 12%. TO AVOID ADDITIONAL FINANCE CHARGES PAY NEW BALANCE BEFORE 10 OF MONTH.	06-01-73	07593		PREVIOUS BALANCE 41.29	974.87	
					933.58	
			41.29 CURRENT	372.72 60 DAYS	519.57 90 DAYS	933.58 NEW BALANCE

FORM NO. 1029 25M 6/71

N C MACHINERY CO. PRINTED IN U.S.A.
CUSTOMER COPY

N C MACHINERY CO. PRINTED IN U.S.A.
CUSTOMER COPY

STATEMENT

N C MACHINERY CO.

A DIVISION OF NORTHERN COMMERCIAL COMPANY

Please REMIT TO:

6450 ARCTIC BLVD.
ANCHORAGE, ALASKA

BOX 6148 99507
ANCHORAGE, ALASKA

IN ACCOUNT WITH:

STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAR ROAD
ANCHORAGE, ALASKA 99501

RECEIVED
DIVISION OF BUILDINGS
ANCHORAGE, ALASKA

SEP 10 1973

CUSTOMER NUMBER 9993112

CLOSING DATE OF THIS BILLING CYCLE IS. 08-31-73

PAGE 1

MAINTENANCE OFFICE

PLEASE DETACH AND RETURN WITH YOUR REMITTANCE \$

TERMS:	DATE	REFERENCE	CHARGES/CREDITS	PAYMENTS	BALANCE
<p>TERMS:</p> <p>T. PAYABLE BY 15TH OF THE FOLLOWING DATE OF CHASE.</p> <p>FINANCE CHARGE* WHICH IS COMPUTED BY A PERIODIC RATE OF 1% PER MONTH APPLIED TO THE PREVIOUS BALANCE, LESS PRESENT PAYMENTS AND CREDITS APPEARING ON THIS STATEMENT, IS CHARGED ON PAST DUE AMOUNTS.</p> <p>ANNUAL PERCENTAGE RATE IS 12%.</p> <p>TO AVOID ADDITIONAL FINANCE CHARGES PAY NEW BALANCE BEFORE END OF MONTH.</p>					933.58
			PREVIOUS BALANCE		933.58
	08 13 73				933.58
					933.58
				933.58	933.58
				90 DAYS	NEW BALANCE

FORM NO. 1029 25M 3/72

N C MACHINERY CO.
CUSTOMER COPY

PRINTED IN U.S.A.

6-27-71

Form 3501

Director

District Engineer

Engineering Equipment

Just as a matter of fact you have a balance that is past due in the amount of \$1,100.00. If your check has not been sent, we will appreciate your bringing to attention to this matter so that payment will reach us in a few days.

If for some reason you are withholding payment, please contact us at once by phone or mail.

*Please enclose all, may use Receipt
you sent: Mr. Hill, Dept.*

*State of Alaska
Div of Buildings
150 W. Green Street
Anchorage, Alaska 99501*

H C MACHINERY CO.
A DIVISION OF WESTHEKA COMMERCIAL COMPANY

Anchorage, Alaska 99502 Ph. 277-2465
P.O. Box 6148

FORM 3501

PRINTED IN U.S.A.

.C O T

1-4-71	07412	2	00	00	00
4-16-71	27385	2	00	00	00
2-22-71	25890	2	00	00	00
11-9-70	21423	2	00	00	00
5-5-70	12165	2	00	00	00
5-8-70	1266	2	00	00	00
5-22-70	12490	2	00	00	02
2-3-70	02830	2	00	00	00
2-16-70	0930	1	00	00	00
2-16-70	08670	1	00	00	13
2-16-70	02627	2	00	00	02
9-10-71	36244	2	00	00	00
9-24-71	36024	2	00	00	00
		22	00	00	00

DEPT. OF PUBLIC WORKS
RECEIVED

SEP 24 1973

DIVISION OF BUILDINGS

A DIVISION OF NORTHERN COMMERCIAL COMPANY

6450 ARCTIC BLVD,
ANCHORAGE, ALASKA

PLEASE REMIT TO:

BOX 6143
ANCHORAGE, ALASKA

CUSTOMER ORDER NO.	DATE SHIPPED 01-23-70	COLLECT	PREPAID	PAGE 1 OF 1	PAGES 1	NO. INV. 2	INVOICE DATE 02-03-70	INVOICE NUMBER 03830
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BACK ORDERED PARTS
TO: FROM:

SHIP:

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CREDIT

STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAR ROAD
ANCHORAGE, ALASKA 99501

9993112

QUANTITY		PART NUMBER	DESCRIPTION	DEPT.	UNIT PRICE	%	EXTENSION
ORDERED	SHIPPED						
2-	2-	*F7003	GASKET	201	1.44		2.88
2-	2-	2A3483	GASKET	201	1.06		2.12

TERMS NET. PAYABLE BY 15TH OF MONTH FOLLOWING DATE OF PURCHASE.

MERCHANDISE WILL NOT BE RETURNED FOR CREDIT 180 M 6/69 WITHOUT OUR PRIOR APPROVAL.

ALL MERCHANDISE ACCEPTED BY US FOR CREDIT IS SUBJECT TO A 10% RESTOCKING CHARGE.

TOTAL
\$ 5.00

1027 6-69 PRINTED IN U.S.A.

A DIVISION OF NORTHERN COMMERCIAL COMPANY

6450 ARCTIC BLVD.
ANCHORAGE, ALASKA

PLEASE REMIT TO:
BOX 6148
ANCHORAGE, ALA.

CUSTOMER ORDER NO. 3438	DATE SHIPPED 02-03-70	COLLECT	PREPAID	PAGE 1 of 1	PAGES 1	NO. INV. 2	INVOICE DATE 02-13-70	INVOICE NUMBER 09033
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BACK ORDERED PARTS
TO: FROM:

SHIP:

3 V
A 277-1667
T
O 9993112 GEORGE TOWN SCHOOL

STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAR ROAD
ANCHORAGE, ALASKA 99501

QUANTITY		PART NUMBER	DESCRIPTION	DEPT.	UNIT PRICE	%	EXTENSION
ORDERED	SHIPPED						
1	1	47-745-000	PUMP	212	111.32		111.32
1	1	NPN	TRAN. CHGS	252	1.64		1.64

AMTS NET. PAYABLE BY 15TH OF MONTH
FOLLOWING DATE OF PURCHASE.

MERCHANDISE WILL NOT BE RETURNED FOR CREDIT 180 M 6/69
WITHOUT OUR PRIOR APPROVAL.

ALL MERCHANDISE ACCEPTED BY US FOR CREDIT IS
SUBJECT TO A 10% RESTOCKING CHARGE.

TOTAL
112.96

1027 6-69 PRINTED IN U.S.A.

H. C. MACHINERY CO.

A DIVISION OF NORTHERN COMMERCIAL COMPANY

6450 ARCTIC BLVD.
ANCHORAGE, ALASKA

PLEASE REMIT TO:

BOX 6149
ANCHORAGE, ALA.

CUSTOMER ORDER NO. 5400	DATE SHIPPED 02-05-70	COLLECT	PREPAID	PAGE 1 OF 1	PAGES 1	NO. INV. 2	INVOICE DATE 02-16-70	INVOICE NUMBER 00000
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BACK ORDERED PARTS
TO: FROM:

SHIP:

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STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAR ROAD
ANCHORAGE, ALASKA 99501

9993112

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PORT HEIDEN
30 WITTE

QUANTITY		PART NUMBER	DESCRIPTION	DEPT.	UNIT PRICE	%	EXTENSION
ORDERED	SHIPPED						
1	1	47-012-657	BRG	212	14.38		14.38
1	1	NPN	TRAN. CHGS	252	.80		.80

IS NET. PAYABLE BY 15TH OF MONTH
FOLLOWING DATE OF PURCHASE.

MERCHANDISE WILL NOT BE RETURNED FOR CREDIT 180 M 6/69
WITHOUT OUR PRIOR APPROVAL.

ALL MERCHANDISE ACCEPTED BY US FOR CREDIT IS
SUBJECT TO A 10% RESTOCKING CHARGE.

TOTAL
15.18

1027 6-69 PRINTED IN U.S.A.

8455 ARCTIC BLVD.
ANCHORAGE, ALASKA

PLEASE REMIT TO
BOX 814
ANCHORAGE, ALASKA

DATE SHIPPED 02-16-70	COLLECT	PREPAID	PAGE 1	NO. INV. 2	INVOICE DATE 02-20-70	INVOICE NO. 01527
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BACK ORDERED PARTS
TO: FROM:

SHIP:

3 VIA PEDRO BAY
9993112 T B D WITTE
O

STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAR ROAD
ANCHORAGE, ALASKA 99501

QUANTITY		PART NUMBER	DESCRIPTION	DEPT.	UNIT PRICE	%	EXTENSION
ORDERED	SHIPPED						
2	2	47-012-857	BRG	212	14.38		29.7
1	1	47-870-003	RING SET	212	4.36		4.6

15% NET, PAYABLE BY 15TH OF MONTH
FOLLOWING DATE OF PURCHASE.

MERCHANDISE WILL NOT BE RETURNED FOR CREDIT 180 M 6/69
WITHOUT OUR PRIOR APPROVAL.

ALL MERCHANDISE ACCEPTED BY US FOR CREDIT IS
SUBJECT TO A 10% RESTOCKING CHARGE.

TOTAL

33.42

1027 6-69 PRINTED IN U.S.A.

6450 ARCTIC BLVD.
ANCHORAGE, ALASKA

BOX 6144
ANCHORAGE, AL

ORDER NO. 5731	DATE SHIPPED 04-23-70	COLLECT	REPAID	PAGE 1 of 1	NO. INV. 2	INV. 05-05-70	TERMS 11115
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BACK ORDERED PARTS
TO: FROM:

SHIP:

STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAR ROAD
ANCHORAGE, ALASKA 99501

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CUSTOMER FILE	QUANTITY		PART NUMBER	DESCRIPTION	DEPT.	UNIT PRICE	%	EXTENSION
	ORDERED	SHIPPED						
	1	1	47-400-594	TRANSFORME	212	36.23		36.2
	1	1	47-400-595	REACTOR	212	37.49		37.4
	1	1	47-400-651	RESISTOR	212	6.10		6.1
	1	1	NPN	TRAN. CHGS	252	7.68		7.6

TERMS NET. PAYABLE BY 15TH OF MONTH FOLLOWING DATE OF PURCHASE.

MERCHANDISE WILL NOT BE RETURNED FOR CREDIT 180 M 6/69 WITHOUT OUR PRIOR APPROVAL.

ALL MERCHANDISE ACCEPTED BY US FOR CREDIT IS SUBJECT TO A 10% RESTOCKING CHARGE.

TOTAL

87.50

6450 ARCTIC BLVD.
ANCHORAGE, ALASKA

BOX 61-1
ANCHORAGE, ALASKA

CUSTOMER ORDER NO. 2007	DATE SHIPPED 05-04-70	COLLECT	PREPAID	PAGE 1 OF 1	PAGE NO. IN V. 2	INVOICE DATE 05-03-70	INVOICE NO. 1220
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BACK ORDERED PARTS

SHIP:

TO: FROM:

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STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAR ROAD
ANCHORAGE, ALASKA 99501

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CUSTOMER FILE	QUANTITY		PART NUMBER	DESCRIPTION	DEPT.	UNIT PRICE	%	EXTENSION
	ORDERED	SHIPPED						
	1	1	47-000-072	BRACKET	212	18.78		18
	1	1	NPN	TRAN. CHGS	252	5.18		5

TERMS NET. PAYABLE BY 15TH OF MONTH FOLLOWING DATE OF PURCHASE.

MERCHANDISE WILL NOT BE RETURNED FOR CREDIT 180 M 6/69 WITHOUT OUR PRIOR APPROVAL.

ALL MERCHANDISE ACCEPTED BY US FOR CREDIT IS SUBJECT TO A 10% RESTOCKING CHARGE.

TOTAL

23.

6450 ARCTIC BLVD.
ANCHORAGE, ALASKA

BOX 6144
ANCHORAGE, AL

ORDER NO. PASS 32	DATE SHIPPED 05-03-70	COLLECT	PREPAID	PAGE 1 OF 1	PAGES 1	NO. INV. 2	INVOICE DATE 05-22-70	INVOICE TOTAL 12.00
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BACK ORDERED PARTS
TO: FROM:
STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAR ROAD
ANCHORAGE, ALASKA 99501

SHIP:
3 VIA 30
9993112 TO WHSE LIGHT PLANT

CUSTOMER FILE	QUANTITY		PART NUMBER	DESCRIPTION	DEPT.	UNIT PRICE	%	EXTENSION
	ORDERED	SHIPPED						
	12	12	47-311-202	SPLASHER	212	0.46		5.52
	1	1	NPN	TRAN. CHGS	252	1.10		1.10

TERMS NET. PAYABLE BY 15TH OF MONTH FOLLOWING DATE OF PURCHASE.

MERCHANDISE WILL NOT BE RETURNED FOR CREDIT 180 DAYS WITHOUT OUR PRIOR APPROVAL.
ALL MERCHANDISE ACCEPTED BY US FOR CREDIT IS SUBJECT TO A 10% RESTOCKING CHARGE.

TOTAL 7.62
1027 6-69 PRINTED IN U.S.A.

ANCHORAGE, ALASKA

BOX 6174
ANCHORAGE, AL

DATE SHIPPED 10-27-70	COLLECT	UNPAID	PAGE 1	OF 1	PAGES	NO. INV. 2	INVOICE DATE 11-09-70	INVOICE NO. 21423
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BACK ORDERED PARTS
TO: FROM:

SHIP:

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A/C WEINS TO KING SALMON-PENIT.

9993112

STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAR ROAD
ANCHORAGE, ALASKA 99501

QUANTITY		PART NUMBER	DESCRIPTION	DEPT	UNIT PRICE	%	EXTENSION
ORDERED	SHIPPED						
1	1	327-36132-	REGULATOR	214	278.00		278.00
8	8	50-12041-0	BRUSH DC	214	1.50		12.00
8	8	50-06041-0	BRUSH AC	214	1.50		12.00

TERMS NET. PAYABLE BY 15TH OF MONTH FOLLOWING DATE OF PURCHASE.

MERCHANDISE WILL NOT BE RETURNED FOR CREDIT 180 M 5/69 WITHOUT OUR PRIOR APPROVAL.

ALL MERCHANDISE ACCEPTED BY US FOR CREDIT IS SUBJECT TO A 10% RESTOCKING CHARGE.

TOTAL

302.00

1027 6-69 PRINTED IN U.S.A.

A DIVISION OF NORTHERN COMMERCIAL COMPANY
 2450 ARCTIC BLVD.
 ANCHORAGE, ALASKA

PLEASE REMIT TO
 BOX 6146
 ANCHORAGE, ALASKA

ORDER NUMBER	DATE SHIPPED	COLLECT	PRE-PAID	PAGE	OF	PAGES	NO. INV.	INVOICE DATE	INVOICE NUMBER
PA517Z	02-18-71			1	1	2		02-22-71	25890

BACK ORDERED PARTS
 TO: FROM:

SHIP:

STATE OF ALASKA
 DIVISION OF BUILDINGS
 1507 SPAR ROAD
 ANCHORAGE, ALASKA 99501

4 VIA AIR MAIL
 9993112 SAME
 CHIGHIK LAGOON SCH
 ALASKA

QUANTITY		PART NUMBER	DESCRIPTION	DEPT.	UNIT PRICE	%	EXTENSION
ORDERED	SHIPPED						
4	4	47-086-225	CELL	212	7.99		31.9
2	2	47-067-400	GSKT	212	.63		1.2

TERMS NET. PAYABLE BY 15TH OF MONTH FOLLOWING DATE OF PURCHASE.

MERCHANDISE WILL NOT BE RETURNED FOR CREDIT 120 M 1/70 WITHOUT OUR PRIOR APPROVAL.
 ALL MERCHANDISE ACCEPTED BY US FOR CREDIT IS SUBJECT TO A 10% RESTOCKING CHARGE.

TOTAL
 33.2
 1027 1-70 PRINTED IN U.S.A.

N C MACHINERY CO.

A DIVISION OF NORTHERN COMMERCIAL COMPANY

PLEASE REMIT TO:

6450 ARCTIC BLVD.
ANCHORAGE, ALASKA

BOX 8148 9950
ANCHORAGE, ALASKA

FORM ORDER NO. 2735	DATE SHIPPED 04-13-71	COLLECT	PREPAID	PAGE 1	OF 1	PAGES	NO. INV. 2	INVOICE DATE 04-18-71	INVOICE NUMBER 27355
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OK ORDERED PARTS
FROM:

SHIP:

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W/C
9993112 T
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STATE OF ALASKA
DIVISION OF BUILDINGS
1507 SPAR ROAD
ANCHORAGE, ALASKA 99501

DIV OF BLDGS

QUANTITY		PART NUMBER	DESCRIPTION	DEPT.	UNIT PRICE	%	EXTENSION
ORDERED	SHIPPED						
1	1	47-400-453	HEAD COMP	212	293.34		293.34
1	1	712006	TRAN. CHGS	252	30.38		30.38

NET. PAYABLE BY 15TH OF MONTH
FOLLOWING DATE OF PURCHASE.

MERCHANDISE WILL NOT BE RETURNED FOR CREDIT 180 M 6/69
WITHOUT OUR PRIOR APPROVAL.
ALL MERCHANDISE ACCEPTED BY US FOR CREDIT IS
SUBJECT TO A 10% RESTOCKING CHARGE.

TOTAL
323.72

1027 6-69 PRINTED IN U.S.A.

NUMBER
27355A

TO STATE OF ALASKA 9993113
DIVISION OF BUILDINGS

W.C. MACHINERY
A DIVISION OF NORTHERN COMMERCIAL COMPANY
W/C

ORDER NO. 21221097
1507 SPAR RD
ANCHORAGE ALASKA 99501 VIA *w/c*

FROM 3-8-71
DATE SHIPPED
WRITTEN BY *W.C.*
CUSTOMER ORDER NO. 6958
CHARGE - 1 X
CASH - 2
C.O.D. - 3
PAGE PAGE OF

6450 ARCTIC BLVD. P.O. B
ANCHORAGE, Phone: 277-2465

LOCATION	BACK ORDERED	DATE ORDERED	DATE SHIPPED	D-SHIP	PART NO.	REPLACED BY	DESCRIPTION	DEPT	UNIT COST	UNIT PRICE	QTY	EXTENDED
<i>N/S</i>	<i>X</i>	<i>1</i>	<i>0</i>	<i>1</i>	<i>47-316-440</i>		<i>HEAD COMPLETE</i>	<i>212</i>				<i>293</i>
					<i>47-400-453</i>		<i>WITH VALVE AND SPRINGS</i>					
		<i>1</i>	<i>1</i>		<i>7120016</i>		<i>FET TO ANCH</i>	<i>252</i>	<i>30.38</i>	<i>30.38</i>	<i>10</i>	<i>303</i>

MERCHANDISE WILL NOT BE RETURNED FOR CREDIT WITHOUT PRIOR APPROVAL. THERE WILL BE A 10% RESTOCKING CHARGE FOR ALL MERCHANDISE ACCEPTED BY US FOR CREDIT.

TERMS NET. PAYABLE BY 15TH OF MONTH FOLLOWING DATE OF PURCHASE. SERVICE CHARGE OF 1% PER MONTH CHARGED ON PAST DUE ACCOUNTS.

RECEIVED BY
Peter Clayton
11/21/71

SALES TAX
TOTAL *323*

THIS INVOICE IS SUBJECT TO THE ADDITIONAL TERMS AND CONDITIONS, INCLUDING WARRANTY LIMITATIONS, SET FORTH ON THE REVERSE SIDE HEREOF

FROM

SHIPPER'S SIGNATURE AND DATE

DECLARED VALUE AGREED AND UNDERSTOOD TO BE NOT MORE THAN THE VALUE STATED IN THE GOVERNING TARIFFS FOR EACH POUND ON WHICH CHARGES ARE ASSESSED UNLESS A HIGHER VALUE IS DECLARED AND APPLICABLE CHARGES PAID THEREON.

(CHECK ONE)

PREPAID

COLLECT

PIECES	DESCRIPTION	WEIGHT	RATE		
1	7/17 02-914-2361 ADV. 25.50	42		9202	
2	10/17/92 VA-MKC-1146 ADV. 9.57	124		9692	
3	4-433, #221, #1215 VA-MKC-1130 ADV. 41.70	173		200	
6	SPECIAL INSTRUCTIONS TO FORWARDER 500-20-225-3308	349			
<p>It is mutually agreed that the goods herein described are accepted in apparent good condition as noted for transportation and delivery at the date hereof which is in accordance with law. Said classifications and tariffs, copies of which are available for inspection by the parties hereto, are hereby incorporated into and made part of this contract.</p>				ADVANCES	
				DELIVERY	
				INSURANCE	
				DECL'D. VALUE	
				C.O.D. FEE	
RECEIVED BY WITS AIR CARGO SERVICE				SHIPPERS	
CONSIGNEE'S SIGNATURE <i>Charlie Brown</i>				C.O.D.	XXXXXX
DATE 4/12/70 TIME 8:30				TOTAL CHGS.	171.70
				AIR BILL NUMBER	SEA 71200

CONSIGNEE'S COPY

FORWARD TO DESTINATION

STATE OF ALASKA
 DEPARTMENT OF PUBLIC WORKS
 Division of Administration
 Fiscal Section
 P. O. Box 1361
 Juneau, Alaska

ADMINISTRATIVE DIFFERENCE STATEMENT
 N C Machinery Company

Name of Vendor:

P.O. Box 6148

Address:

Anchorage, AK 99502

City:

We are unable to process your invoice for payment because:

We have researched our files and are unable to find where they have been paid, except for the \$323.72. Could it be you copied the number wrong and it should be 27352 instead of 27355. The money amount and dates are the same on both. Please send copies of others, I am sure that one time we had them, and sent to our Division of Buildings for coding. Will need copy of credits also. Will do my very best to expedite payment.

We suggest that you issue monthly statements with individual invoices attached. The statement should show invoice numbers and totals. The original sales ticket may be retained by your office at time of purchase and two copies given to the employee.

Name of Public Works Official

W. L. RIDDLE
 CHIEF FISCAL SECTION

Title

W. L. Riddle

Date

12/16/73

THIS SPACE SHOULD BE USED FOR YOUR REPLY

REPLY:

Inv # in question is 27355, a copy of the signed delivery order is attached along with copies of all other outstanding invoices. We have copies of freight bills etc, showing we've ordered and delivered 2 # 47-400-453 on Inv. 27352 & 27355 per 2 separate telephone orders for this item.

Name of Vendor Official

Mrs. Shirley Urquhart

Title

Bookkeeper

Date

9-19-73

MEMORANDUM

State of Alaska

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

DATE: March 15, 1974

FILE NO: 131-1-03 L

TELEPHONE NO:

FROM: John E. Benson, Director
Division of Buildings
Department of Public Works

SUBJECT: Miscellaneous Claims
FY 71-72

The Division of Buildings, Department of Public Works requests that the attached invoices be included in your supplemental claims request in accordance with AS 37.25.010.

It has been determined that the invoices are just charges and that payment has not been made.

JEB:AG:gm
Attachment

Alaska Power & Light Company

Museum Site

November 8, 1971 billing	\$1,094.59
Less Surcharge paid twice	(12.46)
Add payment short in July 1972	<u>.07</u>
Balance Due	\$1,082.20

ORIGINAL



Yukon Office Supply, Inc.

226 SAMBELL
ANCHORAGE, ALASKA 99501

PHONE 277-1111

CUST. P.O. NO. 13-5A-1021 DATE 8/3/71

CUSTOMER State of Alaska Dept. of Public Works

ADDRESS 4 William E. Boltz School - Box 13

CITY Nome Alaska - (City of Nome Control)

SELL BY	CASH	C.O.D.	CHARGE	BY CHECK	POST. MET.	PAYDOWN	REMARKS
<u>HL</u>			<u>X</u>			<u>U</u>	<u>5/2</u>

CA-5531 110+

10 ea Equip # 1964 E
Steel Shoveling Machine
1st each package 3 Pcs
package 12" deep - 91.25 912.50

10 ea Equip # 1964
Steel Shoveling Machine
1st each package 3 Pcs
package 12" deep 75.00 750.00
1102.50

Ship K.D. Wins Alaska Airlines
to William E. Boltz School
Nome Alaska
W/E Al N. Mary Collins
2000 - 2000

Approved for payment
Charles Boltz
Boltz school

RECEIVED BY 561-13-95-2-080-450-131549 1662.50

ADDRESS & ACC

Pouch P
Juneau, Alaska 99801

2202
33

A

S/A Museum Site

DEPOSIT: DATE 1-108

NUMBER 042

AMOUNT \$

BAL. \$

READING DATE	PRESENT READINGS	MULTIPLIER	TARIFF CODES	KW HRS. USED	CHARGES CREDITS BILL TOTAL	ACCOUNT NUMBER	DATE	PAYMENTS - CR. REFUNDS - DR.	C R	BALANCE	UT LE
MAY 11 '71	3,868	40								13,962,202	
MAY 11 '71	4,907	80	23	23,320	1,065.19 + G 31.96 + JS 1,097.15 ◦ R		MAY 11 '71 MAY 27 '71			1,097.15 -	1,097.15 * .00 ◦
JUN 10 '71	4,181	40								13,962,202	
JUN 10 '71	5,035	80	23	22,760	1,057.39 + G 31.72 + JS 1,089.11 ◦ R		JUN 10 '71 MAY 28 '71			1,089.11 -	1,089.11 * .00 ◦
JUL 9 '71	4,430	40								13,962,202	
JUL 9 '71	5,151,760	80	23	21,760	1,013.07 + G 30.39 + JS 1,043.46 ◦ R		JUL 9 '71 AUG 4 '71			1,043.46 -	1,043.46 * .00 ◦
AUG 10 '71	4,752	40								13,962,202	
AUG 10 '71	5,311	80	23	23,160	1,074.82 + G 32.24 + JS 1,107.06 ◦ R		AUG 10 '71 SEP 10 '71			1,107.06 -	1,107.06 * .00 ◦
SEP 8 '71	5,024	40								13,962,202	
SEP 8 '71	5,442	80	23	21,360	995.34 + G 29.86 + JS 1,025.20 ◦ R		SEP 8 '71			1,025.20 -	1,025.20 * .00 ◦
OCT 8 '71	5,313	40								13,962,202	
OCT 8 '71	5,560	80	23	21,000	979.39 + G 29.38 + JS 1,025.20 + BL 2,033.97 ◦ R 133 DUM		OCT 8 '71 OCT 14 '71 NOV 8 '71			1,025.20 - 1,008.77 -	2,033.97 * 1,008.77 * .00 ◦
NOV 8 '71	5,631	40								13,962,202	
NOV 8 '71	5,687	80	23	22,880	1,062.71 + G 31.88 + JS 1,094.59 ◦ R		NOV 8 '71			1,094.59 -	1,094.59 * .00 ◦
DEC 7 '71	5,816	40								13,962,202	
DEC 7 '71	5,794	80	33	15,960	756.01 + G 22.68 + JS 1,094.59 + BL 1,873.28 ◦ R		DEC 7 '71			1,873.28 -	1,873.28 * .00 ◦

DESCRIPTION	TARIFF OTHER	11	12	13	21	22	23	24	31	32	33	34	41	43	45	47	48	51	FC	ST	BL	DC	IR	OT	DM	C	R	*	OTHER INFORMATION				
RESIDENTIAL	A																																
COMMERCIAL	C																																
GOVERNMENT	G																																
RESIDENTIAL	MW																																
RESIDENTIAL	DD																																
RESIDENTIAL	JS																																
RESIDENTIAL	FC																																
RESIDENTIAL	ST																																
RESIDENTIAL	BL																																
RESIDENTIAL	DC																																
RESIDENTIAL	IR																																
RESIDENTIAL	OT																																
RESIDENTIAL	DM																																
RESIDENTIAL	C																																
RESIDENTIAL	R																																
RESIDENTIAL	*																																

516-2222

ADDRESS & ACCT.

Alaska Dept PW Bldgs.
Pouch P
Juneau, Alaska 99801

1396
2202
33

DEPOSIT: DATE *Museum site 1-68*

NUMBER *042*

AMOUNT \$

BAL. 5/873

READING DATE	PRESENT READINGS	MULTIPLIER	TARIFF CODES	KW HRS. USED	CHARGES CREDITS BILL TOTAL	ACCOUNT NUMBER	DATE	PAYMENTS - CR. REFUNDS - DR.	C R	BALANCE
							DEC 31'71	778.69 -		1,094.59 *
JAN 11'72	6,265	40					13,962,202			
JAN 11'72	5,920	80	33	28,040	1,291.41 + G 38.74 + JS 1,094.59 + BL 2,424.74 * R		JAN 11'72 JAN 31'72	1,330.15 -	2,424.74 * 1,094.59 *	
FEB 8'72	6,562	40					13,962,202			
FEB 8'72	6,032	80	33	20,840	972.29 + G 29.17 + JS 1,094.59 + BL 2,096.05 * R		FEB 8'72 MAR 9'72	1,001.46 -	2,096.05 * 1,094.59 *	
MAR 8'72	6,871	40					13,962,202			
MAR 8'72	6,156	80	33	22,280	1,036.12 + G 31.08 + JS 1,094.59 + BL 2,161.79 * R		MAR 8'72 APR 6'72	1,067.20 -	2,161.79 * 1,094.59 *	
APR 10'72	7,185	40					13,962,202			
APR 10'72	6,278	80	33	22,320	1,037.89 + G 31.14 + JS 1,094.59 + BL 2,163.62 * R		APR 10'72 MAY 2'72	1,069.03 -	2,163.62 * 1,094.59 *	
MAY 8'72	7,501	40					13,962,202			
MAY 8'72	6,397	80	33	21,160	985.47 + G 29.59 + JS 1,094.59 + BL 2,110.65 * R		MAY 8'72		2,110.65 *	
JUN 8'72	7,812	40					13,962,202			
JUN 8'72	6,535	80	33	23,480	1,089.30 + G 32.58 + JS 2,110.65 + BL 3,232.63 * R		JUN 8'72		3,232.63 *	

RESIDENTIAL	COMMERCIAL	GOVERNMENT	INDUSTRIAL	OTHER	UNASSIGNED	OTHER INFORMATION
11 L. & Cook	21 Electric	31 Govt	41 M/W	51 JS	61 FC	
12 & Mrs. Hrs.	22 Electric	32 Electric	42 M/W	52 FC	62 ST	
13 Effect.	23 Govt	33 Govt	43 M/W	53 FC	63 BL	
	24 Govt	34 Govt	44 M/W	54 FC	64 DC	
	25 Govt	35 Govt	45 M/W	55 FC	65 IN	
	26 Govt	36 Govt	46 M/W	56 FC	66 OT	
	27 Govt	37 Govt	47 M/W	57 FC	67 DM	
	28 Govt	38 Govt	48 M/W	58 FC	68 C	
	29 Govt	39 Govt	49 M/W	59 FC	69 R	
	30 Govt	40 Govt	50 M/W	60 FC	70 B	
	31 Govt	41 Govt	61 M/W	71 FC	81 L	
	32 Govt	42 Govt	72 M/W	82 FC	92 L	
	33 Govt	43 Govt	83 M/W	93 FC	03 L	
	34 Govt	44 Govt	94 M/W	04 FC	13 L	
	35 Govt	45 Govt	05 M/W	15 FC	23 L	
	36 Govt	46 Govt	16 M/W	26 FC	33 L	
	37 Govt	47 Govt	27 M/W	37 FC	43 L	
	38 Govt	48 Govt	38 M/W	48 FC	53 L	
	39 Govt	49 Govt	49 M/W	59 FC	63 L	
	40 Govt	50 Govt	60 M/W	70 FC	73 L	
	41 Govt	51 Govt	71 M/W	81 FC	83 L	
	42 Govt	52 Govt	82 M/W	92 FC	93 L	
	43 Govt	53 Govt	93 M/W	03 FC	03 L	
	44 Govt	54 Govt	04 M/W	14 FC	13 L	
	45 Govt	55 Govt	15 M/W	25 FC	23 L	
	46 Govt	56 Govt	26 M/W	36 FC	33 L	
	47 Govt	57 Govt	37 M/W	47 FC	43 L	
	48 Govt	58 Govt	48 M/W	58 FC	53 L	
	49 Govt	59 Govt	59 M/W	69 FC	63 L	
	50 Govt	60 Govt	70 M/W	80 FC	73 L	
	51 Govt	61 Govt	81 M/W	91 FC	83 L	
	52 Govt	62 Govt	92 M/W	02 FC	93 L	
	53 Govt	63 Govt	03 M/W	13 FC	03 L	
	54 Govt	64 Govt	14 M/W	24 FC	13 L	
	55 Govt	65 Govt	25 M/W	35 FC	23 L	
	56 Govt	66 Govt	36 M/W	46 FC	33 L	
	57 Govt	67 Govt	47 M/W	57 FC	43 L	
	58 Govt	68 Govt	58 M/W	68 FC	53 L	
	59 Govt	69 Govt	69 M/W	79 FC	63 L	
	60 Govt	70 Govt	80 M/W	89 FC	73 L	
	61 Govt	71 Govt	91 M/W	99 FC	83 L	
	62 Govt	72 Govt	02 M/W	10 FC	93 L	
	63 Govt	73 Govt	13 M/W	20 FC	03 L	
	64 Govt	74 Govt	24 M/W	30 FC	13 L	
	65 Govt	75 Govt	35 M/W	40 FC	23 L	
	66 Govt	76 Govt	46 M/W	50 FC	33 L	
	67 Govt	77 Govt	57 M/W	60 FC	43 L	
	68 Govt	78 Govt	68 M/W	70 FC	53 L	
	69 Govt	79 Govt	79 M/W	80 FC	63 L	
	70 Govt	80 Govt	90 M/W	90 FC	73 L	
	71 Govt	81 Govt	01 M/W	00 FC	83 L	
	72 Govt	82 Govt	12 M/W	10 FC	93 L	
	73 Govt	83 Govt	23 M/W	20 FC	03 L	
	74 Govt	84 Govt	34 M/W	30 FC	13 L	
	75 Govt	85 Govt	45 M/W	40 FC	23 L	
	76 Govt	86 Govt	56 M/W	50 FC	33 L	
	77 Govt	87 Govt	67 M/W	60 FC	43 L	
	78 Govt	88 Govt	78 M/W	70 FC	53 L	
	79 Govt	89 Govt	89 M/W	80 FC	63 L	
	80 Govt	90 Govt	90 M/W	90 FC	73 L	

Alaska Dept Pw Bldgs.
Pouch P
Juneau, Alaska 99801

1596
2202
33

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S/A Museum Site

DEPOSIT: DATE 1/68 NUMBER 42 AMOUNT \$ BAL. \$ 3,232.63

READING DATE	PRESENT READINGS	MULTIPLIER	TARIFF CODES	KW MRS. USED	CHARGES CREDITS BILL TOTAL	ACCOUNT NUMBER	DATE	PAYMENTS - CR. REFUNDS - OR.	C R	BALANCE	UTIL LEOD
JUN 11'72	1,144	40				13,962,202				3,232.63	
JUL 11'72	3,592	80	33	25,840	1,196.70 + G 35.89 + JS 3,232.63 + BL 4,464.92 + R	13,962,202				4,464.92	
AUG 9'72	9,436	40				13,962,202					
AUG 9'72	6,831	80	33	22,800	1,059.16 + G 31.77 + JS 2.40 - G 4,464.82 + BL 5,553.35 + R	13,962,202				5,553.35	
SEP 11'72	8,769	40				13,962,202					
SEP 11'72	7,002	80	33	27,000	1,245.31 + G 24.90 + JS 4,462.42 + BL 5,732.63 + R	13,962,202				5,732.63	
	9,060										
OCT 9	7,130		33	21,880	1,018.39 + G 30.55 + JS 3,320.93 + BL 4,429.87 + R	13,962,202				4,429.87	
NOV 9	9,387	40				13,962,202					
NOV 9	7,260	80	33	23,480	1,089.30 + G 31.78 + JS 12.46 + JS 2,098.26 + BL 3,231.80 + R	13,962,202				3,231.80	
DEC 6	9,681 7,399	40				13,962,202					
			33	22,880	1,063.49 + G 31.90 + JS 3,231.80 + BL 4,327.19 + R 12.46 + JS 4,339.65 + R	13,962,202				4,339.65	

JUNE BILLING

JULY BILLING
minus the 2.40
accrued on Aug. bill
I come up with 7 cents difference??

1,245.31 + G
24.90 + JS

1,018.39 + G
30.55 + JS

1,245.31
24.90
+ 12.46

1,048.24
1,282.57

10945

A	C	G	MW	MIN	DD	JS	FC	ST	BL	DC	IN	OT	DM	C	R	OTHER INFORMATION
11	21	31	41	43	46	51										
12	22	32	42	44	47											
13	23	33	43	45	48											
21	24	34	44	46												
22	25	35	45	47												
23	26	36	46	48												
24	27	37	47													
31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	
41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	
43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	
45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	
49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	
51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	
53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	
55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	
57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	
59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	
61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	
63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	
65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	
67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	
69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	
71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	
73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	
75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	
77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	
79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	
81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	
83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	
85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	

Alaska Dept PW Didsa.
 Touch P
 Ingeau, Alaska 99501

1396
 2202
 33

S/A Museum site

1/68

43

AMOUNT 5

BAL. S

DEPOSIT DATE	PRESENT READINGS	MULTIPLIER	TARIFF CODES	KW HRS. USED	CHARGES CREDITS	BILL TOTAL	ACCOUNT NUMBER	PAYMENTS - CR.	REFUNDS - DR.	C	BALANCE	UTIL. FEE
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6	9,681 7,399	40	33	22,880	1,063.49 + G 31.90 + JS	13,962,202						
					3,231.80 + DL 4,327.19 o R							
					1,387.36 + G 41.62 + JS							
	7,545	80	33	30,240	2,098.26 + DL 3,527.24 o R	13,962,202						
					1,149.58 + G 34.49 + JS							
	7,695	40	33	24,840	1,082.20 + DL 2,266.27 o R	13,962,202						
					1,025.47 + G 30.76 + JS							
	7,820	40	33	22,040	2,266.27 + DL 3,322.50 o R	13,962,202						
					1,082.40 + G 32.47 + JS							
	1,013	80	33	26,640	2,133.43 + DL 3,253.30 o R	13,962,202						
					1,012.60 + G 30.38 + JS							
	9,773 9,773	40 80	33	23,600	1,082.20 + DL 2,125.18 o R	13,962,202						
					1,082.20 + DL 2,125.18 o R							

ACCOUNT NUMBER	OTHER INFORMATION
1396	
2202	
33	
13,962,202	
1,063.49 + G	
31.90 + JS	
3,231.80 + DL	
4,327.19 o R	
1,387.36 + G	
41.62 + JS	
2,098.26 + DL	
3,527.24 o R	
1,149.58 + G	
34.49 + JS	
1,082.20 + DL	
2,266.27 o R	
1,025.47 + G	
30.76 + JS	
2,266.27 + DL	
3,322.50 o R	
1,082.40 + G	
32.47 + JS	
2,133.43 + DL	
3,253.30 o R	
1,012.60 + G	
30.38 + JS	
1,082.20 + DL	
2,125.18 o R	

MEMORANDUM

State of Alaska

TO: Myrton R. Charney
Director
Division of Budget & Management

DATE: November 29, 1974

FILE NO:

TELEPHONE NO:

FROM: Buel A Taggart
Commissioner
Department of Public Works

BA?

SUBJECT: Supplemental Request

RECEIVED
NOV 29 1974
BUDGET & MANAGEMENT

Attached is a claim received from the General Telephone Company of Alaska in the amount of \$717.80 for damage to their cable lines at McGrath, Alaska, in October, 1972.

Inasmuch as the due bill is over two years old and cannot be paid from FY 75 funds, please present this claim to the next legislature for an appropriation.

RECEIVED EVERETT

GENERAL TELEPHONE CO. OF ALASKA
1121 S. BROADWAY, P.O. BOX 413, EVERETT, WASHINGTON 98206

SEP 12 1974

GENERAL TELEPHONE CO. OF ALASKA

TELEPHONE: 206-355 6290

August 27, 1974

B 9/12/74
R.G.

Division of Aviation
State of Alaska
McGrath, Alaska 99627

Dear Customer:

In checking our special accounts receivable, we find a balance due of \$717.80 in your account.

Will you please check your records and notify us if there is a discrepancy. Please forward your payment to the following address:

General Telephone Company of Alaska
P.O. Box 413
Everett, WA 98206

We would appreciate you contacting us within ten (10) days.

Sincerely,

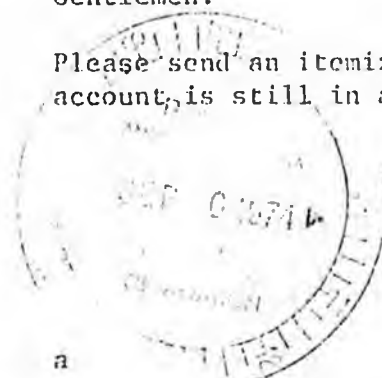
L. D. Briney
L. D. Briney
Accounting Manager

13.835.	201	340	257003
EXAMPLE IN CASE ... IS NOTED.			
By	<i>PR</i>	Date	<i>11/25</i>
APPROVED			

JD:js

Gentlemen:

Please send an itemized statement of the above past due balances, if our account is still in arrears.



Yours truly,

Patricia Rudolph
Patricia Rudolph
Div. of Aviation
Pouch 6909
Anchorage, Alaska 99502

a



GENERAL TELEPHONE COMPANY OF ALASKA
 1318 FOURTH AVE SEATTLE WASHINGTON 98101 RA 4-1754



NOV 1972	DIVISION OF AVIATION STATE OF ALASKA MCGRATH ALASKA 99627	YOUR TELEPHONE NUMBER	AMOUNT
	REPAIR OF DAMAGE TO 25 PR CABLE RESULTING FROM DUMP TRUCK DRIVEN WITH BED UP - OCTOBER 10, 1972		
	AIR FARE ROUND TRIP NOME - MCGRATH		216.00
	3 NIGHTS AT MCGRATH ROADHOUSE @ 15.00 EA		45.00
	4 HOURS LINEMAN @ 7.93 PER HOUR		31.72
	OVERHEAD @ 4.00 PER HOUR		16.00
	100 FEET 25 PAIR CABLE		33.00
	LOSS OF REVENUE - 21 SUBSCRIBERS FOR 5 DAYS		65.37
	AMOUNT DUE -		407.09

PLEASE SEE REVERSE SIDE FOR ADDITIONAL INFORMATION

PRINTED IN U.S.A.

47.72 = 42.16 + 5.56
 1.132 = 2.19 + 2.15 + 1.32

Please return this stub with your payment. When paying in person please bring the entire bill. Thank you.

GENERAL TELEPHONE COMPANY OF ALASKA

Do	Co	TELEPHONE NUMBER	DATE OF BILL	AMOUNT DUE
102	-		NOV 1972	407.09
02	(33.00)			
102	42.16			
035	2.19			
731	2.15			
031	1.22			
011	65.37			

12-8315 201.340. 252003



GENERAL TELEPHONE COMPANY OF ALASKA

1318 FOURTH AVE SEATTLE WASHINGTON 98101 MA 4-1754



NOV
1972

DIVISION OF AVIATION
STATE OF ALASKA
MCGRATH ALASKA 99627

YOUR TELEPHONE NUMBER

AMOUNT

REPAIR OF DAMAGE TO 6 PAIR CABLE RESULTING FROM
DUMP TRUCK DRIVEN WITH BED UP - AUGUST 1972

AIR FARE ROUND TRIP NOME - MCGRATH - NOME

216.00

2 NIGHTS AT MCGRATH ROADHOUSE @ 15.00 EA

30.00

2 HOURS LABOR OF LINEMEN @ 5.28 PER HOUR

10.56

OVERHEAD @ 4.00 PER HOUR

8.00

150 FEET 6 PAIR CABLE

30.65

LOSS OF REVENUE - 3 SUBSCRIBERS FOR 15 DAYS

15.50

AMOUNT DUE -

310.71

PLEASE SEE REVERSE SIDE FOR ADDITIONAL INFORMATION

PRINTED IN U.S.A.

$\frac{18.56}{1.122} = 16.10 + 5.2 = 21.30$ (110M)
 $\times 5.08 = 108.3$ (Preston)
 $\times 2.9 = 218$ (Dump!)
216

JE 6-10-72
 1202 64.71
 C. 602 (20.65)

GENERAL TELEPHONE COMPANY OF ALASKA

Please return this stub with your payment. When paying in person please bring the entire bill. Thank you.

A 602M 16.00
 5035 .85
 7731 .53
 3031 .45
 5011 15.50

TELEPHONE NUMBER

DATE OF BILL

NOV 1972

310.71

AMOUNT DUE

13,825.501 340.259003

MEMORANDUM

State of Alaska

TO: Myrton R. Charney
 Director
 Division of Budget & Management
 Department of Administration

FROM: Buel A Taggart
 Commissioner
 Department of Public Works

DATE: November 19, 1974

FILE NO:

TELEPHONE NO:

SUBJECT: FY 75 Miscellaneous Claims,
 Division of Marine Transportation

RECEIVED
 NOV 21 1974
 BUDGET & MANAGEMENT

Attached are invoices from Southeastern Electric and North Star Terminal and Stevedore Co. totaling \$9,429.58. Payment of these invoices has been delayed due to not having received them prior to the two year cut off date. Attached to the North Star Terminal invoice is a memorandum which is self-explanatory as to the reason for not previously having been billed.

The computer print outs show lapsing funds for the fiscal years in which these expenses were incurred.

Attachments

NORTH STAR TERMINAL & STEVEDORE CO.

Stevedores Ship's Agents Materials Handling

OPERATORS OF
REFRIGERATED WAREHOUSE
AND ARCTIC COLD STORAGE

P. O. BOX 2019 ANCHORAGE
ALASKA 99501

May 22, 1974

Gentlemen:

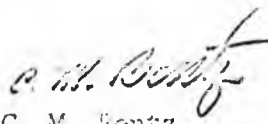
We are enclosing our revised schedule of rates for stevedoring work performed at the Port Of Anchorage effective April 15, 1974. The substantial increase in rates is entirely due to final settlement of wage negotiations with the Anchorage Longshoremen which have been going on since 1971. The long time for settlement involved a jurisdictional dispute which was finally resolved by a National Labor Relations Board election.

The final settlement involves wages and fringe benefits retroactive to July 1, 1971. We regret that it will be necessary for us to send you retroactive billing applicable to the retroactive expenses as soon as the computations can be made.

We are enclosing a summary of the retroactive wage settlement and copies of the wage agreement applicable to wages and fringe benefits which we hope will be helpful.

Very truly yours,

NORTH STAR TERMINAL & STEVEDORE COMPANY


C. M. Bentz
President

CMB:ph

Enclosures

RECEIVED
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ACCOUNTING
MARINE TRANSPORTATION

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NORTH STAR TERMINAL & STEVEDORE COMPANY

SCHEDULE OF RETROACTIVE BILLING RATES FOR HANDLING LINES ON A MAN HOUR BASIS, ANCHORAGE,
ALASKA RATES EFFECTIVE FROM JULY 1, 1973 THROUGH APRIL 14, 1974:

	<u>LONG- SHORE MAN</u>	<u>FORKLIFT OPER WINCH DRIVER</u>	<u>WALKING BOSS</u>	<u>LONGSHORE CRANE MAN</u>	<u>FORE- MAN</u>
BASE STRAIGHTTIME RATE	1.62	1.79	1.95	2.05	2.155
PLUS 39%	.63	.70	.76	.80	.84
PLUS FRINGE BENEFITS	<u>1.005</u>	<u>1.005</u>	<u>1.005</u>	<u>1.005</u>	<u>1.005</u>
BILLING RATE FOR STRAIGHT- TIME	<u>3.26</u>	<u>3.50</u>	<u>3.72</u>	<u>3.86</u>	<u>4.00</u>
OVERTIME DIFFERENTIAL	.81	.895	.975	1.025	1.08
PLUS 29%	.23	.26	.28	.30	.31
PLUS STRAIGHTTIME RATE	<u>3.26</u>	<u>3.50</u>	<u>3.72</u>	<u>3.86</u>	<u>4.00</u>
BILLING RATE FOR OVERTIME	<u>4.30</u>	<u>4.66</u>	<u>4.98</u>	<u>5.19</u>	<u>5.39</u>
PENALTY OVERTIME DIFFERENTIAL	2.025	2.24	2.44	2.56	2.69
PLUS 29%	.57	.65	.71	.74	.78
PLUS STRAIGHT TIME RATE	<u>3.26</u>	<u>3.50</u>	<u>3.72</u>	<u>3.86</u>	<u>4.00</u>
BILLING RATE FOR OVERTIME PENALTY	<u>5.86</u>	<u>6.39</u>	<u>6.87</u>	<u>7.16</u>	<u>7.47</u>

NORTH STAR TERMINAL & STEVEDORE COMPANY

SCHEDULE OF RETROACTIVE BILLING RATES FOR HANDLING LINES AN A MAN HOUR BASIS, ANCHORAGE, ALASKA
 RATES EFFECTIVE FROM JULY 1, 1972 THROUGH JUNE 30, 1973.

	<u>LONGSHORE- MAN</u>	<u>FORKLIFT OPER WINCH DRIVER</u>	<u>WALKING BOSS</u>	<u>LONGSHORE CRANEMAN</u>	<u>FORE MAN</u>
BASE STRAIGHTTIME RATE	1.45	1.62	1.78	1.88	1.985
PLUS 39%	.57	.63	.69	.73	.77
PLUS FRINGE BENEFITS	<u>.55</u>	<u>.55</u>	<u>.55</u>	<u>.55</u>	<u>.55</u>
BILLING RATE FOR STRAIGHT TIME	<u>2.57</u>	<u>2.80</u>	<u>3.02</u>	<u>3.16</u>	<u>3.31</u>
OVERTIME DIFFERENTIAL	.545	.63	.71	.76	.815
PLUS 29%	.16	.18	.21	.22	.24
PLUS STRAIGHTTIME RATE	<u>2.57</u>	<u>2.80</u>	<u>3.02</u>	<u>3.16</u>	<u>3.31</u>
BILLING RATE FOR OVERTIME	<u>3.28</u>	<u>3.61</u>	<u>3.94</u>	<u>4.14</u>	<u>4.37</u>
PENALTY OVERTIME DIFFEREN.	1.36	1.575	1.775	1.90	2.03
PLUS 29%	.39	.46	.51	.55	.59
PLUS STRAIGHT TIME RATE	<u>2.57</u>	<u>2.80</u>	<u>3.02</u>	<u>3.16</u>	<u>3.31</u>
BILLING RATE FOR OT PEN-	<u>4.32</u>	<u>4.84</u>	<u>5.30</u>	<u>5.61</u>	<u>5.93</u>

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NORTH STAR TERMINAL & STEVEDORE COMPANY
 SCHEDULE OF RETROACTIVE BILLING RATES FOR HANDLING LINES, ANCHORAGE, ALASKA FROM
 JULY 1, 1971 THROUGH JUNE 30, 1972

	<u>LONG- SHORE- MAN</u>	<u>FORKLIFT OPER, WINCH DRIVER</u>	<u>WALKING BOSS</u>	<u>LONGSHORE CRANEMAN</u>	<u>FORE- MAN</u>
BASE STRAIGHTTIME RATE	.93	1.10	1.26	1.36	1.465
PLUS 39%	.36	.43	.49	.53	.57
PLUS FRINGE BENEFITS	<u>.55</u>	<u>.55</u>	Z <u>.55</u>	<u>.55</u>	<u>.55</u>
BILLING RATE FOR STRAIGHTTIME	<u>1.84</u>	<u>2.08</u>	<u>2.30</u>	<u>2.44</u>	<u>2.59</u>
OVERTIME DIFFERENTIAL	.285	.37	.45	.50	.55
PLUS 29%	.08	.11	.13	.15	.16
PLUS STRAIGHTTIME RATE	<u>1.84</u>	<u>2.08</u>	<u>2.30</u>	<u>2.44</u>	<u>2.59</u>
BILLING RATE FOR OVERTIME	<u>2.21</u>	<u>2.56</u>	<u>2.88</u>	<u>3.09</u>	<u>3.30</u>
ADDITIONAL OVERTIME DIFFERENTIAL	.71	.925	1.125	1.25	1.38
PLUS 29%	.21	.27	.33	.36	.40
PLUS STRAIGHTTIME RATE	<u>1.84</u>	<u>2.08</u>	<u>2.30</u>	<u>2.44</u>	<u>2.59</u>
BILLING RATE FOR OVERTIME PENALTY	<u>2.76</u>	<u>3.28</u>	<u>3.76</u>	<u>4.05</u>	<u>4.37</u>

ADDITIONAL LABOR PENALTY DIFFERENTIALS WILL BE BILLED AT RATE PAID PLUS 30.7%

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NORTH STAR TERMINAL AND STEVEDORE CO.

P. O. BOX 2019

PHONE 272-7537

ANCHORAGE, ALASKA 99510

TO. STATE OF ALASKA-BILLING
DIVISION OF MARINE TRANSP
POUCH R
JUNEAU, ALASKA 99801

DATE 8/13/1974

BILL NO. RA-44

PURCHASE ORDER

© J
VESSEL
STARTED
FINISHED

PORT
PIER
OPERATION

CHARGES TO COVER RETROACTIVE WAGES PAID TO LONGSHOREMEN JULY 1, 1971
THRU JUNE 30, 1972, JULY 1, 1972 THRU JUNE 30, 1973, JULY 1, 1973 THRU
APRIL 14, 1974. SEE ATTACHED DETAIL LISTINGS AND BILLING RATE SCHEDULES:

	HOURS BILLED	EXTENSIONS
1ST PERIOD	1,053.0	2,348.30
2ND PERIOD	1,043.0	3,285.73
3RD PERIOD	895.5	3,721.55
TOTAL HOURS BILLED	2,991.5	
TOTAL CHARGES:		\$ <u>9,355.58</u>

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DATE 8/13/1974

BILL NO. RA-44

PURCHASE ORDER

①

VESSEL
STARTED
FINISHED

PORT
PIER
OPERATION

CHARGES TO COVER RETROACTIVE WAGES PAID TO LONGBORE MEN JULY 1, 1971
THRU JUNE 30, 1972, JULY 1, 1972 THRU JUNE 30, 1973, JULY 1, 1973 THRU
APRIL 14, 1974. SEE ATTACHED DETAIL LISTINGS AND BILLING RATE SCHEDULES:

	HOURS BILLED	EXTENSIONS
1ST PERIOD	1,053.0	2,348.30
2ND PERIOD	1,043.0	3,285.73
3RD PERIOD	895.5	3,721.55
TOTAL HOURS BILLED	2,991.5	
TOTAL CHARGES:		\$ <u>9,355.58</u>

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MARINE TRANSPORTATION

In going over your account
I find this invoice unpaid.
Please advise.
Thanks!

Southwestern

ELECTRIC CO., INC.



GLACIER VILLAGE
BOX 1748
JUNEAU, ALASKA 99801
PHONE 789-9890

515 WINTON ST
KETCHIKAN, ALASKA 99901
PHONE DAY 225-6678
NIGHT 225-4116

Customer's Order No. *6-9*
Name *State of Alaska*
Address *Department of Marine Transp
M.V. Taku*



QUANTITY	DESCRIPTION	AMOUNT
1	CO ² Check Valve	45.00
1	Hour labor	19.00
	(work performed & made of May)	64.00
2	Long distance phone calls	10.00
		<u>74.00</u>

No Tax

To Order & install Check Valve in CO² Line in Source Berth: M.V. Taku

TOTAL

ALL claims and returned goods MUST be accompanied by this bill

0141 55785
cf.

Rec'd by

001NORTH STAR RETROACTIVE BILLING PERIOD 07/01/71 THRU 06/30/72 STATE OF ALASKA-BILLING

BILL NO.	DATE	VESSEL	LABOR DESC.	TYPE	HOURS	RET RO RATE	AMOUNT
10968	07/14/71	TUSTAMENA	LONG SHORE MAN	OT	10.0	2.21	22.10
10968	07/14/71	TUSTAMENA	LONG SHORE MAN	ST	12.0	1.84	22.08
10968	07/14/71	TUSTAMENA	WALKING BOSS	OT	2.0	2.88	5.76
10968	07/14/71	TUSTAMENA	WALKING BOSS	ST	2.0	2.30	4.60
TOTAL FOR BILL NO. 10968					26.0		54.54 *
10969	07/14/71	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
10969	07/14/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
10969	07/14/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 10969					26.0		59.40 *
10976	07/21/71	TUSTAMENA	LONG SHORE MAN	OT	5.0	2.21	11.05
10976	07/21/71	TUSTAMENA	LONG SHORE MAN	ST	27.0	1.84	49.68
10976	07/21/71	TUSTAMENA	WALKING BOSS	OT	1.0	2.88	2.88
10976	07/21/71	TUSTAMENA	WALKING BOSS	ST	5.0	2.30	11.50
TOTAL FOR BILL NO. 10976					38.0		75.11 *
10978	07/21/71	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
10978	07/21/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
10978	07/21/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 10978					26.0		59.40 *
10990	07/28/71	TUSTAMENA	HT, F/L OPER, ETC	OT	4.0	2.56	10.24
10990	07/28/71	TUSTAMENA	LONG SHORE MAN	OT	16.0	2.21	35.36
10990	07/28/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
10990	07/28/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 10990					26.0		60.80 *
10991	07/28/71	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
10991	07/28/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
10991	07/28/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 10991					26.0		59.40 *
10999	08/04/71	TUSTAMENA	LONG SHORE MAN	OT	5.0	2.21	11.05
10999	08/04/71	TUSTAMENA	LONG SHORE MAN	ST	22.0	1.84	40.48
10999	08/04/71	TUSTAMENA	WALKING BOSS	OT	1.0	2.88	2.88
10999	08/04/71	TUSTAMENA	WALKING BOSS	ST	4.0	2.30	9.20
TOTAL FOR BILL NO. 10999					32.0		63.61 *
20000	08/04/71	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
20000	08/04/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20000	08/04/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 20000					26.0		59.40 *
20004	08/11/71	TUSTAMENA	LONG SHORE MAN	OT	12.5	2.21	27.63
20004	08/11/71	TUSTAMENA	LONG SHORE MAN	ST	9.5	1.84	17.48
20004	08/11/71	TUSTAMENA	WALKING BOSS	OT	2.5	2.88	7.20
20004	08/11/71	TUSTAMENA	WALKING BOSS	ST	1.5	2.30	3.45
TOTAL FOR BILL NO. 20004					26.0		55.76 *
20006	08/11/71	TUSTAMENA	LONG SHORE MAN	OT	25.0	2.21	55.25
20006	08/11/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20006	08/11/71	TUSTAMENA	WALKING BOSS	OT	5.0	2.88	14.40
TOTAL FOR BILL NO. 20006					32.0		73.33 *

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NORTH STAR RETROACTIVE BILLING PERIOD 07/01/71 THRU 06/30/72 STATE OF ALASKA-BILLING

BILL NO.	DATE	VESSEL	LABOR DESC.	TYPE	HOURS	RETRO RATE	AMOUNT
20015	08/18/71	TUSTAMENA	LONG SHORE MAN	OT	5.0	2.21	11.05
20015	08/18/71	TUSTAMENA	LONG SHORE MAN	ST	17.0	1.84	31.28
20015	08/18/71	TUSTAMENA	WALKING BOSS	OT	1.0	2.88	2.88
20015	08/18/71	TUSTAMENA	WALKING BOSS	ST	3.0	2.30	6.90
TOTAL FOR BILL NO. 20015					26.0		52.11 *
20016	08/18/71	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
20016	08/18/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20016	08/18/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 20016					26.0		59.40 *
20036	08/25/71	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
20036	08/25/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20036	08/25/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 20036					26.0		59.40 *
20041	09/01/71	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
20041	09/01/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20041	09/01/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 20041					26.0		59.40 *
20042	09/01/71	TUSTAMENA	LONG SHORE MAN	OT	15.0	2.21	33.15
20042	09/01/71	TUSTAMENA	LONG SHORE MAN	OTPM	5.0	2.76	13.80
20042	09/01/71	TUSTAMENA	LONG SHORE MAN	ST	12.0	1.84	22.08
20042	09/01/71	TUSTAMENA	WALKING BOSS	OT	3.0	2.88	8.64
20042	09/01/71	TUSTAMENA	WALKING BOSS	OTPM	1.0	3.76	3.76
20042	09/01/71	TUSTAMENA	WALKING BOSS	ST	2.0	2.30	4.60
TOTAL FOR BILL NO. 20042					38.0		86.03 *
20056	09/08/71	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
20056	09/08/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20056	09/08/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 20056					26.0		59.40 *
20057	09/08/71	TUSTAMENA	LONG SHORE MAN	OT	15.0	2.21	33.15
20057	09/08/71	TUSTAMENA	LONG SHORE MAN	ST	7.0	1.84	12.88
20057	09/08/71	TUSTAMENA	WALKING BOSS	OT	3.0	2.88	8.64
20057	09/08/71	TUSTAMENA	WALKING BOSS	ST	1.0	2.30	2.30
TOTAL FOR BILL NO. 20057					26.0		56.97 *
20067	09/15/71	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
20067	09/15/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20067	09/15/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 20067					26.0		59.40 *
20068	09/15/71	TUSTAMENA	HT, F/L OPER, ETC	OT	4.0	2.56	10.24
20068	09/15/71	TUSTAMENA	LONG SHORE MAN	OT	40.0	2.21	88.40
20068	09/15/71	TUSTAMENA	LONG SHORE MAN	ST	4.0	1.84	7.36
20068	09/15/71	TUSTAMENA	WALKING BOSS	OT	8.0	2.88	23.04
TOTAL FOR BILL NO. 20068					56.0		129.04 *
20077	09/22/71	TUSTAMENA	LONG SHORE MAN	OT	15.0	2.21	33.15
20077	09/22/71	TUSTAMENA	LONG SHORE MAN	ST	7.0	1.84	12.88
20077	09/22/71	TUSTAMENA	WALKING BOSS	OT	3.0	2.88	8.64

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NORTH STAR RETROACTIVE BILLING PERIOD 07/01/71 THRU 06/30/72 STATE OF ALASKA-BILLING

BILL NO.	DATE	VESSEL	LABOR DESC.	TYPE	HOURS	RETRO RATE	AMOUNT
20077	09/22/71	TUSTUMENA	WALKING BOSS	ST	1.0	2.30	2.30
			TOTAL FOR BILL NO. 20077		26.0		56.97 *
20079	09/22/71	TUSTUMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
20079	09/22/71	TUSTUMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20079	09/22/71	TUSTUMENA	WALKING BOSS	OT	4.0	2.88	11.52
			TOTAL FOR BILL NO. 20079		26.0		59.40 *
20092	09/29/71	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
20092	09/29/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20092	09/29/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
			TOTAL FOR BILL NO. 20092		26.0		59.40 *
20093	09/29/71	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
20093	09/29/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20093	09/29/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
			TOTAL FOR BILL NO. 20093		26.0		59.40 *
20104	10/06/71	TUSTAMENA	LONG SHORE MAN	OT	5.0	2.21	11.05
20104	10/06/71	TUSTAMENA	LONG SHORE MAN	OTPM	5.0	2.76	13.80
20104	10/06/71	TUSTAMENA	LONG SHORE MAN	ST	17.0	1.84	31.28
20104	10/06/71	TUSTAMENA	WALKING BOSS	OT	1.0	2.88	2.88
20104	10/06/71	TUSTAMENA	WALKING BOSS	OTPM	1.0	3.76	3.76
20104	10/06/71	TUSTAMENA	WALKING BOSS	ST	3.0	2.30	6.90
			TOTAL FOR BILL NO. 20104		32.0		69.67 *
20106	10/06/71	TUSTAMENA	LONG SHORE MAN	OT	24.0	2.21	48.62
20106	10/06/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
			TOTAL FOR BILL NO. 20106		26.0		60.14 *
20119	10/13/71	TUSTAMENA	LONG SHORE MAN	OT	34.0	2.21	75.14
20119	10/13/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20119	10/13/71	TUSTAMENA	WALKING BOSS	OT	8.0	2.88	23.04
			TOTAL FOR BILL NO. 20119		44.0		101.86 *
20120	10/13/71	TUSTAMENA	LONG SHORE MAN	OT	32.0	2.21	70.72
20120	10/13/71	TUSTAMENA	LONG SHORE MAN	ST	4.0	1.84	7.36
20120	10/13/71	TUSTAMENA	WALKING BOSS	OT	8.0	2.88	23.04
			TOTAL FOR BILL NO. 20120		44.0		101.12 *
20122	10/13/71	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
20122	10/13/71	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20122	10/13/71	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
			TOTAL FOR BILL NO. 20122		26.0		59.40 *
20292	06/07/72	TUSTAMENA	LONG SHORE MAN	OT	5.0	2.21	11.05
20292	06/07/72	TUSTAMENA	LONG SHORE MAN	OTPM	5.0	2.76	13.80
20292	06/07/72	TUSTAMENA	LONG SHORE MAN	ST	22.0	1.84	40.48
20292	06/07/72	TUSTAMENA	WALKING BOSS	OT	1.0	2.88	2.88
20292	06/07/72	TUSTAMENA	WALKING BOSS	OTPM	1.0	3.76	3.76
20292	06/07/72	TUSTAMENA	WALKING BOSS	ST	4.0	2.30	9.20
			TOTAL FOR BILL NO. 20292		38.0		81.17 *
20293	06/07/72	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20

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NORTH STAR RETROACTIVE BILLING PERIOD 07/01/71 THRU 06/30/72 STATE OF ALASKA-BILLING

BILL NO.	DATE	VESSEL	LABOR DESC.	TYPE	HOURS	RETRO RATE	AMOUNT
20293	06/07/72	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20293	06/07/72	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 20293					26.0		59.40 *
20303	06/14/72	TUSTAMENA	LONG SHORE MAN	OT	5.0	2.21	11.05
20303	06/14/72	TUSTAMENA	LONG SHORE MAN	CTPM	5.0	2.76	13.80
20303	06/14/72	TUSTAMENA	LONG SHORE MAN	ST	19.5	1.84	35.88
20303	06/14/72	TUSTAMENA	WALKING BOSS	OT	1.0	2.88	2.88
20303	06/14/72	TUSTAMENA	WALKING BOSS	CTPM	1.0	3.76	3.76
20303	06/14/72	TUSTAMENA	WALKING BOSS	ST	3.5	2.30	8.05
TOTAL FOR BILL NO. 20303					35.0		75.42 *
20304	06/14/72	TUSTAMENA	LONG SHORE MAN	CT	20.0	2.21	44.20
20304	06/14/72	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20304	06/14/72	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 20304					26.0		59.40 *
20313	06/21/72	TUSTAMENA	LONG SHORE MAN	OT	5.0	2.21	11.05
20313	06/21/72	TUSTAMENA	LONG SHORE MAN	OTPM	5.0	2.76	13.80
20313	06/21/72	TUSTAMENA	LONG SHORE MAN	ST	22.0	1.84	40.48
20313	06/21/72	TUSTAMENA	WALKING BOSS	OT	1.0	2.88	2.88
20313	06/21/72	TUSTAMENA	WALKING BOSS	OTPM	1.0	3.76	3.76
20313	06/21/72	TUSTAMENA	WALKING BOSS	ST	4.0	2.30	9.20
TOTAL FOR BILL NO. 20313					38.0		81.17 *
20314	06/21/72	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
20314	06/21/72	TUSTAMENA	LONG SHORE MAN	ST	2.0	1.84	3.68
20314	06/21/72	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 20314					26.0		59.40 *
20326	06/28/72	TUSTAMENA	LONG SHORE MAN	OT	20.0	2.21	44.20
20326	06/28/72	TUSTAMENA	LONG SHORE MAN	ST	4.0	1.84	7.36
20326	06/28/72	TUSTAMENA	WALKING BOSS	OT	4.0	2.88	11.52
TOTAL FOR BILL NO. 20326					28.0		63.08 *
TOTAL FOR CO. NO. 003					1,053.0		2,348.30 ***

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BILL NO.	DATE	VESSEL	LABOR DESC.	TYPE	HOURS	RETRO RATE	AMOUNT
20342	07/05/72	TUSTAMENA	LONG SHORE MAN	CT	20.0	3.28	65.60
20342	07/05/72	TUSTAMENA	LONG SHORE MAN	ST	2.0	2.57	5.14
20342	07/05/72	TUSTAMENA	WALKING BOSS	CT	4.0	3.94	15.76
TOTAL FOR BILL NO. 20342					26.0		86.50 *
20343	07/05/72	TUSTAMENA	LONG SHORE MAN	CT	25.0	3.28	82.00
20343	07/05/72	TUSTAMENA	LONG SHORE MAN	ST	2.0	2.57	5.14
20343	07/05/72	TUSTAMENA	WALKING BOSS	CT	5.0	3.94	19.70
TOTAL FOR BILL NO. 20343					32.0		106.84 *
20348	07/12/72	TUSTAMENA	LONG SHORE MAN	CT	5.0	3.28	16.40
20348	07/12/72	TUSTAMENA	LONG SHORE MAN	CTPM	5.0	4.32	21.60
20348	07/12/72	TUSTAMENA	LONG SHORE MAN	ST	22.0	2.57	56.54
20348	07/12/72	TUSTAMENA	WALKING BOSS	CT	1.0	3.94	3.94
20348	07/12/72	TUSTAMENA	WALKING BOSS	CTPM	1.0	5.30	5.30
20348	07/12/72	TUSTAMENA	WALKING BOSS	ST	4.0	3.02	12.08
TOTAL FOR BILL NO. 20348					38.0		115.86 *
20349	07/12/72	TUSTAMENA	LONG SHORE MAN	CT	20.0	3.28	65.60
20349	07/12/72	TUSTAMENA	LONG SHORE MAN	ST	2.0	2.57	5.14
20349	07/12/72	TUSTAMENA	WALKING BOSS	CT	4.0	3.94	15.76
TOTAL FOR BILL NO. 20349					26.0		86.50 *
20362	07/19/72	TUSTAMENA	LONG SHORE MAN	CT	5.0	3.28	16.40
20362	07/19/72	TUSTAMENA	LONG SHORE MAN	CTPM	5.0	4.32	21.60
20362	07/19/72	TUSTAMENA	LONG SHORE MAN	ST	24.5	2.57	62.97
20362	07/19/72	TUSTAMENA	WALKING BOSS	CT	1.0	3.94	3.94
20362	07/19/72	TUSTAMENA	WALKING BOSS	CTPM	1.0	5.30	5.30
20362	07/19/72	TUSTAMENA	WALKING BOSS	ST	4.5	3.02	13.59
TOTAL FOR BILL NO. 20362					41.0		123.80 *
20364	07/19/72	TUSTAMENA	LONG SHORE MAN	CT	20.0	3.28	65.60
20364	07/19/72	TUSTAMENA	LONG SHORE MAN	ST	2.0	2.57	5.14
20364	07/19/72	TUSTAMENA	WALKING BOSS	CT	4.0	3.94	15.76
TOTAL FOR BILL NO. 20364					26.0		86.50 *
20386	08/02/72	TUSTAMENA	LONG SHORE MAN	CT	20.0	3.28	65.60
20386	08/02/72	TUSTAMENA	LONG SHORE MAN	ST	2.0	2.57	5.14
20386	08/02/72	TUSTAMENA	WALKING BOSS	CT	4.0	3.94	15.76
20386	08/02/72	TUSTAMENA	WALKING BOSS	ST	2.0	3.02	6.04
TOTAL FOR BILL NO. 20386					28.0		92.54 *
20387	08/02/72	TUSTAMENA	LONG SHORE MAN	CT	10.0	3.28	32.80
20387	08/02/72	TUSTAMENA	LONG SHORE MAN	ST	12.0	2.57	30.84
20387	08/02/72	TUSTAMENA	WALKING BOSS	CT	2.0	3.94	7.88
TOTAL FOR BILL NO. 20387					24.0		71.52 *
20396	08/09/72	TUSTAMENA	LONG SHORE MAN	CT	7.5	3.28	24.60
20396	08/09/72	TUSTAMENA	LONG SHORE MAN	ST	19.5	2.57	50.12
20396	08/09/72	TUSTAMENA	WALKING BOSS	CT	1.5	3.94	5.91
20396	08/09/72	TUSTAMENA	WALKING BOSS	ST	3.5	3.02	10.57
TOTAL FOR BILL NO. 20396					32.0		91.20 *
20397	08/09/72	TUSTAMENA	LONG SHORE MAN	CT	20.0	3.28	65.60

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BILL NO.	DATE	VESSEL	LABOR DESC.	TYPE	HOURS	RETRO RATE	AMOUNT
20397	08/09/72	TUSTAMENA	LONG SHOREMAN	ST	2.0	2.57	5.14
20397	08/09/72	TUSTAMENA	WALKING BESS	CT	4.0	3.94	15.76
			TOTAL FOR BILL NO. 20397		26.0		86.50 *
20404	08/16/72	TUSTAMENA	LONG SHOREMAN	CT	10.0	3.28	32.80
20404	08/16/72	TUSTAMENA	LONG SHOREMAN	ST	12.0	2.57	30.84
20404	08/16/72	TUSTAMENA	WALKING BESS	CT	2.0	3.94	7.88
20404	08/16/72	TUSTAMENA	WALKING BESS	ST	2.0	3.02	6.04
			TOTAL FOR BILL NO. 20404		26.0		77.56 *
20407	08/16/72	TUSTAMENA	HT, F/L OPER, ETC	CT	4.0	3.61	14.44
20407	08/16/72	TUSTAMENA	LONG SHOREMAN	CT	16.0	3.28	52.48
20407	08/16/72	TUSTAMENA	LONG SHOREMAN	ST	2.0	2.57	5.14
20407	08/16/72	TUSTAMENA	WALKING BESS	CT	4.0	3.94	15.76
			TOTAL FOR BILL NO. 20407		26.0		87.82 *
20413	08/23/72	TUSTAMENA	LONG SHOREMAN	CT	10.0	3.28	32.80
20413	08/23/72	TUSTAMENA	LONG SHOREMAN	ST	12.0	2.57	30.84
20413	08/23/72	TUSTAMENA	WALKING BESS	CT	2.0	3.94	7.88
20413	08/23/72	TUSTAMENA	WALKING BESS	ST	2.0	3.02	6.04
			TOTAL FOR BILL NO. 20413		26.0		77.56 *
20414	08/23/72	TUSTAMENA	LONG SHOREMAN	CT	20.0	3.28	65.60
20414	08/23/72	TUSTAMENA	LONG SHOREMAN	ST	2.0	2.57	5.14
20414	08/23/72	TUSTAMENA	WALKING BESS	CT	4.0	3.94	15.76
			TOTAL FOR BILL NO. 20414		26.0		86.50 *
20420	08/30/72	TUSTAMENA	LONG SHOREMAN	CT	15.0	3.28	49.20
20420	08/30/72	TUSTAMENA	LONG SHOREMAN	ST	7.0	2.57	17.99
20420	08/30/72	TUSTAMENA	WALKING BESS	CT	3.0	3.94	11.82
20420	08/30/72	TUSTAMENA	WALKING BESS	ST	1.0	3.02	3.02
			TOTAL FOR BILL NO. 20420		26.0		82.03 *
20422	08/30/72	TUSTAMENA	LONG SHOREMAN	CT	20.0	3.28	65.60
20422	08/30/72	TUSTAMENA	LONG SHOREMAN	ST	2.0	2.57	5.14
20422	08/30/72	TUSTAMENA	WALKING BESS	CT	4.0	3.94	15.76
			TOTAL FOR BILL NO. 20422		26.0		86.50 *
20427	09/06/72	TUSTAMENA	LONG SHOREMAN	CT	7.5	3.28	24.60
20427	09/06/72	TUSTAMENA	LONG SHOREMAN	ST	27.0	2.57	56.54
20427	09/06/72	TUSTAMENA	WALKING BESS	CT	1.5	3.94	5.91
20427	09/06/72	TUSTAMENA	WALKING BESS	ST	4.0	3.02	12.08
			TOTAL FOR BILL NO. 20427		35.0		99.13 *
20428	09/06/72	TUSTAMENA	LONG SHOREMAN	CT	20.0	3.28	65.60
20428	09/06/72	TUSTAMENA	LONG SHOREMAN	ST	2.0	2.57	5.14
20428	09/06/72	TUSTAMENA	WALKING BESS	CT	4.0	3.94	15.76
			TOTAL FOR BILL NO. 20428		26.0		86.50 *
20439	09/13/72	TUSTAMENA	LONG SHOREMAN	CT	10.0	3.28	32.80
20439	09/13/72	TUSTAMENA	LONG SHOREMAN	ST	12.0	2.57	30.84
20439	09/13/72	TUSTAMENA	WALKING BESS	CT	2.0	3.94	7.88
20439	09/13/72	TUSTAMENA	WALKING BESS	ST	2.0	3.02	6.04
			TOTAL FOR BILL NO. 20439		26.0		77.56 *

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20440	09/13/72	TUSTAMENA	LONG SHOREMAN	CT	20.0	3.28	65.60
20440	09/13/72	TUSTAMENA	LONG SHOREMAN	ST	2.0	2.57	5.14
20440	09/13/72	TUSTAMENA	WALKING BOSS	CT	4.0	3.94	15.76
TOTAL FOR BILL NO. 20440					26.0		86.50 *
20447	09/20/72	TUSTAMENA	LONG SHOREMAN	CT	25.0	3.28	82.00
20447	09/20/72	TUSTAMENA	LONG SHOREMAN	ST	2.0	2.57	5.14
20447	09/20/72	TUSTAMENA	WALKING BOSS	CT	5.0	3.94	19.70
TOTAL FOR BILL NO. 20447					32.0		106.84 *
20450	09/20/72	TUSTAMENA	LONG SHOREMAN	CT	5.0	3.28	16.40
20450	09/20/72	TUSTAMENA	LONG SHOREMAN	CTPM	5.0	4.32	21.60
20450	09/20/72	TUSTAMENA	LONG SHOREMAN	ST	22.0	2.57	56.54
20450	09/20/72	TUSTAMENA	WALKING BOSS	CT	1.0	3.94	3.94
20450	09/20/72	TUSTAMENA	WALKING BOSS	CTPM	1.0	5.30	5.30
20450	09/20/72	TUSTAMENA	WALKING BOSS	ST	4.0	3.02	12.08
TOTAL FOR BILL NO. 20450					38.0		115.86 *
20456	09/27/72	TUSTAMENA	LONG SHOREMAN	CT	5.0	3.28	16.40
20456	09/27/72	TUSTAMENA	LONG SHOREMAN	CTPM	5.0	4.32	21.60
20456	09/27/72	TUSTAMENA	LONG SHOREMAN	ST	19.5	2.57	50.12
20456	09/27/72	TUSTAMENA	WALKING BOSS	CT	1.0	3.94	3.94
20456	09/27/72	TUSTAMENA	WALKING BOSS	CTPM	1.0	5.30	5.30
20456	09/27/72	TUSTAMENA	WALKING BOSS	ST	3.5	3.02	10.57
TOTAL FOR BILL NO. 20456					35.0		107.93 *
20457	09/27/72	TUSTAMENA	LONG SHOREMAN	CT	20.0	3.28	65.60
20457	09/27/72	TUSTAMENA	LONG SHOREMAN	ST	2.0	2.57	5.14
20457	09/27/72	TUSTAMENA	WALKING BOSS	CT	4.0	3.94	15.76
TOTAL FOR BILL NO. 20457					26.0		86.50 *
20464	10/04/72	TUSTAMENA	LONG SHOREMAN	CT	5.0	3.28	16.40
20464	10/04/72	TUSTAMENA	LONG SHOREMAN	CTPM	5.0	4.32	21.60
20464	10/04/72	TUSTAMENA	LONG SHOREMAN	ST	17.0	2.57	43.69
20464	10/04/72	TUSTAMENA	WALKING BOSS	CT	1.0	3.94	3.94
20464	10/04/72	TUSTAMENA	WALKING BOSS	CTPM	1.0	5.30	5.30
20464	10/04/72	TUSTAMENA	WALKING BOSS	ST	3.0	3.02	9.06
TOTAL FOR BILL NO. 20464					32.0		99.99 *
20466	10/04/72	TUSTAMENA	LONG SHOREMAN	CT	20.0	3.28	65.60
20466	10/04/72	TUSTAMENA	WALKING BOSS	CT	4.0	3.94	15.76
TOTAL FOR BILL NO. 20466					24.0		81.36 *
20630	06/06/73	TUSTAMENA	HT, F/L CFER, ETC	CT	4.0	3.61	14.44
20630	06/06/73	TUSTAMENA	LONG SHOREMAN	CT	20.0	3.28	65.60
20630	06/06/73	TUSTAMENA	LONG SHOREMAN	ST	19.5	2.57	50.12
20630	06/06/73	TUSTAMENA	WALKING BOSS	CT	4.0	3.94	15.76
20630	06/06/73	TUSTAMENA	WALKING BOSS	ST	3.5	3.02	10.57
TOTAL FOR BILL NO. 20630					51.0		156.49 *
20632	06/06/73	TUSTAMENA	LONG SHOREMAN	CT	20.0	3.28	65.60
20632	06/06/73	TUSTAMENA	LONG SHOREMAN	ST	2.0	2.57	5.14
20632	06/06/73	TUSTAMENA	WALKING BOSS	CT	4.0	3.94	15.76
TOTAL FOR BILL NO. 20632					26.0		86.50 *

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BILL NO.	DATE	VESSEL	LABOR DESC.	TYPE	HOURS	RETRO RATE	AMOUNT
20640	06/13/73	TUSTAMENA	LONG SHOREMAN	CT	5.0	3.28	16.40
20640	06/13/73	TUSTAMENA	LONG SHOREMAN	ST	24.5	2.57	62.97
20640	06/13/73	TUSTAMENA	WALKING BOSS	CT	1.0	3.94	3.94
20640	06/13/73	TUSTAMENA	WALKING BOSS	ST	4.5	3.02	13.59
TOTAL FOR BILL NO. 20640					35.0		96.90 *
20643	06/13/73	TUSTAMENA	LONG SHOREMAN	CT	20.0	3.28	65.60
20643	06/13/73	TUSTAMENA	LONG SHOREMAN	ST	2.0	2.57	5.14
20643	06/13/73	TUSTAMENA	WALKING BOSS	CT	4.0	3.94	15.76
TOTAL FOR BILL NO. 20643					26.0		86.50 *
20653	06/20/73	TUSTAMENA	LONG SHOREMAN	CT	10.0	3.28	32.80
20653	06/20/73	TUSTAMENA	LONG SHOREMAN	ST	17.0	2.57	43.69
20653	06/20/73	TUSTAMENA	WALKING BOSS	CT	2.0	3.94	7.88
20653	06/20/73	TUSTAMENA	WALKING BOSS	ST	3.0	3.02	9.06
TOTAL FOR BILL NO. 20653					32.0		93.43 *
20654	06/20/73	TUSTAMENA	LONG SHOREMAN	CT	20.0	3.28	65.60
20654	06/20/73	TUSTAMENA	LONG SHOREMAN	ST	2.0	2.57	5.14
20654	06/20/73	TUSTAMENA	WALKING BOSS	CT	4.0	3.94	15.76
TOTAL FOR BILL NO. 20654					26.0		86.50 *
20659	06/27/73	TUSTAMENA	LONG SHOREMAN	CT	10.0	3.28	32.80
20659	06/27/73	TUSTAMENA	LONG SHOREMAN	ST	18.0	2.57	46.26
20659	06/27/73	TUSTAMENA	WALKING BOSS	CT	2.0	3.94	7.88
20659	06/27/73	TUSTAMENA	WALKING BOSS	ST	4.0	3.02	12.08
TOTAL FOR BILL NO. 20659					34.0		99.02 *
20660	06/27/73	TUSTAMENA	LONG SHOREMAN	CT	20.0	3.28	65.60
20660	06/27/73	TUSTAMENA	LONG SHOREMAN	ST	2.0	2.57	5.14
20660	06/27/73	TUSTAMENA	WALKING BOSS	CT	4.0	3.94	15.76
TOTAL FOR BILL NO. 20660					26.0		86.50 *
20663	07/05/73	TUSTAMENA	LONG SHOREMAN	CT	5.0	3.28	16.40
20663	07/05/73	TUSTAMENA	LONG SHOREMAN	CTPM	5.0	4.32	21.60
20663	07/05/73	TUSTAMENA	LONG SHOREMAN	ST	17.0	2.57	43.69
20663	07/05/73	TUSTAMENA	WALKING BOSS	CT	1.0	3.94	3.94
20663	07/05/73	TUSTAMENA	WALKING BOSS	CTPM	1.0	5.30	5.30
20663	07/05/73	TUSTAMENA	WALKING BOSS	ST	3.0	3.02	9.06
TOTAL FOR BILL NO. 20663					32.0		99.99 *
TOTAL FOR CO. NO. 003					1,043.0		3,285.73 ***

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BILL NO.	DATE	VESSEL	LABOR DESC.	TYPE	HOURS	RETRO RATE	AMOUNT
20668	07/11/73	TUSTAMENA	LONG SHOREMAN	CT	25.0	4.30	107.50
20668	07/11/73	TUSTAMENA	LONG SHOREMAN	CTPM	5.0	5.86	29.30
20668	07/11/73	TUSTAMENA	LONG SHOREMAN	ST	2.0	3.26	6.52
20668	07/11/73	TUSTAMENA	WALKING BESS	CT	5.0	4.98	24.90
20668	07/11/73	TUSTAMENA	WALKING BESS	CTPM	1.0	6.87	6.87
TOTAL FOR BILL NO. 20668					38.0		175.09 *
20671	07/11/73	TUSTAMENA	LONG SHOREMAN	CT	5.0	4.30	21.50
20671	07/11/73	TUSTAMENA	LONG SHOREMAN	CTPM	5.0	5.86	29.30
20671	07/11/73	TUSTAMENA	LONG SHOREMAN	ST	12.0	3.26	39.12
20671	07/11/73	TUSTAMENA	WALKING BESS	CT	1.0	4.98	4.98
20671	07/11/73	TUSTAMENA	WALKING BESS	CTPM	1.0	6.87	6.87
20671	07/11/73	TUSTAMENA	WALKING BESS	ST	2.0	3.72	7.44
TOTAL FOR BILL NO. 20671					26.0		109.21 *
20672	07/11/73	TUSTAMENA	LONG SHOREMAN	CT	20.0	4.30	86.00
20672	07/11/73	TUSTAMENA	LONG SHOREMAN	ST	2.0	3.26	6.52
20672	07/11/73	TUSTAMENA	WALKING BESS	CT	4.0	4.98	19.92
TOTAL FOR BILL NO. 20672					26.0		112.44 *
20675	07/18/73	TUSTAMENA	LONG SHOREMAN	CT	5.0	4.30	21.50
20675	07/18/73	TUSTAMENA	LONG SHOREMAN	CTPM	5.0	5.86	29.30
20675	07/18/73	TUSTAMENA	LONG SHOREMAN	ST	17.0	3.26	55.42
20675	07/18/73	TUSTAMENA	WALKING BESS	CT	1.0	4.98	4.98
20675	07/18/73	TUSTAMENA	WALKING BESS	CTPM	1.0	6.87	6.87
20675	07/18/73	TUSTAMENA	WALKING BESS	ST	3.0	3.72	11.16
TOTAL FOR BILL NO. 20675					32.0		129.23 *
20676	07/18/73	TUSTAMENA	LONG SHOREMAN	CT	20.0	4.30	86.00
20676	07/18/73	TUSTAMENA	LONG SHOREMAN	ST	2.0	3.26	6.52
20676	07/18/73	TUSTAMENA	WALKING BESS	CT	4.0	4.98	19.92
TOTAL FOR BILL NO. 20676					26.0		112.44 *
20684	07/25/73	TUSTAMENA	LONG SHOREMAN	CT	4.5	4.30	19.35
20684	07/25/73	TUSTAMENA	LONG SHOREMAN	ST	9.5	3.26	30.97
20684	07/25/73	TUSTAMENA	WALKING BESS	CT	1.5	4.98	7.47
20684	07/25/73	TUSTAMENA	WALKING BESS	ST	2.5	3.72	9.30
TOTAL FOR BILL NO. 20684					18.0		67.09 *
20686	07/25/73	TUSTAMENA	LONG SHOREMAN	CT	4.0	4.30	17.20
20686	07/25/73	TUSTAMENA	LONG SHOREMAN	CTPM	8.0	5.86	46.88
20686	07/25/73	TUSTAMENA	LONG SHOREMAN	ST	14.0	3.26	45.64
20686	07/25/73	TUSTAMENA	WALKING BESS	CT	1.0	4.98	4.98
20686	07/25/73	TUSTAMENA	WALKING BESS	CTPM	2.0	6.87	13.74
20686	07/25/73	TUSTAMENA	WALKING BESS	ST	3.0	3.72	11.16
TOTAL FOR BILL NO. 20686					32.0		139.60 *
20687	07/25/73	TUSTAMENA	LONG SHOREMAN	CT	20.0	4.30	86.00
20687	07/25/73	TUSTAMENA	LONG SHOREMAN	ST	2.0	3.26	6.52
20687	07/25/73	TUSTAMENA	WALKING BESS	CT	4.0	4.98	19.92
TOTAL FOR BILL NO. 20687					26.0		112.44 *
20695	08/01/73	TUSTAMENA	LONG SHOREMAN	CT	7.5	4.30	32.25
20695	08/01/73	TUSTAMENA	LONG SHOREMAN	ST	17.0	3.26	55.42

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STATE OF ALASKA-BILLING

BILL NO.	DATE	VESSEL	LABOR DESC.	TYPE	HOURS	RETRO RATE	AMOUNT
20695	08/01/73	TUSTAMENA	WALKING BOSS	CT	1.5	4.98	7.47
20695	08/01/73	TUSTAMENA	WALKING BOSS	ST	3.0	3.72	11.16
			TOTAL FOR BILL NO. 20695		29.0		106.30 *
20696	08/01/73	TUSTAMENA	LONG SHORE MAN	CT	25.0	4.30	107.50
20696	08/01/73	TUSTAMENA	LONG SHORE MAN	ST	2.0	3.26	6.52
20696	08/01/73	TUSTAMENA	WALKING BOSS	CT	5.0	4.98	24.90
			TOTAL FOR BILL NO. 20696		32.0		138.92 *
20697	08/08/73	TUSTAMENA	LONG SHORE MAN	CTPM	10.0	5.86	58.60
20697	08/08/73	TUSTAMENA	LONG SHORE MAN	ST	27.0	3.26	88.02
20697	08/08/73	TUSTAMENA	WALKING BOSS	CTPM	2.0	6.87	13.74
20697	08/08/73	TUSTAMENA	WALKING BOSS	ST	5.0	3.72	18.60
			TOTAL FOR BILL NO. 20697		44.0		178.96 *
20699	08/08/73	TUSTAMENA	LONG SHORE MAN	CT	20.0	4.30	86.00
20699	08/08/73	TUSTAMENA	LONG SHORE MAN	ST	2.0	3.26	6.52
20699	08/08/73	TUSTAMENA	WALKING BOSS	CT	4.0	4.98	19.92
			TOTAL FOR BILL NO. 20699		26.0		112.44 *
20706	08/15/73	TUSTAMENA	LONG SHORE MAN	CT	5.0	4.30	21.50
20706	08/15/73	TUSTAMENA	LONG SHORE MAN	CTPM	5.0	5.86	29.30
20706	08/15/73	TUSTAMENA	LONG SHORE MAN	ST	22.0	3.26	71.72
20706	08/15/73	TUSTAMENA	WALKING BOSS	CT	1.0	4.98	4.98
20706	08/15/73	TUSTAMENA	WALKING BOSS	CTPM	1.0	6.87	6.87
20706	08/15/73	TUSTAMENA	WALKING BOSS	ST	4.0	3.72	14.88
			TOTAL FOR BILL NO. 20706		38.0		149.25 *
20707	08/15/73	TUSTAMENA	LONG SHORE MAN	CT	20.0	4.30	86.00
20707	08/15/73	TUSTAMENA	LONG SHORE MAN	ST	2.0	3.26	6.52
20707	08/15/73	TUSTAMENA	WALKING BOSS	CT	4.0	4.98	19.92
			TOTAL FOR BILL NO. 20707		26.0		112.44 *
20717	08/22/73	TUSTAMENA	LONG SHORE MAN	CT	8.0	4.30	34.40
20717	08/22/73	TUSTAMENA	LONG SHORE MAN	ST	16.0	3.26	52.16
20717	08/22/73	TUSTAMENA	WALKING BOSS	CT	2.0	4.98	9.96
20717	08/22/73	TUSTAMENA	WALKING BOSS	ST	3.5	3.72	13.02
			TOTAL FOR BILL NO. 20717		29.5		109.54 *
20718	08/22/73	TUSTAMENA	LONG SHORE MAN	CT	20.0	4.30	86.00
20718	08/22/73	TUSTAMENA	LONG SHORE MAN	ST	2.0	3.26	6.52
20718	08/22/73	TUSTAMENA	WALKING BOSS	CT	4.0	4.98	19.92
			TOTAL FOR BILL NO. 20718		26.0		112.44 *
20719	08/29/73	TUSTAMENA	LONG SHORE MAN	CTPM	10.0	5.86	58.60
20719	08/29/73	TUSTAMENA	LONG SHORE MAN	ST	27.0	3.26	88.02
20719	08/29/73	TUSTAMENA	WALKING BOSS	CTPM	2.0	6.87	13.74
20719	08/29/73	TUSTAMENA	WALKING BOSS	ST	5.0	3.72	18.60
			TOTAL FOR BILL NO. 20719		44.0		178.96 *
20720	08/29/73	TUSTAMENA	HT, F/L OPER, ETC	CT	4.0	4.66	18.64
20720	08/29/73	TUSTAMENA	LONG SHORE MAN	CT	16.0	4.30	68.80
20720	08/29/73	TUSTAMENA	LONG SHORE MAN	ST	2.0	3.26	6.52
20720	08/29/73	TUSTAMENA	WALKING BOSS	CT	4.0	4.98	19.92

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AUG 14 1974

ACCOUNTING
MARINE TRANSPORTATION

NORTH STAR RETROACTIVE BILLING

PERIOD 07/01/73 THRU 04/14/74

STATE OF ALASKA-BILLING

BILL NO.	DATE	VESSEL	LABOR DESC.	TYPE	HOURS	RETRD RATE	AMOUNT
TOTAL FOR BILL NO. 20720					26.0		113.88 *
20727	09/05/73	TUSTUMENA	LONG SHOREMAN	CT	5.0	4.30	21.50
20727	09/05/73	TUSTUMENA	LONG SHOREMAN	CTPM	5.0	5.86	29.30
20727	09/05/73	TUSTUMENA	LONG SHOREMAN	ST	17.0	3.26	55.42
20727	09/05/73	TUSTUMENA	WALKING BOSS	CT	1.0	4.98	4.98
20727	09/05/73	TUSTUMENA	WALKING BOSS	CTPM	1.0	6.87	6.87
20727	09/05/73	TUSTUMENA	WALKING BOSS	ST	3.0	3.72	11.16
TOTAL FOR BILL NO. 20727					32.0		129.23 *
20728	09/05/73	TUSTUMENA	LONG SHOREMAN	CT	16.0	4.30	68.80
20728	09/05/73	TUSTUMENA	LONG SHOREMAN	ST	2.0	3.26	6.52
20728	09/05/73	TUSTUMENA	WALKING BOSS	CT	4.0	4.98	19.92
TOTAL FOR BILL NO. 20728					22.0		55.24 *
20731	09/12/73	TUSTUMENA	LONG SHOREMAN	CT	5.0	4.30	21.50
20731	09/12/73	TUSTUMENA	LONG SHOREMAN	CTPM	5.0	5.86	29.30
20731	09/12/73	TUSTUMENA	LONG SHOREMAN	ST	22.0	3.26	71.72
20731	09/12/73	TUSTUMENA	WALKING BOSS	CT	1.0	4.98	4.98
20731	09/12/73	TUSTUMENA	WALKING BOSS	CTPM	1.0	6.87	6.87
20731	09/12/73	TUSTUMENA	WALKING BOSS	ST	4.0	3.72	14.88
TOTAL FOR BILL NO. 20731					38.0		149.25 *
20732	09/12/73	TUSTUMENA	LONG SHOREMAN	CT	20.0	4.30	86.00
20732	09/12/73	TUSTUMENA	LONG SHOREMAN	ST	2.0	3.26	6.52
20732	09/12/73	TUSTUMENA	WALKING BOSS	CT	4.0	4.98	19.92
TOTAL FOR BILL NO. 20732					26.0		112.44 *
20739	09/19/73	TUSTUMENA	LONG SHOREMAN	CT	5.0	4.30	21.50
20739	09/19/73	TUSTUMENA	LONG SHOREMAN	CTPM	5.0	5.86	29.30
20739	09/19/73	TUSTUMENA	LONG SHOREMAN	ST	14.5	3.26	47.27
20739	09/19/73	TUSTUMENA	WALKING BOSS	CT	1.0	4.98	4.98
20739	09/19/73	TUSTUMENA	WALKING BOSS	CTPM	1.0	6.87	6.87
20739	09/19/73	TUSTUMENA	WALKING BOSS	ST	2.5	3.72	9.30
TOTAL FOR BILL NO. 20739					29.0		119.22 *
20742	09/19/73	TUSTUMENA	LONG SHOREMAN	CT	16.0	4.30	68.80
20742	09/19/73	TUSTUMENA	LONG SHOREMAN	ST	2.0	3.26	6.52
20742	09/19/73	TUSTUMENA	WALKING BOSS	CT	4.0	4.98	19.92
TOTAL FOR BILL NO. 20742					22.0		95.24 *
20746	09/26/73	TUSTUMENA	LONG SHOREMAN	CT	5.0	4.30	21.50
20746	09/26/73	TUSTUMENA	LONG SHOREMAN	CTPM	5.0	5.86	29.30
20746	09/26/73	TUSTUMENA	LONG SHOREMAN	ST	22.0	3.26	71.72
20746	09/26/73	TUSTUMENA	WALKING BOSS	CT	1.0	4.98	4.98
20746	09/26/73	TUSTUMENA	WALKING BOSS	CTPM	1.0	6.87	6.87
20746	09/26/73	TUSTUMENA	WALKING BOSS	ST	4.0	3.72	14.88
TOTAL FOR BILL NO. 20746					38.0		149.25 *
20748	09/26/73	TUSTUMEN	HT, F/L OPER, ETC	CT	4.0	4.66	18.64
20748	09/26/73	TUSTUMEN	LONG SHOREMAN	CT	16.0	4.30	68.80
20748	09/26/73	TUSTUMEN	LONG SHOREMAN	ST	2.0	3.26	6.52
20748	09/26/73	TUSTUMEN	WALKING BOSS	CT	4.0	4.98	19.92
TOTAL FOR BILL NO. 20748					26.0		113.88 *

RECEIVED

AUG 14 1974

ACCOUNTING
MARINE TRANSPORTATION

NORTH STAR RETROACTIVE BILLING PERIOD 07/01/73 THRU 04/14/74 STATE OF ALASKA-BILLING

BILL NO.	DATE	VESSEL	LABOR DESC.	TYPE	HOURS	RETRO RATE	AMOUNT
20754	10/03/73	TUSTUMEAN	HT, F/L OPER, ETC	CT	4.0	4.66	18.64
20754	10/03/73	TUSTUMEAN	LONGSHOREMAN	CT	16.0	4.30	68.80
20754	10/03/73	TUSTUMEAN	LONGSHOREMAN	ST	2.0	3.26	6.52
20754	10/03/73	TUSTUMEAN	WALKING BOSS	CT	4.0	4.98	19.92
TOTAL FOR BILL NO. 20754					26.0		113.88 *
20755	10/03/73	TUSTUMENA	LONGSHOREMAN	CT	5.0	4.30	21.50
20755	10/03/73	TUSTUMENA	LONGSHOREMAN	CTPM	5.0	5.86	29.30
20755	10/03/73	TUSTUMENA	LONGSHOREMAN	ST	12.0	3.26	39.12
20755	10/03/73	TUSTUMENA	WALKING BOSS	CT	1.0	4.98	4.98
20755	10/03/73	TUSTUMENA	WALKING BOSS	CTPM	1.0	6.87	6.87
20755	10/03/73	TUSTUMENA	WALKING BOSS	ST	2.0	3.72	7.44
TOTAL FOR BILL NO. 20755					26.0		109.21 *
20774	10/24/73	TUSTUMENA	LONGSHOREMAN	CT	12.0	4.30	51.60
20774	10/24/73	TUSTUMENA	LONGSHOREMAN	ST	22.0	3.26	71.72
20774	10/24/73	TUSTUMENA	WALKING BOSS	CT	4.0	4.98	19.92
20774	10/24/73	TUSTUMENA	WALKING BOSS	ST	4.0	3.72	14.88
TOTAL FOR BILL NO. 20774					42.0		158.12 *
20775	10/24/73	TUSTUMENA	LONGSHOREMAN	CT	20.0	4.30	86.00
20775	10/24/73	TUSTUMENA	WALKING BOSS	CT	4.0	4.98	19.92
TOTAL FOR BILL NO. 20775					24.0		105.92 *
TOTAL FOR CO. NO. 003					895.5		3,721.55 ***

RECEIVED
 AUG 14 1974
 ACCOUNTING
 MARINE TRANSPORTATION

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13.20
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3,520.88
128.00
190.00
30.00
168.75
771.00
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100.00
99.50
134.10
62.90
3.40
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5.30
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18.68
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180.00
122.40
10.80
79.20
24.48
344.29
7.00
6.84
91.00
56.00
43.50
64.00
24.00
11.50
390.50
98.70
1,763.85
70.00
102.00
56.40
11.80
15.00
12,199.62

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF BUDGET & MANAGEMENT

POUCH C — JUNEAU 99801

March 14, 1975

JAY S. HAMMOND, Governor

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


Dear Representative Malone:

We hereby request the House Finance Committee's consideration of a proposed amendment to Senate Bill 78 which would increase the total miscellaneous claims amount requested for the Department of Health and Social Services by \$12,375.51 to \$21,678.02.

This additional amount is required to pay billings recently received in our office which are more than 2 years old and not eligible for payment from current appropriations. This proposed amendment when combined with the adjustment requested in my letter of February 20 to Senator Ray (copy attached) would adjust the total requested in the bill to \$57,377.61.

Should further information be desired by the Committee, myself and my staff are at your pleasure.

Sincerely,



V. Kent Dawson, Director

Attachment:
VKD/bc

February 20, 1975

The Honorable Bill Ray
Chairman
Senate Finance Committee
Pouch V
Juneau, Alaska 99811

Attention: Senator George Hohman

Dear Senator Ray:

This is in response to a question raised by Senator Hohman at this morning's Senate Finance hearing concerning the Governor's requested supplemental appropriation for miscellaneous claims (SB 78).

After reviewing AS 37.25.010 (b) it is our interpretation that the claims associated with SB 78 are not legally payable with current year authorization. This is due to the fact that the provisions (1) and (2) of subsection (b) preclude such payment.

A copy of the proposed change to the SB 78 appropriated amount which I mentioned this morning is also attached. This alteration has the following effect:

Remove:	N.C. Machinery Claim	(\$935.58)
Add:	Spenard Builders	
	(in. no. R27639)	18.04
Add:	Spenard Builders	
	(in. no. C5972)	8.96
	Net effect of revision	<u>(598.58)</u>

We accordingly recommend that SB 78 be amended to reduce the appropriated amount from \$45,900 to \$44,992; a reduction of \$908.00. Within the bill the amount appropriated to the Department of Public Works should be reduced by a like amount: \$908.58.

February 20, 1975

To avoid miscellaneous claim supplemental appropriations in future fiscal years we have proposed that the General Appropriation Bill be footnoted to include the provision that it be allowable for the Governor's Contingency Fund to be used to pay obligations for any agency for any time period. HB 70 now includes that provision. We solicit your support in having such a provision included in the Senate's version of the budget bill this session!

Sincerely,


V. Kent Dawson, Director

cc: Jay Hogan, Director, Legislative Finance
Attachment:
VKD/bc

STATE
of ALASKA**MEMORANDUM**TO: Ron Lind
Budget & Management

DATE : February 27, 1975

FROM: Ray Davidson
Fiscal Officer
Dept. of Health & Soc. Svcs

SUBJECT:

Ron:

Please find up date to original submission of 2 year old billings.

		<u>Curr. Year</u>	<u>Prior Year</u>	<u>Total</u>
Original:	Reg.	640.86	549.01	1,189.87
	Medical	--	8,112.64	8,112.64
	TOTAL	640.86	8,661.65	9,302.51
Update:	Reg.	175.89		175.89
	Medical	12,199.62		12,199.62
	TOTAL	13,016.37	8,661.65	21,678.02

Legislative Billings for year 1974-75

Submitted November 22, 1974

	Invoice #	Date of Service	Amount	Date Received	Code	Reason for Delay
Family & Children Services						
Alaska Children Services	69355	03-16-72	307.20	5-15-74	06-21-3-265-336	Vendor Inv. not rcvd
Frank Chasley	482677	02-16-72	115.00	5-02-74	06-21-3-150-730	Wt. misplaced 2 yrs.
Anchorage Daily Times	L-79415	12-22-70	11.70	8-15-74	06-21-3-263-325	Vendor Inv. not rcvd
Anchorage Daily Times	L-79156	6-24-71	67.20	5-30-74	06-21-3-263-325	" " " "
Anchorage Daily Times	L-79156	6-03-71	63.60	5-30-74	06-21-3-263-325	" " " "
Corrections						
Schmolsk Plumbing & Heating	12473	5-04-71	24.25	3-04-74	06-66-04-112-450	Vendor Inv. not rcvd
Public Health						
National Academy of Engineers	266362	11-02-70	29.90	2-13-74	06-31-1-980-490	Vendor Inv. not rcvd
Sea Land	992908461		22.01	10-19-74	06-26-5-117-350	
(Previously submitted)						
TOTAL			640.86			
<hr/>						
Sea Land	992907090		84.21	5-08-74	06-26-5-117-350	
National Car Rental	H022095		13.68	12-18-74	06-26-5-610	
Mrs. Florence Eilertson			78.00	9-25-74	06-31-1-761-390	
TOTAL			816.75			
Medical Assistance (detail attached)			12,199.62			
Health & Social Services TOTAL			13,016.37			

Legislative Billings for year 1974-75

Submitted November 22, 1974

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Anchorage Daily Times	L-79415	12-22-70	11.70	8-15-74	06-21-3-263-325	Vendor Inv. not rcvd
Anchorage Daily Times	L-79156	6-24-71	67.20	5-30-74	06-21-3-263-325	" " " "
Anchorage Daily Times	L-79156	6-03-71	63.60	5-30-74	06-21-3-263-325	" " " "
Corrections						
Schmolsk Plumbing & Heating	12473	5-04-71	24.25	3-04-74	06-66-04-112-450	Vendor Inv. not rcvd
Public Health						
National Academy of Engineers	266362	11-02-70	29.90	2-13-74	06-31-1-980-490	Vendor Inv. not rcvd
Sea Land	992908461		22.01	10-19-74	06-26-5-117-350	
(Previously submitted)						
TOTAL			640.86			
<hr/>						
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TOTAL			816.75			
Medical Assistance (detail attached)			12,199.62			
Health & Social Services						
TOTAL			13,016.37			

25 1973

SEATTLE, WASHINGTON

952307000

DATE OF SHIPMENT 10 7 72	SHIPMENT NO. 53 515	CONSIGNEE AFF	SHIPPER HONDA COMMERCIAL REFRIGERATOR CO	SHIPMENT TYPE GENERAL	SHIPMENT WEIGHT GL 50 11	SHIPMENT VOLUME 10 5 27 1500	SHIPMENT VALUE NONE
SHIPPER'S OFFICE 5 1				SPECIAL INSTRUCTIONS CONSIGNEE HAS-DIV-OF PUBLIC HLTH SECT OF LA35 627 E BOUNTY AVE ANCHORAGE ALASKA			
SHIPPER'S OFFICE HONDA COMMERCIAL REFRIGERATOR CO 2200 KENNEDY ST PHILA PA				BILL TO 3000 3rd Ave Seattle WA 531 1st Ave			

NOV 17 1972

Sealand Service, Inc.
A MEMBER OF THE SEALAND SERVICE GROUP

CONSIGNEE'S MEMO 6

SHIPPER HONDA COMMERCIAL REFRIGERATOR CO 2200 KENNEDY ST PHILA PA 19137	CONSIGNEE SEALAND SERVICE INC SEATTLE WASH	SHIPMENT NO. 952307000
DESCRIPTION OF ARTICLES RECEIVED REFRIGERATOR UNIT 17 1/2 TON AVE ANCHORAGE ALASKA		DATE 10 5 72
FREIGHT BILL		DATE 10 5 72
FREIGHT CHARGES 12375		TOTAL CHARGES 12375
PREPAID		COLLECT

SEA-LAND SERVICE, INC.

CONTAINERS LOADED ZA D-66-100	CHECKER 620	NO. PCS. 1	FROM AFF	TO 53515	DATE 10/2
SPECIAL HANDLING 47111	TOTAL WT 507	FEES 1661	DECLAR CHARGES 2421	TOTAL CHARGES 8421	
NEED FROM FREIGHTING <input type="checkbox"/>	ORDER NOTES <input type="checkbox"/>	11 COD PAYMENT 12 COD FEE 13 COMMODITY 14 EXPORT DOCUMENTS 15 SPECIAL DELIVERY 16 SPECIAL RATE 17 STOP IN TRANSIT 18 STOPPAGE 19 OTHER 20 ADVANCE PAYMENT 21 DEFERRED PAYMENT	5/3		

4 CASHIER

ALASKA
 FOR TRANSPORTATION
 NT OF

ATO
 STA NO. 02 (01) R.A. NO.

H022095 4

CAR WILL BE RETURNED TO: Anchorage, AK
 CAR WILL BE RETURNED BY: 6/6/77
 MILEAGE DETERMINED BY READING FACTORY INSTALLED ODOMETER: 18535
 TIME IN: 2:20 6-6-77
 TIME OUT: 11:00 6-6-77
 MILES IN: 18535
 MILES OUT: 18514
 MILES DRIVEN: 21
 ALTERNATE CAR AND DATE: NONE
 MILES IN: NONE
 MILES OUT: NONE
 MILES DRIVEN: NONE
 COMMISSIONABLE SOURCE:

(57) BILLING INFORMATION ONLY
 State TR 4
 348079
 NAME: Dept. of Health & Soc. Serv.
 ADDRESS: Rm. 214 McKay Bldg.
 CITY: Anchorage, Alaska 99501

DRIVERS LICENSE NO.: 172870
 STATE: Alaska
 EXPIRATION DATE: 7/9/73
 NAME: Virginia M. Blamhord
 ADDRESS: 1507 Crescent Ave
 CITY: Anchorage, Alaska 99501
 LOCAL ADDRESS: [Blank]
 PHONE NO.: [Blank]

(137) TIME IN	A.M. 2:20 6-6-77
(138) MILES IN	18535
(139) MILES OUT	18514
(140) MILES DRIVEN	21
(141) MILES (41)	168
(142) DAYS (42)	12.00 12.00
(143) WEEKS (43)	
(144) HOURS (44)	
(145)	
(146) SUB-TOTAL	13.68
(147)	
(148) TOTAL TIME AND MILEAGE OR MINIMUM CHARGE	13.68
(149) INTER-CITY FEE	
(150) C. DAYS WEEKS	No
(151) SUB-TOTAL	13.68
(152) TAX	
(153)	
(154) P. DAYS WEEKS	No
(155) TOTAL CHARGES	13.68
(156) LESS GAS, ETC.	
(157) NET CHARGE	
(158) LESS DEPOSIT	
(159)	
(160) AMOUNT DUE (U.S.)	13.68
(161) PAID BY	CASH
(162) CUSTOMER INITIALS	6/6
(163) DR B DATE	6/6

I HAVE READ THE TERMS AND CONDITIONS ON BOTH SIDES OF THIS RENTAL AGREEMENT AND AGREE THERETO.
 X Virginia M. Blamhord
 ADDITIONAL DRIVER

RATE DOES NOT INCLUDE GAS
 MINIMUM RENTAL-ONE DAY PLUS MILEAGE.
 INTER-CITY FEE MAY BE APPLIED IF VEHICLE IS NOT RETURNED TO LOCATION SPECIFIED ABOVE. CUSTOMER IS LIABLE FOR ALL PARKING AND TRAFFIC VIOLATIONS.
 INVOICE SUBJECT TO FINAL AUDIT.
 NO REIMBURSEMENT WILL BE MADE WITHOUT GAS RECEIPTS.

ACCEPTS COLLISION DAMAGE WAIVER: X
 DECLINES: X
 CUSTOMER ACCEPTS OR DECLINES PURCHASE OF C.D.W. AT RATE SPECIFIED C.D.W. IS APPLICABLE ONLY IF ACCEPTED.
 ACCEPTS P.A.I. PERSONAL ACCIDENT INSURANCE: X
 DECLINES P.A.I.:
 CUSTOMER ACCEPTS OR DECLINES P.A.I. AT RATE SHOWN IN SEPARATE BROCHURE. WAIVER IS PROOF OF COVERAGE UNDER POLICY ISSUED TO LESSEE AS CONTAINED IN SEPARATE BROCHURE.
 CASH COUPON N.D.R.



LICENSEE
 IN CANADA ITS TILDEN CAR RENTAL

COMMENTS:
 CITY NAME AND ADDRESS

ISSUED: [Blank]
 STAMPED BY: [Blank]
 TO BE MAILED: [Blank]
 DATE: 6/6/77

RENTAL AGREEMENT NO.
H022095 4

THIS RENTAL AGREEMENT NO. MUST APPEAR ON ALL PAYMENTS AND CORRESPONDENCE

MAKE CHECK PAYABLE TO: NATIONAL CAR RENTAL
 MAIL TO
 PLEASE DETACH AND RETURN THIS STUB WITH YOUR PAYMENT

GOLDENROD - CUSTOMER MEMO
 PAGE 2

13
 ass fare
 de) (To
 carrier v
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 for
 your
 218079

SUPVR. APPROVAL

AUTHORIZATION

ORIGINAL

BY

DEPARTMENT OF HEALTH AND WELFARE

DIVISION OF PUBLIC HEALTH

POUCH H JUNEAU, ALASKA 99801

SECTION OF CHILD HEALTH

AUTHORIZATION NO.

00426

*TO Mrs. Florence Ellertson
6633 Debarr Road
Address Anchorage, Alaska 99504

DATE 7-28-72

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

Patient REID, Michael

Birthdate: 6-26-59

Address Sitka

Code: CSC 06-85-11-00

DATE(S) SERVICE RENDERED	DESCRIPTION OF SERVICE (ITEMIZE)	PRICE
	Boarding home care at \$6 per day for 13 days Admitted 2-14-72 discharged 2-26-72	\$78.00 L.M.

Please submit claims first to:

Mrs. Florence Ellertson

\$78.00

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.

©263564

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.

DIVISION OF MEDICAL ASSISTANCE
 Stale Dated Bills
 02/24/75

VENDOR	INVOICE # OR SVC DATE	AMOUNT	*CODING
Alaska Clinic	50973	13.20	150
" "	135371 & 135372	78.08	350
" "	6/19/72	66.00	"
" "	216846	74.40	"
" "	216847 & 216848	464.50	"
" "	11/15/71	20.00	"
" "	7/1/72	16.00	"
" "	6/2/72	12.00	"
" "	6/2/72	12.00	"
" "	59549	32.00	"
" "	8/9/72	12.00	"
" "	1/9/72	142.00	"
" "	12/27/71	29.00	"
" "	7/9/72	20.00	"
" "	8/30/71	23.00	"
" "	5/24/72	64.00	"
" "	6/26/72	7.50	"
" "	1/10/72	7.50	"
" "	82366	46.00	"
Alaskan Opticians	2786	10.70	411
Anc Comm Hospital	504999	60.00	310
" " "	534222	1,746.23	"
Kenneth Behymer, MD	4/27/72	62.00	350
G Blankinship, MD	161178	104.00	"
Fairbanks Med & Surg	96636	99.00	150
" " "	96612	50.00	"
" " "	96677 & 96678	3,520.88	350
" " "	145489	128.00	"
" " "	145490	190.00	"
" " "	145491	30.00	"
" " "	145492	168.75	"
" " "	145493	771.00	"
" " "	145494	55.00	"
" " "	145495	12.00	"
" " "	145496	29.00	"
" " "	145497	12.00	"
" " "	151086	100.00	"
" " "	151083	99.50	"
" " "	151084 & 151085	134.10	"
" " "	151087	62.90	"
" " "	137476	3.40	"
" " "	137473	1.60	"
" " "	137467	5.30	"
" " "	137474 & 137475	4.88	"
" " "	137466	6.10	"
" " "	137463 & 137464	18.68	"
" " "	137465	2.16	"
" " "	96703	180.00	"
" " "	96901	122.40	"
" " "	96702	10.80	"

DIVISION OF MEDICAL ASSISTANCE
 State Dated Bills
 02/24/75

II

Fairbanks Med & Surg	96704		79.20	350
" " "	96810		24.48	"
" " "	63960, 61, 62, 65		344.29	"
	64, 65, 66 - Bal after Medicare			
Lab of Clin Med		10/9/72	7.00	"
" " " "	148270		6.84	"
D J McIntyre, Inc	144130		91.00	"
Ohlson Psych Svcs		11/1/72	56.00	66-4-241-380
R Peterson, MD	162167		43.50	31-1-674-380
" " "	162168		64.00	"
Providence Hosp		8/17/72	24.00	310
" " "		8/22/72	11.50	"
" " "		7/20/72	390.50	"
E Stanley Ray, MD	159178		98.70	350
Seward Gen Hosp		7/18/72	1,763.85	310
" " "		6/15/72	70.00	"
" " "		8/15/72	102.00	"
J Arlyn Smith, MD	160761		56.40	31-1-677-380
Wright Drug	643975		11.80	390
Wm Reinbold, MD	125073		15.00	350
			<u>12,199.62</u>	

* 3 digit account codes are preceded by 33-6 unless otherwise indicated.

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DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 50973A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER 72-320-71-975		RACE W	NAME OF PROVIDER THE ALASKA CLINIC	
NAME OF PATIENT SHAW GREEN			DR. BOSVELD	
DATE OF BIRTH 4-13-70	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE 20 P	PROVIDER I.D. NO. POB 389	CATEGORY 05
CASE NO. 38326-03	RESOURCE X	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) A/c 501		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST ANGIONEUROTIC EDEMA		PRIMARY 781
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		REFERRING OR CONSULTING PHYSICIAN
COMMENTS:		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

11 SERVICES RENDERED							
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
10/29/72	OH	EMER. ROOM	00500	20.50	1320	1 01	
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE		
DO DOCTORS OFFICE	IL INDEPENDENT LAB.	MEDICARE PAID	OTHER INS.	TOTAL	20.50	1320	
H PATIENTS HOME	IN INPATIENT HOSPITAL				LESS		
OL OTHER LOCATION	NH NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL			
ECP EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL				UNPAID BALANCE	2050 1320	

PROVIDER CERTIFICATION

<p>"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.</p>	REMARKS: <i>State dated.</i> <i>33-6-150-380</i>
	<p>PROVIDER SIGNATURE <i>R. Bosveld MD</i> DATE <i>1/15/75</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 135372

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER <i>The Alaska Clinic</i>	
NAME OF PATIENT Glenwood Brown		RACE	PROVIDER ID. NO.	
CASE NO. <i>CASE NO. OAA 39572</i>				
DATE OF BIRTH <i>6/25/00</i>	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	CATEGORY	
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above) <i>ALC 501</i>		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST		PRIMARY
Page 2		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
062672	DO	Upper GI without KUB	74240	56.00	
030372	DO	Upper GI Series	74240	56.00	
040472	DO	Upper GI Series	74240	56.00	
				TOTAL CHARGE	390.80
				LESS	312.32
				UNPAID BALANCE	78.08

PROVIDER CERTIFICATION

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	<p>Medicare payment \$312.32.</p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 135371



10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT GLENWOOD BROWN <i>Case No. OAA39572</i>		RACE	The Alaska Clinic	
DATE OF BIRTH 6 / 25 / 00		ELIG. CODE	PROVIDER ID. NO.	CATEGORY
CASE NO.		RESOURCE	None at that time No longer with us	
			PAYEE ID NO. (if different from above) ALC 501	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST		PRIMARY
Refer to Dr. Hale's report for diagnosis		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN Dr. Hale

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
011472	DO	Upper GI Series	74240	56.00	
011472	DO	Cholecystography oral	74290	38.40	
011572	DO	Cholecystography oral (repeat)	74291	12.20	
012172	DO	Colon barium enema	74270	48.00	
012172	DO	UrographyExcretory IVP	74400	60.80	
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS	TOTAL CHARGE	50	
OO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	
IL INDEPENDENT LAB					
H PATIENT'S HOME					
IH INPATIENT HOSPITAL					
OL OTHER LOCATIONS					
NH NURSING HOME					
ECF EXTENDED CARE FACILITY					
OH OUTPATIENT HOSPITAL					
			LESS		
			UNPAID BALANCE		

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>Carolyn Goudie</i> DATE <i>9/27</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

THE ALASKA CLINIC

a professional corporation

825 L ST.
ANCHORAGE, AK. 99501

PLEASE RETURN

THIS STUB WITH

YOUR PAYMENT

Phone 274-1303

For appt. 272-4551

ACCOUNT NUMBER

DEPT. OF HEALTH & SOCIAL SERVICES

GREG DARRAGH

CURRENT	30-60	60-90	OVER 90	TOTAL DUE
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TOTAL DUE

DATE	PATIENT/DOCTOR	DESCRIPTION	CRVS	AMOUNT
6/19/72	DR. WIELAND	CHEST 2 VIEW	71020	24.00
"	"	Office Call	90040	12.00
"	"	CBC	85010	8.00
"	"	SED. RATE	85650	6.00
"	"	COLD AGG.	80000	16.00

66.00

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 *m*

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 216846

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>11024075 A</i>		RACE <i>W</i>	NAME OF PROVIDER <i>The Alaska Clinic</i>	
NAME OF PATIENT <i>LINDA J. NALL</i>			Dr. Dietz	
DATE OF BIRTH <i>4/25/51</i>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE <i>2E</i>	PROVIDER ID. NO. <i>DMD 393</i>	CATEGORY <i>05</i>
CASE NO. <i>7515601</i>	RESOURCE <input checked="" type="checkbox"/>	PAYEE ID NO. (if different from above) <i>ALC 501</i>		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST <i>Acute Appendicitis</i>		PRIMARY <i>540</i>
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

11	SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
<i>10/16/72</i>	<i>IH</i>	<i>Assistant SURGEON</i>	<i>44950</i>	<i>77.90</i>	<i>7440</i>	<i>4</i>	<i>01</i>
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	<i>77.90</i>	<i>7440</i>	
DO DOCTOR'S OFFICE	MEDICARE PAID	OTHER INS.	TOTAL	LESS			
IL INDEPENDENT LAB							
H PATIENT'S HOME							
IH INPATIENT HOSPITAL	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL				
OL OTHER LOCATIONS							
NH NURSING HOME							
ECF EXTENDED CARE FACILITY							
OH OUTPATIENT HOSPITAL				UNPAID BALANCE	<i>7790</i>	<i>7440</i>	

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>Dm Dietz M.D.</i> DATE <i>1/14/75</i></p>

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 M

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 216847

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER 710 24075 A.		RACE W	NAME OF PROVIDER The Alaska Clinic	
NAME OF PATIENT LINDA J. HALL			Dr. Depalatis	
DATE OF BIRTH 4/25/51	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE 21E	PROVIDER ID. NO. 5AD 417	CATEGORY OS
CASE NO. 75156-01	RESOURCE X	PAYEE ID NO. (if different from above) ALC 501		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST <i>Acute Appendicitis</i>		PRIMARY 540
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
10/16/72	DO	Brief Exam Eval A/Tr.	90040	12.30	1200	1	01
10/16/72	DO	CHEST TWO VIEWS	71020	24.60	2400	5	01
10/16/72	DO	ABD w/addl ABILITY OF CONC	74010	24.60	2460	5	
10/16/72	DO	GRAM STAIN	87000	8.20	820	6	
10/16/72	DO	SAP SMEAR	88100	7.70	770	6	
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS	TOTAL CHARGE				
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB	MEDICARE PAID	OTHER INS.	TOTAL			
H PATIENT'S HOME	IH INPATIENT HOSPITAL						
OL OTHER LOCATIONS	NH NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL			
ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL						
				UNPAID BALANCE			

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>Dr. Depalatis MD</i> DATE <i>1/15/75</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 216848

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER 710 240 75 A		RACE W	NAME OF PROVIDER THE ALASKA CLINIC	
NAME OF PATIENT LINDA J. HALL pg 2			DR. DEPALATIS	
DATE OF BIRTH 4/25/51	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE ZIE	PROVIDER ID. NO. SAD417	CATEGORY
CASE NO. 75156-01	RESOURCE <input checked="" type="checkbox"/>	PAYEE ID NO. (if different from above) ALC 521		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST Acute Appendicitis		PRIMARY
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

11	DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
	10/16/72	DO	UA	81000	4.10	400	6 01
	10/16/72	DO	CRBC	85010	8.20	800	6 01
	10/16/72	IH	APPENDECTOMY	44950	329.50	37600	3 01
*PLACE OF SERVICE				12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	
DO DOCTOR'S OFFICE	MEDICARE PAID		OTHER INS.	TOTAL		479.20 - 46450	
IL INDEPENDENT LAB						LESS	
PH PATIENT'S HOME							
IH INPATIENT HOSPITAL							
OL OTHER LOCATIONS							
NH NURSING HOME	MEDICARE CO-INS.		MEDICARE DEDUCT.	TOTAL			
ECF EXTENDED CARE FACILITY							
OH OUTPATIENT HOSPITAL						UNPAID BALANCE 479.20 46450	

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>A. Depalatis MD</i> DATE <u>1/15/75</u></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

THE ALASKA CLINIC

a professional corporation

825 L ST.
ANCHORAGE, AK. 99501

PLEASE RETURN
THIS STUB WITH
YOUR PAYMENT

Phone 274-1303

For appt. 272-4551

ACCOUNT NUMBER

DEPT OF HEALTH AND SOCIAL SERVICES
DIVISION OF FAMILY AND CHILDREN SERVICES
MACKAY BUILDING ROOM 222
338 DENALI ST.
ANCHORAGE, AK 99501

ANTHONY HERRINGTON

CURRENT

30-60

60-90

OVER 90

TOTAL DUE

TOTAL DUE

(Mother: Leonardine)

DATE	PATIENT/DOCTOR	DESCRIPTION	CRVS	AMOUNT
11/15/71	DR. WEBB	EMER. RM.	90500	20.00

diag. 708 urticaria

THE ALASKA CLINIC

a professional corporation

825 I ST.
ANCHORAGE, AK. 99501

Phone 274-1303

For appt. 272-4551

Call me if you

PLEASE RETURN
THIS STUB WITH
YOUR PAYMENT

ACCOUNT NUMBER

DEPARTMENT OF HEALTH & SOCIAL SERVICES

JUDY JONES

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

DATE	PATIENT/DOCTOR	DESCRIPTION	CRVS	AMOUNT
7/1/72	DR. WIELAND	UA	81000	4.00
7/1/72	" "	OFFICE CALL	90040	12.00

16.00

I certify that this is a just and proper bill
and hereby authorize the Department of Health
Officer to collect the same.

Marian Merrill 4-5-74

Cystitis

06-33 6 350
~~06-33-3-330~~ - 385-71-0080

ADC-62191-01
Care or Med. Card No. Remarks

THE ALASKA CLINIC

a professional corporation

825 L ST.
ANCHORAGE, AK. 99501

PLEASE RETURN

THIS STUB WITH

YOUR PAYMENT

Phone 274-1303

For appt. 272-4551

ACCOUNT NUMBER

DEPARTMENT OF HEALTH & SOCIAL SERVICES

MARIA LIPSCOMB B.D. 4-27-70 Case No. 67866

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

DATE	PATIENT/DOCTOR	DESCRIPTION
6/2/72	DR. CATES	BRIEF EXAM EVAL A/O TREATMENT

CRVS	AMOUNT
90040	12.00

Diagnosis: 470 Influenza, unqualified

Not paid as of 5/17/74

THE ALASKA CLINIC

a professional corporation

825 L ST.
ANCHORAGE, AK. 99501

PLEASE RETURN

THIS STUB WITH

YOUR PAYMENT

Phone 274-1303

For appl. 272-4551

ACCOUNT NUMBER

DEPARTMENT OF HEALTH & SOCIAL SERVICES

TAMMIE LIPSCOMB B.D. 11-11-69 case 67866

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

DATE	PATIENT/DOCTOR	DESCRIPTION
6/2/72	Dr. Cates	BRIEF EXAM EVAL A/O TREATMENT

CRVS	AMOUNT
90640	12.00

Diagnosis: 463 Acute tonsillitis

not paid as of 5/17/73

06 M

DEPARTMENT OF HEALTH & SOCIAL SERVICES
OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 59549A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION		
COUPON OR AUTHORIZATION NUMBER H10-57454 B P1105		RACE U	NAME OF PROVIDER ALASKA CLINIC DR ARCHER		
NAME OF PATIENT L. MIONI			PROVIDER I.D. NO. GAA 415		
DATE OF BIRTH 4-8-16	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	EUG. CODE 21E	CATEGORY 05	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) ALC 501	
CASE NO. 75362-01		RESOURCE X			

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST. <i>essential benign hypertension</i>		PRIMARY 401
		SECONDARY 401
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
10-17-72		X-RAY SKULL	70260	47.20	000	5 05
10-17-72		PAPANICOLAU SMears	70260	36.10	000	5 05
10-17-72		SMA	80012	18.45	000	6 01
10-17-72		OFFICE CALL	70040	.00	0	1
10-18-72		CHEST XRAY	71020	34.60	2400	5 01
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	3200	
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB						
M PATIENT'S HOME						
IN INPATIENT HOSPITAL						
OL OUTPATIENT LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
				UNPAID BALANCE	128.35 3200	

PROVIDER CERTIFICATION

<p>"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.</p>	REMARKS: LUCILLE - 75362 no pending charges 9-18-72 <i>(circled)</i> we never had 57... service
	<p>PROVIDER SIGNATURE: <i>Clara A. Archer MD</i> DATE: <i>12-30-73</i></p>

THE ALASKA CLINIC

a professional corporation

825 L ST.
ANCHORAGE, AK. 99501

PLEASE RETURN

THIS STUB WITH

YOUR PAYMENT

Phone 274-1303

For appl. 272-4551

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

RICHARD MUNDTS (^{DEANNA} Emmett, ~~Dean~~ mother)

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

DATE	PATIENT/DOCTOR	DESCRIPTION
3/9/72	DR. LITTLE	OFFICE CALL

CRVS
90040

AMOUNT
12.00

THE ALASKA CLINIC

a professional corporation

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ANCHORAGE, AK. 99501

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Phone 274-1303

For appl. 272-4551

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

RICHARD NICHOLSON

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

DATE	PATIENT/DOCTOR	DESCRIPTION	CRVS	AMOUNT
1/9/72	DR. DE PALATIS	EMER. ROOM	90050	20.00
"	" "	History & physical	90215	50.00
"	" "	Hospital Visit	90240	12.00
1/10/72	" "	" " x2	90240	24.00
1/11/72	" "	" "	90240	12.00
1/12/72	" "	" "	90240	12.00
1/13/72	" "	" "	90240	12.00

~~192.00~~

142.00

THE ALASKA CLINIC

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ANCHORAGE, AK. 99501

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Phone 274-1303

For appt. 272-4551

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

JOYCELYNE NIELSON

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

DATE	PATIENT/DOCTOR	DESCRIPTION	CRVS	AMOUNT
12/27/71	DR. GILLS	O.B.	99420	30.00 <i>Paid</i>
"	" "	O.B. LAB	80018	16.00 <i>Paid</i>
"	" "	TYPE & R.H.	86100	9.00
"	" "	O.B. VISIT	99420	10.00
"	" "	O.B. VISIT	99420	10.00
				29.00
				75.00

Not paid as of 5-16-74

THE ALASKA CLINIC

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825 L ST.
ANCHORAGE, AK. 99501

PLEASE RETURN

THIS STUB WITH

YOUR PAYMENT

Phone 274-1303

For appl. 272-4351

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

ALBERTA PERKINS

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

DATE
7.9/72

PATIENT/DOCTOR
DR. JACKSON

DESCRIPTION
EMER. ROOM

CRVS
90500

AMOUNT
20.00

THE ALASKA CLINIC

a professional corporation

825 L ST.
ANCHORAGE, AK. 99501

PLEASE RETURN

THIS STUB WITH

YOUR PAYMENT

Phone 274-1303

For appl. 272-4551

ACCOUNT NUMBER

D.O. of Health + Soc. Secs.

SHARON REID

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

DATE	PATIENT/DOCTOR	DESCRIPTION	CRVS	AMOUNT
8/30/71	DR. IVY	UCG	83160	6.00
8/30/71	" "	200 mgm. PIGAN	00047	5.00
8/30/71	" "	OFFICE CALL	90040	12.00

23.00

Not paid as of 5-16-74

THE ALASKA CLINIC

a professional corporation

825 L ST.
ANCHORAGE, AK. 99501

Phone 274-1303

For appt. 272-4551

PLEASE RETURN

THIS STUB WITH

YOUR PAYMENT

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

DONNIE SHARP

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

DATE	PATIENT/DOCTOR	DESCRIPTION	CRVS	AMOUNT
5/24/72		EMER. ROOM	90500	20.00
7/17/72	DR. LARSON	OFFICE CALL	90040	12.00
7/17/72	" "	CHEST	71020	24.00
7/20/72	" "	OFFICE CALL	90030	8.00

64.00

THE ALASKA CLINIC

a professional corporation

825 L ST.
ANCHORAGE, AK. 99501

PLEASE RETURN

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YOUR PAYMENT

Phone 274-1303

For appt. 272-4551

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

PHYLLIS SHORT

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

DATE	PATIENT/DOCTOR	DESCRIPTION	CRVS	AMOUNT
6/26/72	DR. CURTIS	PAP	88100	7.50

Not paid as of 5-16-73.

THE ALASKA CLINIC

a professional corporation

825 L ST.
ANCHORAGE, AK. 99501

PLEASE RETURN

THIS STUB WITH

YOUR PAYMENT

Phone 274-1303

For appt. 272-4551

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

AGNES SMITH

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

DATE	PATIENT/DOCTOR	DESCRIPTION	CRVS	AMOUNT
5/4/72	DR. CURTIS	BRIEF EXAM	90040	12.00
1/10/72 ✓	" "	IUD	58300	30.00
" "	" "	Pap Smear	88100	7.50
6/18/72	Dr. Webb	Intermed. Exam	90060	20.00
8/7/72	Dr. Cates	Physical	90005	15.00
5/2/72	Outside Dr.	Tissue Path.	88310	20.00

~~104.50~~

7.50

paid
paid
paid
paid
paid

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 82366 A

10	PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER		The Alaska Clinic	
08604 C r new 08604 B april		RACE		Dr. Curtis	
NAME OF PATIENT		ELIG. CODE		PROVIDER I.D. NO.	
Betty Thomason				BIW RMC 418	
DATE OF BIRTH		CATEGORY		PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE)	
12/29/53 M <input type="checkbox"/> F <input checked="" type="checkbox"/>				AIC 501	
CASE NO.		RESOURCE			

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST		PRIMARY
Right adnedal mass probable PID		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:		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	
031372	DO	Brief exam eval a/o treatment	90040	12.00		
040572	DO	CBC	85010	8.00		
040572	DO	SEB	85650	6.00		
040572	DO	Intermed exam eval a/o treatment	90060	20.00		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	
DO DOCTORS OFFICE	MEDICARE PAID	OTHER INS.	TOTAL	46.00		
IL INDEPENDENT LAB.				LESS		
H PATIENTS HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION	MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL			
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>"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.</p>	REMARKS:
	No record of payment
PROVIDER SIGNATURE <i>Richard Curtis MD</i> DATE <i>9-12-74</i>	RESUBMITTAL INDICATOR <i>XXXX</i> MEDICAL REVIEW

59736-42-38


ALASKAN OPTICIANS INC.
2520 C Street
ANCHORAGE, ALASKA 99503

INVOICE

NO 2785

TO: **Phone 277-7810**
Dept. of Health & Social Services
Division of Family & Children Services
P. O. Box 1089
Petersburg, Alaska 99833

DATE	May 3, 1972
CUSTOMER ORDER NO.	
SALESMAN	
VIA	

4/6/72	GIRRO, Sharon Feminique Frames w/single vision lenses <i>Appointments ineligibile</i>	\$10.70	<i>State of Alaska we want you</i> 
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33-6-11-380

QUADRUPPLICATE

Thank You!

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

Send white & canary copies w/ payment.

25 R01-39058
 Provider Ref Elwell, M

06

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES
 Health Care Facility Invoice

Nº 504999 **B**

20 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number #691869517 (REBILL) #502420571			Name of Provider Anchorage Community Hospital	
Name of Patient Elwell, Mabel G.		Race	825 L. Street Anch, AK. 99501	
Date of Birth 10 / 1 / 92	Sex: M <input type="checkbox"/> F <input checked="" type="checkbox"/>	Elig. Code	Provider ID Number ACH889	Category 01
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Resource	Payee ID Number (if different from above)	
Comments:		Attending Physician R. Fraser		ID Number 227000
		Service Pre-Authorization No. (if applicable)		

21 DIAGNOSIS AND PROCEDURES

Date of Admission 9 / 9 / 71	Ref.Code 03	Svc.Unit 01	Primary Diagnosis premature atrial contractions	Code 429
Billing Period 9 / 9 / 71 thru 9 / 11 / 71		Tot.Days 7	Secondary Diagnosis	Code
Date of Discharge 9 / 11 / 71	Dis.Code 01	Primary Procedure Performed non-surgical in-pt hospital care		Code 90199
Consulting Physician	ID Number	Secondary Procedure Performed		Code

22 STATEMENT OF SERVICES RENDERED

Blood Pts. Supplied	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 & I.V.		70.90	
13	Radiology		24.00	
14	Laboratory		32.00	
15	Medical & Surgical Supplies		8.60	
16	Physical Therapy			
17	Occupational Therapy			
18	Speech Therapy			
19	Inhalation Therapy & Oxygen		198.50	
20	Other (Specify) EKG		30.25	
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.

Signature S. Kallas Date 8/17/74

Remarks:
33-6-310-380

Resubmittal Indicator	Medical Review
-----------------------	----------------

23 COORDINATION OF OTHER BENEFITS

Other Benefits	Medicare
Medicare Paid	Co-Ins.
Ins. or Other Pd	Ded.
Total	Total
308.25	

Total Charge	868.25	Less	309.25	Amount Billed	50.00
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06

HEALTH CARE FACILITY INVOICE

NO. 534242

B

20 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER Prior to coupon days per John Lappo			NAME OF PROVIDER Anchorage Community Hospital 825 "L" Street Anch., Ak. 99501	
NAME OF PATIENT Wooding, Jeanne		RACE		
DATE OF BIRTH 03 / 21 / 48	SEX: M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE	PROVIDER ID NO. ACH 889	CATEGORY 01
CASE NUMBER		RESOURCE	PAYEE ID NO. (if different from above)	
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		ATTENDING PHYSICIAN Dr. DePalatis		ID NO.
COMMENTS:		SERVICE PRE-AUTHORIZATION NO. (if applicable)		

DIAGNOSIS AND PROCEDURES

21 DATE OF ADMISSION 08 / 07 / 72	REF. CODE 03	SVC UNIT 02	PRIMARY DIAGNOSIS Regional enteritis	CODE 563
BILLING PERIOD 08 / 07 / 72 08 / 14 / 72	TOT. DAYS 07	SECONDARY DIGANOSIS Chronic active appendicitis		CODE 540
DATE OF DISCHARGE 08 / 14 / 72	DIS. CODE 01	PRIMARY PROCEDURE PERFORMED Tube enterostomy		CODE 4300
CONSULTING PHYSICIAN	ID NO.	SECONDARY PROCEDURE PERFORMED Colostomy		CODE 44320

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	72.00	288.00
4	3 OR MORE BEDS		8 2	66.60	133.20
5	INTENSIVE CARE		13 hours	7.60	98.80
6	SELF CARE				
7	NURSERY				
8	OPERATING ROOM				247.20
9	ANESTHESIA				244.83
10	OUTPATIENT SERVICES				
11	BLOOD ADMINISTRATION				
12	PHARMACY				191.10
13	RADIOLOGY				48.00
14	LABORATORY				216.50
15	MEDICAL & SURGICAL SUPPLIES				100.95
16	PHYSICAL THERAPY				
17	OCCUPATIONAL THERAPY				
18	SPEECH THERAPY				
19	INHALATION THERAPY				74.00
20	OTHER (SPECIFY) IV's				103.65
21					
22					

PROVIDER CERTIFICATION

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TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE B. Simpson

DATE 9-4-74

REMARKS: This was prior to coupon days.

RESUBMITTAL INDICATOR	MEDICAL REVIEW
-----------------------	----------------

COORDINATION OF OTHER BENEFITS

	OTHER BENEFITS		MEDICARE	
	MEDICARE PAID	INSURANCE OR OTHER PAY.	CO-INS.	DED.
23				
	TOTAL		TOTAL	%

TOTAL CHARGE 1746.23 LESS 00.00

AMOUNT BILLED 1746.23

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

Send White & carry copies for payment.

15 Provider Ref: FRIEDE, P

06 ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES
 Outpatient Hospital-Practitioner-Home Health Agency Invoice **0161178** **A**

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization number <u>PRIOR To Couposu Needed</u>		Name of Provider <u>Dr. Blankenship</u> A Professional Corporation 3300 Providence Drive, Suite 314 Anchorage, Alaska 99503	Provider ID No. <u>GBM 374</u>	
Name of Patient <u>FRIEDE PATRICK</u>			Category	
Date of Birth <u>7 / 18 / 01</u>	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Elig. Code	Payee ID No. (if different from above)	
Case No.	Resource			

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First		Primary
<ol style="list-style-type: none"> ①. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH A) CORONARY INSUFFICIENCY AND ANGINA ②. CARCINOMA of prostate, WITHOUT EVIDENCE of METASTASES AT THIS POINT 3) RECURRENT URINARY TRACT INFECTIONS 		429
Secondary		
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable)
Comments:		Referring or Consulting Physician

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY		
12-1/12/69	IH	Hosp Visits 26 2/12	90240	312.00			
*Place of Service		12 Coordination of Other Benefits		Total Charge			
DO Doctor's Office	IL Independent Lab	H/Care Pd.	Other Paid	Total			
H Patient's Home	IH Inpatient Hospital						
OL Other Location	NH Nursing Home						
ECF Extended Care Fac.	OH Outpatient Hosp.	H/Care CoIn	M/Care Ded.	Total			
				Unpaid Balance	104.00		

PROVIDER CERTIFICATION

<p>"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."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
	<p><u>33-6-350-380</u></p>
Signature <u>A.P. Blankenship MD/AG</u> Date <u>1-30-74</u>	Resubmittal Indicator
	Medical Review

FERRUPATO

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96636A

06 M

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER 410-12575 X		RACE W	NAME OF PROVIDER Dr. Hoi P. Lee	
NAME OF PATIENT Ferrupato, Pamela			ELIG. CODE 20P	PROVIDER I.D. NO. HPL 320
DATE OF BIRTH 10/02/49		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	PROVIDER I.D. NO. HPL 320	CATEGORY AS
CASE NO. 076188-01		RESOURCE X	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 881	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST INFECTIVE DISEASES OF CERVIX UTERI		PRIMARY 620
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED		COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	LESS	UNPAID BALANCE
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
01/14/73	IH	SURGERY-ANESTHESIA 1 Hr. 40 Min.	58805	115.20	99.00	2 01
* PLACE OF SERVICE		MEDICARE PAID	OTHER INS.	TOTAL		
DO DOCTORS OFFICE						
IL INDEPENDENT LAB						
H PATIENTS HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
				115.20	99.00	
				115.20	99.00	

PROVIDER CERTIFICATION

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	<p>PROVIDER SIGNATURE: <i>Phyllis Mayr</i> DATE: <i>11-8-74</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

STEFFENS

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96612A

06

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER A1072-327-41-773			NAME OF PROVIDER Dr. Glen Straatsma	
NAME OF PATIENT Steffens, Gladys		RACE W	PROVIDER I.D. NO. GWS 318	
DATE OF BIRTH 03/17/74		ELIG. CODE ZOP		
CASE NO. OSTOR4-01		RESOURCE X	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 881	
			CATEGORY 05	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST AGUTE MYOCARDIAL INFARCTION		PRIMARY 410
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
11/13/72	DO	COMPR HE EV	90620	70.00	5000	4 61
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	70.00	5000
DO DOCTORS OFFICE	II INDEPENDENT LAB	MEDICARE PAID	OTHER INS.	TOTAL		
II PATIENTS HOME	III INPATIENT HOSPITAL			LESS		
III INPATIENT HOSPITAL	IV OTHER LOCATION	MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
IV OTHER LOCATION	V NURSING HOME			UNPAID BALANCE	70.00	50.00
V NURSING HOME	ECF EXTENDED CARE FACILITY					
ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL					

PROVIDER CERTIFICATION

<p>"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.</p>	REMARKS:
	<p>PROVIDER SIGNATURE: <i>Glen Straatsma</i> DATE: 11-12-74</p>

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96778A

10	PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER			
NAME OF PATIENT Anderson, Cherie <i>page 2</i>		RACE			
DATE OF BIRTH 5/24/50		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE	PROVIDER I.D. NO.	CATEGORY
CASE NO.		RESOURCE		PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE)	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			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	
07/21/72	IH	SURGERY (HA)	27506	855.00		
07/21/72	IH	SURGERY (HA)	27594	315.00		
07/21/72	IH	SURGERY (HA)	27598	630.00		
07/21/72	IH	SURGERY (LINDIG)	15100	33.75		
07/21/72	IH	SURGERY (LEE)	27594	139.20		
07/21/72	IH	DISCOUNT (LINDIG)	01005	14.88-		
07/21/72	IH	SURGERY (LEE)	27506	180.00		
07/21/72	IH	E R EXTENDED RE-EXAM (HANEK)	90570	55.00		
07/21/72	IH	DISCOUNT (HA)	01005	132.75-		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	
DO DOCTOR'S OFFICE	MEDICARE PAID		OTHER INS.	TOTAL	3520.88	
IL INDEPENDENT LAB					LESS	
H PATIENT'S HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION	MEDICARE CO-INS.		MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL					UNPAID BALANCE	

PROVIDER CERTIFICATION

<p>"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.</p>		REMARKS:	
PROVIDER SIGNATURE	<i>P. Gray</i>	DATE	11/1/74
		RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96777A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER		RACE	NAME OF PROVIDER	
NAME OF PATIENT			Dr. Edwin Lindig, Jr.	
DATE OF BIRTH		ELIG. CODE	Dr. Robert D. Hanek	
5/24/50		PROVIDER I.D. NO.	Dr. Hoi P. Lee Dr. Young Ha	
CASE NO.		RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE)	
			FMS S81	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
FRACTURE OF LOWER LIMB			820
FRACTURE OF UPPER LIMB			810
SUPERFICIAL INJURY			910
OTHER DISEASES OF MUSCULOSKELETAL SYSTEM			730
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED					
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1989 RVS PROC. CODE	CHARGE	STATE USE ONLY
07/21/72	IH	SURGERY (LINDIG)	27506	213.75	
07/21/72	IH	SURGERY (HANEK)	24120	90.00	
07/21/72	IH	INIT HOSP CARE-INTER (LINDIG)	90215	50.00	
07/21/72	IH	DISCOUNT (HANEK)	01005	15.13-	
07/21/72	IH	DISCOUNT (LEE)	01005	22.56-	
07/21/72	IH	SURGERY (LEE)	27594	132.00	
07/21/72	IH	SURGERY (HA)	15100	135.00	
07/21/72	IH	SURGERY (HA)	24360	360.00	
07/21/72	IH	SURGERY (HA)	24120	360.00	
07/21/72	IH	SURGERY (HANEK)	27598	157.50	
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	
00 DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	
10 INDEPENDENT LAB					
11 PATIENTS HOME					
12 INPATIENT HOSPITAL					
13 OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL	
14 NURSING HOME					
15 EXTENDED CARE FACILITY					
16 OUTPATIENT HOSPITAL					
				UNPAID BALANCE	

PROVIDER CERTIFICATION

<p>"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.</p>		REMARKS:	
<p>PROVIDER SIGNATURE <i>P. Oray</i> DATE <i>11/1/74</i></p>		RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 145489

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER 410 99999			NAME OF PROVIDER Dr Joseph Johnson	
NAME OF PATIENT JEROCK, John		RACE W		
DATE OF BIRTH 07/12/21	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE 20 C	PROVIDER ID. NO. NJKJ 379	CATEGORY
CASE NO. 56786-01	RESOURCE	PAYEE ID NO. (if different from above) FMS 881		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST cholecystitis		PRIMARY
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

11 5 5 43		SERVICES RENDERED				
DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
04-25-71	III	Brief Eet 4 visits X \$12.00	90240	48.00		
04-25-71	III	Initial hosp care comp	90220	70.00		
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	128.00	
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB.						
H PATIENT'S HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATIONS						
NH NURSING HOME		MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL		
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>" 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>		<p>REMARKS: April 26, 27, 28, 29 - 1971 April 26, 27, 28, 29 - 1971 Brief Eet - 1971</p>	
PROVIDER'S SIGNATURE <i>James Lopez</i>	DATE 3-4-74	RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 145490

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Jerock, John		RACE	Dr Glen Straatsma	
DATE OF BIRTH ___/___/___	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. GMS 318	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above) FMS 881		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST		PRIMARY
diagnoses colerystitis		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

11	B S-131				
DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
04-27-71	III	Consult comm	90620	70.00	
MAY 1, 2, 3, 4, 5, 6, 1971	III	Limited Eet 6 visits X \$20.00	90250	120.00	
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	100.00
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB	MEDICARE PAID	OTHER INS.	TOTAL	
H PATIENT'S HOME	IH INPATIENT HOSPITAL				
OL OTHER LOCATIONS	NH NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL	
ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL				
				UNPAID BALANCE	

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>James J. Hayes</i> DATE 3-4-74</p>

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 145491

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Jarock, John		RACE	Dr Edwin Lindig	
DATE OF BIRTH ___/___/___	SEX M <input type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. ELN 831	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above)		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST <i>cholecystitis</i>		PRIMARY
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		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	
05-05-71	III	Surgery (cholecyst = Cholangiograph) <i>Assist.?</i> <i>surgery assist</i>	47605-81	30.00		
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	30.00	
IL INDEPENDENT LAB.						
H PATIENT'S HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATIONS						
NH NURSING HOME		MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL		
ECP EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
					UNPAID BALANCE	

PROVIDER CERTIFICATION

<p>" 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 1954 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: <i>what service was performed</i>
	<p>PROVIDER'S SIGNATURE <i>James Spis</i> DATE <i>5-4-74</i></p>

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 145492

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Jarock John		RACE	Dr Joseph Ribar	
DATE OF BIRTH ___ / ___ / ___	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. JNR 304	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above) FMS 331		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST <i>Cholecystitis</i>		PRIMARY
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

11	6.6.7				
DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
05-06-71	III	Surger: <i>Cholecystectomy (troungiograph)</i>	47605-81	168.75	
		<i>assist(?)</i>			
		<i>surgery assist -</i>			
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	168.75
IL INDEPENDENT LAB.					
H PATIENT'S HOME					
IH INPATIENT HOSPITAL					
OL OTHER LOCATIONS					
NH NURSING HOME		MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL	
ECP EXTENDED CARE FACILITY					
OH OUTPATIENT HOSPITAL					
				UNPAID BALANCE	

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>James Lopez</i> DATE <i>3-4-74</i></p>
	RESUBMITTAL INDICATOR
	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 145493

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Jerock, John		RACE	Dr Joseph Johnson	
DATE OF BIRTH ___/___/___	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. J11 467	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above) F45 001		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST		PRIMARY
<i>Collect Stitic</i>		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

11	<i>6-7</i>						
DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
05-06-71	IH	Brief Eet 2 visits X \$12	90240	26.00			
	IH	Surgery	47605	675.00			
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	771.00		
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL			
IL INDEPENDENT LAB.							
H PATIENT'S HOME							
IH INPATIENT HOSPITAL							
OL OTHER LOCATIONS							
NH NURSING HOME		MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL			
ECF EXTENDED CARE FACILITY							
OH OUTPATIENT HOSPITAL							
				UNPAID BALANCE			

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>Jeanne Apis</i> DATE <i>3-4-74</i></p>

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 145494

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Jerock, John		RACE	Dr Raymond Evans	
DATE OF BIRTH ___ / ___ / ___	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. RDE 319	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above) FHS 881		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST <i>Pneumonia</i>		PRIMARY
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC CODE	CHARGE	STATE USE ONLY	
10-28-71 Oct 28-71	11	Initial hosp care brief	90200	25.00		
10-29 & 30-71		Brief Ect 2 visits X \$15	90240	30.00		
*PLACE OF SERVICE				TOTAL CHARGE	55.00	
12 COORDINATION OF OTHER BENEFITS						
DO DOCTOR'S OFFICE	MEDICARE PAID	OTHER INS.	TOTAL	LESS		
I INDEPENDENT LAB						
H PATIENT'S HOME						
IN INPATIENT HOSPITAL						
CL OTHER LOCATIONS						
NH NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL			
ECF EXTENDED CARE FACILITY						
CH OUTPATIENT HOSPITAL				UNPAID BALANCE		

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>Jeannette Spive</i> DATE <i>3-4-74</i></p>	<table border="1"> <tr> <td>RESUBMITTAL INDICATOR</td> <td>MEDICAL REVIEW</td> </tr> </table>	RESUBMITTAL INDICATOR
RESUBMITTAL INDICATOR	MEDICAL REVIEW		

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 145495

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10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER		RACE <i>W</i>	NAME OF PROVIDER Dr Joseph Johnson	
NAME OF PATIENT Jerock, John			ELIG. CODE <i>30E</i>	PROVIDER ID. NO. <i>JKJ 167</i>
DATE OF BIRTH <i>5/12/31</i>	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	RESOURCE	PAYEE ID NO. (if different from above) <i>FIS 331</i>	
CASE NO. <i>56786-01</i>				

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST Acute and subacute necrosis of liver		PRIMARY 570
		SECONDARY

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO	SERVICE PRE-AUTHORIZATION NO. (if applicable)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:		

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
<i>05-25-72</i>	<i>09</i>	<i>Brief Et</i>	<i>99040</i>	<i>12.00</i>	
<i>1972 is correct year - chart notes:</i>					
<i>"Shakey - also weakness in left side (lumbar area)"</i>					
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	
DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	
INDEPENDENT LAB					
PATIENT'S HOME					
INPATIENT HOSPITAL					
OTHER LOCATIONS					
NURSING HOME		MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL	
EXTENDED CARE FACILITY					
OUTPATIENT HOSPITAL					
				UNPAID BALANCE	

PROVIDER CERTIFICATION

I AM 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 MISREPRESENTATION OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS. TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.	REMARKS: <i>Possible follow up care</i> <i>Surg 5/6/71 7/14 = 45 days</i> <i>1972</i>
	PROVIDER'S SIGNATURE <i>Jeanne Spies</i> DATE <i>3-4-74</i>

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DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 145496

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION		
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER		
NAME OF PATIENT Jerock, John		RACE		Dr Edwin Lindig	
DATE OF BIRTH ___/___/___	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. ELM 831	CATEGORY	
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above) FHS 331			

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST Seborrheic dermatitis		PRIMARY 699
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
06-02-72	00	Brief Et	90040	12.00			
06-05-72	00	Brief ET	90040	12.00			
		Supplies and material	90070	5.00			
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	29.00		
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB.	MEDICARE PAID	OTHER INS.	TOTAL			
H PATIENT'S HOME	IH INPATIENT HOSPITAL				LESS		
OL OTHER LOCATIONS	NH NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL			
ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>" 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <i>Joannes Lipes</i> DATE <u>3-4-74</u></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 145497

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER Dr Edwin Lindig	
NAME OF PATIENT Jerock, John		RACE		
DATE OF BIRTH ___/___/___	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. ELM 831	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above) E.S. 231		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST seborrheic dermatitis		PRIMARY 690
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

11	DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
	07-01-72 07-01-72	DO	Brief ET	90040	12.00		
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	12.00		
DO DOCTOR'S OFFICE	MEDICARE PAID	OTHER INS.	TOTAL	LESS			
IL INDEPENDENT LAB							
H PATIENT'S HOME							
IH INPATIENT HOSPITAL							
OL OTHER LOCATIONS							
NH NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL				
ECF EXTENDED CARE FACILITY							
OH OUTPATIENT HOSPITAL				UNPAID BALANCE			

PROVIDER CERTIFICATION

<p>" 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 PROHIBITS 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <i>James Apia</i> DATE <u>3-4-74</u></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

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10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER See attached certification			NAME OF PROVIDER Dr Francis Whelan	
NAME OF PATIENT Monicold, Georgie		RACE		
DATE OF BIRTH 03 / 22 / 33	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. FJM 305	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above) 595 081		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST neuroses		PRIMARY 300
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
26-04-23572	III	Extensive exam	90610	50.00			
05-30-72	III	Extensive Exam	90610	50.00			
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS	TOTAL CHARGE				
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB	MEDICARE PAID	OTHER INS.	TOTAL	100.00		
H PATIENT'S HOME	IH INPATIENT HOSPITAL				LESS		
OL OTHER LOCATIONS	NH NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL			
ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>" 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <i>James Lypie</i> DATE <i>3-5-74</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 151083

10	PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER See attached certification		NAME OF PROVIDER Dr Charles Townsend			
NAME OF PATIENT Monigold, Georgie		RACE		PROVIDER ID. NO. CIT 302	
DATE OF BIRTH 03 / 22 / 33		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE	CATEGORY	
CASE NO.		RESOURCE	PAYEE ID NO. (if different from above) FIS 881		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST Intestinal obstruction without mention of hernia Neuroses Cholera		PRIMARY 560 300C 000
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

11	DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
	05-18-72	00	UGI	74240	60.00			
	05-22-72	00	Brief Et	90040	12.00			
	06-12-72	00	Brief Et	90040	12.00			
			XXXXXX Urinalysis	81000	5.20			
			Blood count CBC	85910	10.30			
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	99.50			
DO	DOCTOR'S OFFICE	MEDICARE PAID	OTHER INS.	TOTAL				
IL	INDEPENDENT LAB.							
H	PATIENT'S HOME							
IH	INPATIENT HOSPITAL							
OL	OTHER LOCATIONS							
NH	NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL				
ECF	EXTENDED CARE FACILITY							
OH	OUTPATIENT HOSPITAL							
						UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>" 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>		REMARKS:
PROVIDER'S SIGNATURE	<i>James D. ...</i>	DATE
	3-5-74	
RESUBMITTAL INDICATOR		MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 151085

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10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Georgie Monigold		RACE	Ha	
DATE OF BIRTH ___/___/___	SEX M <input type="checkbox"/> F <input type="checkbox"/>	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
710 840		
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

11	DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RV5 PROC. CODE	CHARGE	STATE USE ONLY	
	04-17-72	00	Sofine lumb ltd	72100	28.00		
	05-03-72	00	Brief Et	90040	12.00		
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	134.10		
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS. TOTAL	LESS			
IL INDEPENDENT LAB							
H PATIENT'S HOME							
IH INPATIENT HOSPITAL							
OL OTHER LOCATIONS							
NH NURSING HOME		MEDICARE CO-INS.	MEDICARE DEDUCT. TOTAL				
ECF EXTENDED CARE FACILITY							
OH OUTPATIENT HOSPITAL				UNPAID BALANCE			

PROVIDER CERTIFICATION

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TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.			
PROVIDER'S SIGNATURE	<i>James Lopez</i>	DATE	3-5-74
		RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 151084

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER See attached certification.			NAME OF PROVIDER Dr Young II	
NAME OF PATIENT Georgia Homicold		RACE		
DATE OF BIRTH 02 / 27 / 33	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. YOH 542	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above) FMS 881		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST Acute arthritis due to pyogenic organisms Sprains and strain of shoulder and upper arm			PRIMARY 710 240
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:			

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
05-22-72	00	Brief Et	00040	12.00		
		Culture	07000	6.00		
		Urinalysis	01000	5.20		
04-17-72	III	Initial hospital care inter	00215	50.00		
	00	Brief Et	00000	20.00		
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE		
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL.		
IL INDEPENDENT LAB						
H PATIENT'S HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATIONS						
NH NURSING HOME		MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL		
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>" 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: <i>continued</i>
	<p>PROVIDER'S SIGNATURE _____ DATE _____</p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 151087

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10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER See attached certification.			NAME OF PROVIDER Dr Robert Hanek	
NAME OF PATIENT Monicold, Georgie		RACE		
DATE OF BIRTH 03 / 22 / 33	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. RDH 315	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above) FHS 991		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST Nervousness and debility		PRIMARY 700
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
05-30-72	IH	Initial hosp care brief	90200	35.00			
05-30-72	III	Brief Cst	90240	15.00			
05-30-72	DD	Ini valium	90705	6.00			
		HGB HCT	35055 85050	6.00			
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE			
DO	DOCTOR'S OFFICE	MEDICARE PAID	OTHER INS.	TOTAL			
L	INDEPENDENT LAB						
I	PATIENT'S HOME						
H	INPATIENT HOSPITAL						
XL	OTHER LOCATIONS						
IH	NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL			
ICF	EXTENDED CARE FACILITY						
H	OUTPATIENT HOSPITAL						
				UNPAID BALANCE			

PROVIDER CERTIFICATION

<p>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. 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.</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:	
	<p>PROVIDER'S SIGNATURE <i>James [Signature]</i> DATE <u>3-5-74</u></p>	RESUBMITTAL INDICATOR

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 *M*

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 137476

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION		
COUPON OR AUTHORIZATION NUMBER <i>attached 41-099999X</i>		RACE <i>W</i>	NAME OF PROVIDER DR. JOHNSON		
NAME OF PATIENT GENES, IMOGENE			PROVIDER ID. NO. JKJ 309	CATEGORY <i>05</i>	
DATE OF BIRTH <i>01/04/06</i>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE <i>20A</i>	PAYEE ID NO. (if different from above) FMS 881		
CASE NO. <i>57369-01 OAA</i>	RESOURCE <i>5</i>				

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST diseases of viens lymphatics and other circulatory system		PRIMARY 450
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
10/6/71	DO	1 MODALITIE	97000	12.00	850	1	01
10/8/71	DO	1 MODALITIE	97000	12.00	850	1	01
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	24.00	17.00	
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB.	OTHER INS.	TOTAL	LESS	1340	1360	
H PATIENT'S HOME	IH INPATIENT HOSPITAL	MEDICARE PAID					
OL OTHER LOCATIONS	NH NURSING HOME	1360	1360				
ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL	MEDICARE CO-INS.	TOTAL				
		340	340	UNPAID BALANCE	1040	3.40	

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>P. May</i> DATE <i>1/10/74</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 137473

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>attached 41-099999X</i>			NAME OF PROVIDER DR. MURPHY	
NAME OF PATIENT GENES, IMOGENE		RACE <i>W</i>	PROVIDER ID. NO. GBM 311	CATEGORY <i>05</i>
DATE OF BIRTH <i>01/04/06</i>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE <i>20A</i>	PAYEE ID NO. (if different from above) FMS 881	
CASE NO. <i>57369-0AA</i>	RESOURCE <i>J</i>			

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST DISEASES OF THER ENDOCRINE GLANDS		PRIMARY 250
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
10/04/71	DO	GLUCOSE FBS	84330	8.60	<i>8.00</i>	<i>6</i>	<i>01</i>
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	8.60	<i>8.00</i>	
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB	MEDICARE PAID	OTHER INS.	TOTAL	LESS	<i>6.40</i>	
H PATIENT'S HOME	IH INPATIENT HOSPITAL	<i>6.40</i>		<i>6.40</i>			
OL OTHER LOCATIONS	NH NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL			
ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL	<i>1.00</i>		<i>1.60</i>	UNPAID BALANCE	<i>2.20</i>	<i>1.60</i>

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <u><i>P. Murphy</i></u> DATE <u><i>1/10/74</i></u></p>

06 M

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 137467

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>attached 41-099999X</i>			NAME OF PROVIDER DR. RIBAR	
NAME OF PATIENT GENES, IMOGENE		RACE <i>W</i>	PROVIDER ID. NO. JMR 304	CATEGORY <i>05</i>
DATE OF BIRTH <i>01/04/66</i>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE <i>20A</i>	PAYEE ID NO. (if different from above) FMS 831	
CASE NO. <i>57.369-01 OAA</i>		RESOURCE <i>5</i>		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
DISEASES OF OTHER ENDOCRINE GLANDS			250
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
10/04/71	DO	BRIEF ET	90040	12.00	<i>10.80</i>	<i>1 01</i>
10/08/71	DO	BRIEF ET	90040	8.00	<i>570</i>	<i>1 01</i>
10/08/71	DO	SUPPLIES MATERIAL	99070	10.00	<i>10.00</i>	<i>1</i>
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS	TOTAL CHARGE	30.00	<i>2650</i>	
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB	MEDICARE PAID	OTHER INS.	TOTAL		
H PATIENT'S HOME	IH INPATIENT HOSPITAL	<i>2120</i>		<i>2120</i>		
OL OTHER LOCATIONS	NH NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL		
ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL	<i>530</i>		<i>530</i>		
			UNPAID BALANCE	<i>880</i>	<i>530</i>	

PROVIDER CERTIFICATION

<p>" 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:	
	PROVIDER'S SIGNATURE <i>P. Gray</i>	DATE <i>1/10/74</i>
	RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 *M*

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 137474

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>Attached 4-099999X</i>		RACE <i>W</i>	NAME OF PROVIDER DR. DOOLITTLE	
NAME OF PATIENT GENES, IMOGENE			PROVIDER ID. NO. <i>WHD 333</i>	CATEGORY <i>05</i>
DATE OF BIRTH <i>011 24 06</i>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE <i>20A</i>	PAYEE ID NO. (if different from above) FMS 881	
CASE NO. <i>57369-0125A</i>		RESOURCE <i>J</i>		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST diseases of the endocrine glands		PRIMARY 250
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
10/6/71	DO	URINALYSIS	81000	4.80	<i>180</i>	<i>6</i>	<i>9</i>
10/06/71	DO	CHOLESTEROL	82465	8.80	<i>250</i>	<i>6</i>	<i>01</i>
10/6/71 10/6/71	DO	GLUCOSE	84330	8.00	<i>250</i>	<i>6</i>	<i>01</i>
10/6/71	DO	RUIN	84520	8.80	<i>250</i>	<i>6</i>	<i>01</i>
10/6/71	DO	URIC ACID	84550	8.00	<i>250</i>	<i>6</i>	<i>01</i>
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	CON'T		
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB	MEDICARE PAID	OTHER INS.	TOTAL			
H PATIENT'S HOME	IK INPATIENT HOSPITAL			LESS			
OK OTHER LOCATIONS	NH NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL			
ECP EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL			UNPAID BALANCE			

PROVIDER CERTIFICATION

<p>" 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <u><i>P. Maye</i></u> DATE <u><i>1/10/74</i></u></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06 *M*

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 137475

A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>attached</i>			NAME OF PROVIDER DR. DOOLITTLE	
NAME OF PATIENT GENES, IMOGENE		RACE		
DATE OF BIRTH ___/___/___	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. <i>WHO 333</i>	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above) <i>FMS 881</i>		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST diseases of the endocrine glands		PRIMARY 250
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

11	DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
	10/6/71	DQ	BLOOD COUNT	85010	9.60	900	6
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	48.00	24.40	
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB	H PATIENT'S HOME	IH INPATIENT HOSPITAL	OL OTHER LOCATIONS	NH NURSING HOME	ECP EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL
MEDICARE PAID		OTHER INS.	TOTAL	LESS	1952	1952	
1952			1952				
MEDICARE CO-INS.		MEDICARE DEDUCT.	TOTAL	UNPAID BALANCE	2849	4.88	
4.88			4.88				

PROVIDER CERTIFICATION

<p>" 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:	
	PROVIDER'S SIGNATURE <i>D. Maye</i>	DATE <i>1/10/74</i>
	RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 137466

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>attached 41-099999X</i>			NAME OF PROVIDER DR. JOHNSON	
NAME OF PATIENT GENES, IMOGENE		RACE <i>W</i>	PROVIDER ID. NO. JKJ 309	
DATE OF BIRTH <i>01/04/1966</i>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE <i>20A</i>	CATEGORY <i>05</i>	
CASE NO. <i>57369-01 BAA</i>		RESOURCE <i>5</i>	PAYEE ID NO. (if different from above) FMS 881	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST GOLD LEAF TREATMENT		PRIMARY <i>450</i>
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
10/1/71	DO	1. MODALITIE	97000	12.00	8.50	1 01
10/1/71	DO	BRI ? ET	90040	12.00	12.00	1
10/1/71	DO	SUPPLIES MATERIAL	99070	10.00	10.00	1
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE		
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB		<i>24.40</i>		<i>24.40</i>		
H PATIENT'S HOME				LESS	<i>24.40</i>	<i>24.40</i>
IH INPATIENT HOSPITAL						
OL OTHER LOCATIONS		MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL		
NH NURSING HOME		<i>6.10</i>		<i>6.10</i>		
ECF EXTENDED CARE FACILITY				UNPAID BALANCE	<i>9.60</i>	<i>6.10</i>
OH OUTPATIENT HOSPITAL						

PROVIDER CERTIFICATION

<p>" 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 PA' 'ENT 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <i>P. Gray</i> DATE <i>1/10/74</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 137464

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>Attached</i>			NAME OF PROVIDER DR. JOHNSON	
NAME OF PATIENT GENES, IMOGENE J		RACE		
DATE OF BIRTH ___/___/___	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. JKJ 309	CATEGORY
CASE NO. 57369 OAA		RESOURCE	PAYEE ID NO. (if different from above) FMS 831	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST GOLD LEAF TREATMENT		PRIMARY
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
9/29/71	DO	1 MODALITIE	97000	12.00	850	1 01	
9/29/71	DO	SUPPLIES MATERIAL	99070	10.00	10.00	1	
9/30/71	DO	1 MODALITIE	97000	12.00	850	1 01	
9/30/71	DO	SUPPLIES MATERIAL	99070	10.00	10.00	1	
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	103.90	93.40	
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
MEDICARE PAID		OTHER INS.	TOTAL	LESS	74.72	74.72	
74.72			74.72				
MEDICARE CO-INS.		MEDICARE DEDUCT.	TOTAL	UNPAID BALANCE	29.18	18.68	
18.68			18.68				

PROVIDER CERTIFICATION

<p>" 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <u>A. Gray</u> DATE <u>11/10/74</u></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 137463

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>attached 41-099999X</i>			NAME OF PROVIDER DR. JOHNSON	
NAME OF PATIENT GENES, IMOGENE J		RACE <i>AW</i>	PROVIDER ID. NO. JKJ 309	CATEGORY <i>05</i>
DATE OF BIRTH <i>01 104 1 06</i>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE <i>FOA</i>	PAYEE ID NO. (if different from above) FMS 881	
CASE NO. <i>57369-51 BAA</i>	RESOURCE <i>J</i>			

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST GOLD LEAF-SURGICAL STOCKING TREATMENT		PRIMARY <i>450</i>
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

11	DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
	9/23/74	DO	1 MODALITIE	97000	12.00	<i>8.50</i>	<i>1</i>	<i>01</i>
	9/23/74	DO	BRIEF ET	90040	12.00	<i>12.00</i>	<i>1</i>	
	9/23/74	DO	SUPPLIES MATERIAL	99070	10.00	<i>10.00</i>	<i>1</i>	
	9/23/74	do	ELASTIC HOSE	99072	12.95	<i>12.95</i>	<i>1</i>	
	9/23/74	DO	ELASTIC HOSE	99072	12.95	<i>12.95</i>	<i>1</i>	
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	CON'T		
DO	DOCTOR'S OFFICE	MEDICARE PAID	OTHER INS.	TOTAL	LESS			
IL	INDEPENDENT LAB.							
H	PATIENT'S HOME							
IH	INPATIENT HOSPITAL							
OL	OTHER LOCATIONS	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL				
NH	NURSING HOME							
ECF	EXTENDED CARE FACILITY							
OH	OUTPATIENT HOSPITAL				UNPAID BALANCE			

PROVIDER CERTIFICATION

<p>" 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:	
	<p>PROVIDER'S SIGNATURE <i>J. May</i> DATE <i>1/10/74</i></p>	RESUBMITTAL INDICATOR

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 M

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 137465

A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>attached 41-099999X</i>			NAME OF PROVIDER DR. DOOLITTLE, WILLIAM H	
NAME OF PATIENT GENES, IMOGENE J		RACE <i>W</i>	PROVIDER ID. NO. <i>WHD 333</i>	CATEGORY <i>05</i>
DATE OF BIRTH <i>8/1/04/06</i>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE <i>20A</i>	PAYEE ID NO. (if different from above) FMS 881	
CASE NO. <i>57369-0102A</i>	RESOURCE <i>J</i>			

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST GOLD LEAF TREATMENT		PRIMARY <i>788</i>
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
9/30/71	DO	BRIEF ET	90040	12.00	<i>10.80</i>	<i>, 01</i>
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	12.00	<i>10.80</i>
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB	MEDICARE PAID	OTHER INS.	TOTAL		
H PATIENT'S HOME	IH INFANT HOSPITAL	<i>864</i>		<i>8.64</i>	LESS	
OL OTHER LOCATIONS	NH NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL	<i>864</i>	<i>864</i>
ECP EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL	<i>216</i>		<i>216</i>	UNPAID BALANCE	<i>335</i>
					<i>2.16</i>	

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>P. Gray</i> DATE <i>1/10/74</i></p>

06 M

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96703A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER 11-099999X		RACE W	NAME OF PROVIDER Dr. Philip W. Hardie	
NAME OF PATIENT Rosgen, Donna R.			PROVIDER I.D. NO. PWH 321	
DATE OF BIRTH 10/26/49	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE 21E	CATEGORY OS	
CASE NO. 71214-01	RESOURCE X	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 881		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST		PRIMARY
ABORTION INDUCED FOR MEDICAL INDICATIONS		640
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:		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	
07/20/72	IH	SURGERY	59850	180.00	180.00	2
PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	180.00	180.00
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB						
H PATIENT'S HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
CH OUTPATIENT HOSPITAL						
				UNPAID BALANCE	180.00	180.00

PROVIDER CERTIFICATION

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	<p>PROVIDER SIGNATURE: <i>DD May</i> DATE: 11/1/74</p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

~~Dr. Young HA~~
NO. 96901 A

06 m

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER 72 343 41 225 410 99999 X			NAME OF PROVIDER DR YOUNG HA	
NAME OF PATIENT MC CONNELL LYNDIA K		RACE W	PROVIDER I.D. NO. YOH 542	
DATE OF BIRTH 6-18-47	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE DIE	CATEGORY 05	
CASE NO. 74148-02	RESOURCE X	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 881		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST OPEN WOUND OF SHOULDER AND UPPER ARM		PRIMARY 880
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:		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	
11-12-72	IH	SURGERY	25412	180.00	12240	3 01
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE		
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB						
H PATIENT'S HOME				LESS		
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECP EXTENDED CARE FACILITY				UNPAID BALANCE		
OH OUTPATIENT HOSPITAL				180.00	122.40	

PROVIDER CERTIFICATION

<p>"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.</p>	REMARKS: RESUBMISSION OF OLD 1972 CHARGES NEVER PAID - PLEASE HOLD FOR SPECIAL LEGISLATIVE APPROVAL
	<p>PROVIDER SIGNATURE: <i>P. Gray</i> DATE: 10/29/74</p>

06 M

NO. 96702 A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER 71-099999X		RACE W	NAME OF PROVIDER Dr. Philip W. Hardie	
NAME OF PATIENT Rosgen, Donna R.			PROVIDER I.D. NO. PWH 321	CATEGORY OS
DATE OF BIRTH 10/26/49	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE DIE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 881	
CASE NO. 71214-01		RESOURCE X		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST		PRIMARY
INFECTIVE DISEASES OF CERVIX UTERI		620
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		REFERRING OR CONSULTING PHYSICIAN
COMMENTS:		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)

11 SERVICES RENDERED		COORDINATION OF OTHER BENEFITS		TOTAL CHARGE		STATE USE ONLY	
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE			
09/06/72	DO	BRIEF ET-EST	90040	12.00	1080	1	01
PLACE OF SERVICE		MEDICARE PAID	OTHER INS.	TOTAL	LESS		
DO DOCTOR'S OFFICE					12.00	1080	
IL INDEPENDENT LAB							
H PATIENT'S HOME							
IN INPATIENT HOSPITAL							
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL			
NR NURSING HOME							
EC EXTENDED CARE FACILITY							
OH OUTPATIENT HOSPITAL					UNPAID BALANCE	1200	1080

PROVIDER CERTIFICATION

<p>"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.</p>		REMARKS:	
PROVIDER SIGNATURE D. Mayr	DATE 11/1/74	RESUBMITTAL INDICATOR	MEDICAL REVIEW

06 M

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96704 A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER 71-099999X		RACE W	NAME OF PROVIDER Dr. Hoi P. Lee	
NAME OF PATIENT Rosgen, Donna R.			PROVIDER I.D. NO. HPL 320	
DATE OF BIRTH 10/26/49	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE 21E	CATEGORY OS	
CASE NO. 71214-01		RESOURCE X	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 881	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST ABORTION INDUCED FOR MEDICAL INDICATIONS		PRIMARY 640
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:		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	
07/20/72	IH	SURGERY-ANESTHESIA	59850	79.20	10500	2 01
07/20/72	IH	DISCOUNT	01005	3.96		
* PLACE OF SERVICE			12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	
DO DOCTOR'S OFFICE	II INDEPENDENT LAB	III PATIENT'S HOME	IV INPATIENT HOSPITAL	Q1 OTHER LOCATION	Q2 NURSING HOME	Q3 EXTENDED CARE FACILITY
Q4 OUTPATIENT HOSPITAL	MEDICARE PAID	OTHER INS.	TOTAL	LESS	UNPAID BALANCE	
		396	396		7920	6300
	MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		75.24	
					396	396
					7524	59.04

PROVIDER CERTIFICATION

<p>"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.</p>	REMARKS: 3 Bu 4 Tu <hr/> 7 X 9
	<p>PROVIDER SIGNATURE: P-9max DATE: 11/1/74</p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06 M

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96810A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER 72-515 41-099999X 41-099999X			NAME OF PROVIDER DR RICHARD RICKLEFS	
NAME OF PATIENT MCCONNELL LYNDIA K		RACE W	PROVIDER I.D. NO. WRR 541	
DATE OF BIRTH 6-18-47	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE 21E	CATEGORY OS	
CASE NO. 74148 -02		RESOURCE X	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 991	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST		PRIMARY
OPEN WOUND OF SHOULDER AND UPPER ARM		880
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED		COORDINATION OF OTHER BENEFITS		TOTAL CHARGE		UNPAID BALANCE	
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
11-12-72	IH	SURGERY	26418	45.00	2448	4	01
* PLACE OF SERVICE		MEDICARE PAID		TOTAL CHARGE		LESS	
DO DOCTORS OFFICE	IL INDEPENDENT LAB	OTHER INS.		4500		2448	
M PATIENTS HOME	IH INPATIENT HOSPITAL	TOTAL					
OL OTHER LOCATION	NH NURSING HOME	MEDICARE CO-INS.					
ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL	MEDICARE DEDUCT					
		TOTAL					
				UNPAID BALANCE		4500 2448	

PROVIDER CERTIFICATION

<p>"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.</p>	REMARKS:
	<p>RESUBMISSION OF OLD 1972 CHARGES NEVER PAID - PLEASE HOLD FOR SPECIAL LEGISLATIVE APPROVAL.</p>
PROVIDER SIGNATURE <i>P. Jones</i>	DATE 10/29/74
RESUBMITTAL INDICATOR	MEDICAL REVIEW

FAIRBANKS MEDICAL & SURGICAL CLINIC

BOX 1330 1 922 FIFTH AVENUE

FAIRBANKS, ALASKA 99701

message DATE 12-6-73

reply DATE

Re: MARK DALEY

OAA 32866

INVOICE # 63958 PD 683393
63959 VO 87.20 MS5X

63964 225.00 ✓

63965 990.00 ✓

63966 100.00 ✓

63967 PD 683393 25.60 - 5.12*

63960 12.00 ✓

63961 60.00 ✓

63962 1651.50 ✓

63963 315.00 ✓

TOTAL 3466.30

3466.30

MEDICARE

DISALLOWED

(985.70) 985.71

MEDICARE PD.

(2124.63)-

DUE MEDICAID

360.86

*

16.67

344.29

CIRCLE FOLLOW-UP DATE AND FILE

J	F	M	A	M	J	J	A	S	O	N	D
1	2	3	4	5	6	7	8	9	10	11	12
13	14	15	16	17	18	19	20	21	22	23	24
25	26	27	28	29	30	31					

SENT BY _____

ANSWERED BY _____

© BUSINESS ENVELOPE MFG. INC., BROOK, N. Y. 10471

SENDER'S FOLLOW-UP COPY

DALY, MARK

TOTAL CHARGES	3466.30
MEDICARE DISALLOWED	<u>- 985.71</u>
	2480.59
MEDICARE PAID	<u>- 2119.63</u>
	360.96
MEDICAID PAID VO 683393	<u>- 16.67</u>
	<u>344.29</u>

33-6-350-380

**STATE OF ALASKA
MEDICAL ASSISTANCE PROGRAM**
Outpatient Hospital - Practitioner - Home Health Agency Invoice

A

10 **17596 B** 1 **4/18/73** **33001**
INVOICE NUMBER INVOICE DATE FILE NUMBER

Laboratory of Clinical Medicine **LCM 526** **03** **1016-DL 10/9/72**
NAME OF PROVIDER ID NUMBER AGE CATEGORY PROVIDER REFERENCE

James Montensen, MD **9190500438**
NAME OF PHYSICIAN PATIENT ID NUMBER

Alice Perry **033001-01** **09-09-97** **F** **W** **20A** **23**
NAME OF PATIENT INSURANCE NUMBER DATE OF BIRTH SEX RACE REG CODE EXP DATE

MEDICARE STATUS CODE -- Circle One **OTHER INSURANCE CODE -- Circle One** **TYPE OF ACCIDENT -- Circle One**

Patient not eligible for Medicare coverage
 Patient over 65, no Medicare Part "A" or "B" coverage
 Service not covered by patient's Medicare coverage
 Medicare payment has been received

0 - Patient not a policy holder
 1 - Benefits of the patient have been exhausted
 2 - Service not covered by patient's insurance
 3 - Other insurance payment has been received

Not an accident.
 An accident, no third party involvement
 An accident, possible third party liability

The Laboratory does not have the diagnosis

PRIMARY DIAGNOSIS CODE SECONDARY DIAGNOSIS CODE

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	CODE	UNIT	CHARGE
10/9/72	7 (IL)	Papanicolaou smear	8915		7.00

PLACE OF SERVICE

INPATIENT HOSPITAL
 OUTPATIENT HOSPITAL
 PRACTITIONER'S OFFICE
 PATIENT'S HOME
 DRIVING HOME
 AMBULANCE
 OTHER

← MEDICARE - TITLE VIII →

12 **CO-INS** **PERCENT** **PAID** **ILL PAID** **TOTAL PAID**

WRITTEN CERTIFICATION:

I HEREBY CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND CORRECT, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PROHIBITS EXCLUSION OR DISCRIMINATION ON THE BASIS 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 OMISSIONS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

ON THE BASIS OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

RESULTS OF OTHER LABORATORY

APPROVED **DATE**

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 M

OUTPATIENT, HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 148270

10 PATIENT INFORMATION			STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <u>23-013456 A</u>				NAME OF PROVIDER Laboratory of Clinical Medicine 67 Cobb Building Seattle, Washington 98101	
NAME OF PATIENT Felicia Mange			RACE <u>W</u>		
DATE OF BIRTH <u>6 / 13 / 85</u>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE <u>20 A</u>	PROVIDER ID. NO. LCM526	CATEGORY <u>25</u>	
CASE NO. <u>04696-01</u>			RESOURCE <u>J</u>	PAYEE ID NO. (if different from above) <u>01</u>	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST The Laboratory does not have the Diagnosis		PRIMARY <u>788</u>
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	SERVICE PRE-AUTHORIZATION NO. (if applicable)	REFERRING OR CONSULTING PHYSICIAN J.A. Wilson, MD Ketchikan, Aka.
COMMENTS:		

SERVICES RENDERED

11	DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
	8/17/72	IL	Tissue	8903	\$ 21.00	<u>17.70</u>	<u>6 01</u>
*PLACE OF SERVICE			12 COORDINATION OF OTHER BENEFITS	TOTAL CHARGE	21.00	<u>17.70</u>	
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
			MEDICARE PAID	OTHER INS.	TOTAL		
			<u>14.16</u>		<u>14.16</u>		
			MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL		
			<u>3.54</u>		<u>3.54</u>		
			UNPAID BALANCE	6.84	<u>3.54</u>		

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		REMARKS:	
PROVIDER'S SIGNATURE <u>[Signature]</u>		DATE <u>6/31/72</u>	
RESUBMITTAL INDICATOR	XX	MEDICAL REVIEW	

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 M

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 144130

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <u>24-074469-B</u>			NAME OF PROVIDER <u>Dr McIntyre MD</u>	
NAME OF PATIENT <u>WILLIE H MCGILTON</u>		RACE <u>W</u>	PRCVIDER ID. NO. <u>DLM 899</u>	CATEGORY <u>05</u>
DATE OF BIRTH <u>12 1 09 1 03</u>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE <u>20A</u>	PAYEE ID NO. (if different from above)	
CASE NO. <u>40008-01</u>	RESOURCE <input checked="" type="checkbox"/>			

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST <u>Hyperopia - Presbyopia</u>		PRIMARY <u>370</u>
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS	CHARGE	STATE USE ONLY
<u>11 Oct 74</u>	<u>DOCTOR'S OFFICE</u>	<u>Complete oph. exam</u>	<u>9200</u>	<u>30.00</u>	
<u>11 Oct 74</u>		<u>optical goods & services</u>		<u>61-</u>	
<u>24 Oct 74</u>		Complete oph exam		30	
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	
IL INDEPENDENT LAB					
H PATIENT'S HOME					
IH INPATIENT HOSPITAL					
OL OTHER LOCATIONS					
NH NURSING HOME		MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL	
ECF EXTENDED CARE FACILITY					
OH OUTPATIENT HOSPITAL					
				UNPAID BALANCE	

PROVIDER CERTIFICATION

<p>" 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: <u>MC-EOB not available</u> <u>EOB rec'd by request</u>
	<p>PROVIDER'S SIGNATURE <u>[Signature]</u> DATE <u>2 Jan 74</u></p>

OHLSON PSYCHOLOGICAL SERVICES

140 EAGLE STREET SUITE 103

P.O. BOX 3295

ANCHORAGE, ALASKA 99501

TELEPHONE (907) 272-7924

RONALD W. OHLSON, PH. D
CLINICAL PSYCHOLOGY
TANYA J. MAURER, PH. D
CLINICAL PSYCHOLOGY

IGOR MAGIER, M.D.
PSYCHIATRIC CONSULTANT
PATRICIA G. OHLSON, M.A., M.S.
COUNSELING AND EDUCATIONAL
THERAPY

January 31, 1974

Department of Corrections
Box 3811
Kenai, Alaska 99611

Attention: Keith Armstrong

Re: FREEL, Roy CP-72-154

STATEMENT

November, 1, 1972 *	Diagnostic Interview	\$ 40.00
	Psychological Report	16.00

Total Charges \$ 56.00

Please Remit: \$ 56.00

* Please note the date of services rendered.

WH333: State File
 C14343: State Suspense
 P157: Provider's Copy

Send white & primary copies for payment.

15 Provider Ref. Jorgenson

OS P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES
 Outpatient Hospital-Practitioner-Home Health Agency Invoice 4162167 **A**

10	PATIENT INFORMATION	STATE USE ONLY	PROVIDER INFORMATION
Coupon or Authorization number <u>Crippled Children's Services</u>		Name of Patient <u>Jorgenson, Dawn</u>	Name of Provider <u>Richard Peterson, M.D.</u>
Name of Patient			<u>3300 Providence Drive</u>
Date of Birth <u>10 / 15 / 69</u>	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Elig. Code <u>ESP</u>	Provider ID No. <u>5</u>
Case No. <u>6074-370</u>	Resource <u>X</u>	Payee ID No. (if different from above)	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First		Primary
<u>Cerebellar Dysfunction</u>		<u>438</u>
<u>Linear Fracture</u>		<u>428</u>
<u>Congenital Heart Disease</u>		Secondary
		<u>746</u>
		<u>429</u>
Have all other payment sources been exhausted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Service Preauthorization No. (if applicable) <u>F0001</u>
Comments:		Referring or Consulting Physician

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY	
5-2-71	DO	<u>Brief</u>	90040	20.00	1110	1 01
6-7-71	DO	<u>Medial</u>	90030	8.00	710	1 01
3-21-71	DO	<u>Brief</u>	90040	12.00	1110	1 01
6-16-71	DO	<u>Medial</u>	90030	14.00	710	1 01
6-18-71	DO	<u>Medial</u>	90030	8.00	710	1 01
*Place of Service		12 Coordination of Other Benefits		Total Charge		
DO Doctor's Office	IL Independent Lab	M/Care Pd.	Other Paid	Total		
H Patient's Home	IH Inpatient Hospital					
OL Other Location	NH Nursing Home					
ECF Extended Care Fac.	CH Outpatient Hosp.	M/Care CoIn	M/Care Ded.	Total		
				Unpaid Balance	<u>62.00</u>	<u>43.50</u>

PROVIDER CERTIFICATION

<p>"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."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
	<p>Signature <u>[Signature]</u> Date <u>4-11-74</u></p>
Resubmittal Indicator	Medical Review

WRITE: State File
 CALAMY: State Statement
 PIP: Provider's Copy

Send white & copy copies for payment.

15 Provider Ref: Jorgensen

06 ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES
 Outpatient Hospital-Practitioner-Home Health Agency Invoice **4162168 A**

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization number <i>Brushed Children's Services</i>		Name of Provider <i>Richard Peterson MD</i> <i>3300 Prudhoe Drive</i> <i>Anchorage, Alaska 99504</i>	Name of Provider	
Name of Patient <i>Jorgensen, Dawn</i>			Address	
Date of Birth <i>10/15/69</i>	Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Elig. Code <i>309</i>	Provider ID No.	Category <i>5</i>
Case No. <i>674-380</i>	Resources	Payee ID No. (if different from above)		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First		Primary
<i>Cardiac Limitation</i>		<i>438</i>
<i>Cerebellar Dysfunction</i>		Secondary
<i>Congenital heart disease</i>		<i>746</i> <i>429</i>
Have all other payment sources been exhausted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Service Preauthorization No. (if applicable) <i>F0001</i>
Comments:		Referring or Consulting Physician

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 FVS Proc. Code	Charge	OTHER PAYMENT SOURCES		
<i>8-5-71</i>	<i>DO</i>	<i>Limited</i>	<i>90050</i>	<i>16.00</i>			
<i>12-15-71</i>	<i>DO</i>	<i>Limited</i>	<i>90050</i>	<i>16.00</i>			
<i>3-17-72</i>	<i>DO</i>	<i>Brief</i>	<i>90040</i>	<i>12.00</i>			
<i>4-26-72</i>	<i>DO</i>	<i>Minimal</i>	<i>90030</i>	<i>8.00</i>			
<i>5-23-72</i>	<i>DO</i>	<i>Brief</i>	<i>90040</i>	<i>12.00</i>			
*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	Total Charge	<i>64.00</i>			
		M/Care Pd. Other Paid Total	Less				
		M/Care CoIn M/Care Ded. Total	Unpaid Balance	<i>64.00</i>			

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: *Richard Peterson* Date: *4-11-74*

Remarks:

Resubmittal Indicator: Medical Review:

Revised 6/1/73 06 7014

PROVIDENCE PROFESSIONAL BUILDING
 1300 PROVIDENCE DRIVE - ANCHORAGE, ALASKA
 14592-0015429N

PROVIDENCE HOSPITAL - PROVIDENCE PROFESSIONAL BUILDING

Welfare

Jo Ann L. Judeen
 1400 E. Bluff Dr.
 Bldg #45, Apt. 2221
 Anchorage, Alaska

NAME JUDEEN, JO ANN L. NRAY #5911,055
 DATE 8/15/72 TIME 4:20 SERVICE
 ADDRESS 1400 E. BLUFF DR., BLDG 45, APT 2221,
 CITY/STATE/ZIP ANCHORAGE, AK 99501
 HOME PHONE 272-4335 BIRTH 7/8/47 AGE 25 SOC. SEC. ID
 DOCTOR VON RIPPEN SEX F MARITAL STATUS DIV. RACE W
 PT./STATE OF ALASKA/DEPT OF MILITARY AFFAIRS
 SECRETARY

ASSIGNMENT OF INSURANCE BENEFITS. I hereby authorize payment directly to PROVIDENCE HOSPITAL of the hospital benefits otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am responsible to the hospital for charges not paid under this agreement.

EMP/OCCUP.
 WORK
 COMP /INS.

BLUE CROSS
 GRP 7500-01 M574-16-8382

(JOANNE WOODS)

State dated we did not have funds for P.Y. till Sept.

DATE _____
 SIGNED *Jo Ann Judeen*

DATE (DESCRIPTION)	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	CREDITS	BALANCE	O.D. BALANCE
AUG 17 72				24.00			24.00	.00

HOSPITAL FILE

NAME JUDEEN, JO ANN L PATIENT NO. 10 356
 DATE 8/31/72 TIME 9:45AM SERVICE ER
 ADDRESS 1400 E BLUFF DR BLDG 45 AP 2221 99501
 CITY/STATE/ZIP
 HOME PHONE 472-4335 BIRTH 7/3/47 AGE 25 SOC. SEC. NO.
 DOCTOR MILLS SEX F MARITAL STATUS S RACE W

Welfare

SS AD: NONE

ASSIGNMENT OF INSURANCE BENEFITS. I hereby authorize payment directly to PROVIDENCE HOSPITAL of the hospital benefits otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am responsible to the hospital for charges not paid under this agreement.

EMP/OCUP.
 WORK
 COMP/INS.

PT/ST OF HL/SECRETARY
ERS/EC/GP 7500 GL/HL 574-154-9332

(K MC GOWEN)

DATE _____
 SIGNATURE J. Ann Judeen

DATE (DESCRIPTION)	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	CREDITS	BALANCE	OLD BALANCE
AUG 22 72 CR CR MAT	7.50 4.00						11.50	.00

HOSPITAL FILE

REYNOLDS, THOMAS E.
 GEN, DEL.
 KODIAK, AK 99615

307 07-20-72 8:25PM 72-23471

PROVIDENCE HOSPITAL
 Anchorage, Alaska

IRS-92-0016429N

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to the above named hospital of the Hospital Benefits otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the hospital for charges not paid under this agreement.

DATE & TIME OF DISCHARGE

Date 7-22-72 1972 Signed THOMAS E. REYNOLDS
INSURED

DATE	DESCRIPTION	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
JUL 20 72				10.00			65.00		75.00	.00
JUL 21 72	TECH CALL				16.00 8.00		65.00		164.00	75.00
JUL 22 72							9.00		173.00	164.00
JUL 24 72	IV		2.00	3.50					178.50	173.00
JUL 25 72	ER FEE	3.00								178.50
JUL 25 72	ER MAT	4.00								
JUL 25 72	IV			2.00		24.00			239.50	239.50
JUL 26 72	TECH CALL IV			3.00	84.00 8.00	19.00			390.50	

EXPLANATION OF SYMBOLS

TERMS: BILLS ARE PAYABLE WEEKLY IN ADVANCE AND MUST BE SETTLED IN FULL BEFORE PATIENT LEAVES THE HOSPITAL.

This statement is as complete as possible to render at this time. However, if there are any omissions an additional statement will be mailed to you. The Hospital Day ends at 11:00 A.M. This allows the patient to leave the Hospital without an extra day's charge being made.

- Anes - Anesthesia
- Circum - Circumcision
- Del Rm - Delivery Room
- EEG - Electroencephalogram
- EKG - Electrocardiogram
- ER - Emergency Room
- ES - Emergency Surgery
- IN TH - Inhalation Therapy
- IV - Intravenous
- - Departmental Credit
- OR - Operating Room
- O2 - Oxygen
- PT - Physiotherapy
- RR - Recovery Room
- Tel - Telephone
- Tl - Tissue
- TR - Transfusion

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

Thomas E. Reynolds 5-7-74
 Signature Date

MA-06 0001-371-336350-384-71-0180
 8-Digit Account Code 3-Digit Output Code

GRM 53067-01
 Case or Med. Card No. Remarks

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 159178

A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER SEE REMARKS		RACE	NAME OF PROVIDER Joseph D. Riederer, M.D. E. Stanley Ray, M.D.	
NAME OF PATIENT Roy Elliott			PROVIDER ID. NO. EDR384 SER 271	
DATE OF BIRTH 12 / 02 / 91	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	CATEGORY	PAYEE ID NO. (if different from above)
CASE NO.	RESOURCE			

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST		PRIMARY
Severe rheumatoid arthritis		712
Diabetes Melitis		SECONDARY 250
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS: See attached copy of EOB		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
6/13/72	IH	Admit to hospital	90220	27.50	
7/11/72	IH	Hosp. discharge - 28 days	90250	280.00	
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS	TOTAL CHARGE	307.50	
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB	MEDICARE PAID OTHER INS. TOTAL	LESS	208.80	
H PATIENT'S HOME	IH INPATIENT HOSPITAL	MEDICARE CO-INS. MEDICARE DEDUCT. TOTAL	UNPAID BALANCE	98.70	
OL OTHER LOCATIONS	NH NURSING HOME				
ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL				

PROVIDER CERTIFICATION

<p>" 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."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p> <p>covered by Welfare at the time & if you can still pay on this we would sure appreciate it.</p> <p>PROVIDER'S SIGNATURE <i>Joseph H. Clair</i> DATE 6/24/74</p>	REMARKS: Medicare was billed repeatedly on this with no results & no answer to our notes. I finally called the Soc. Sec. office and they found that the check had been sent to the patient. We had just written this off, but he was	
	<table border="1"> <tr> <td>RESUBMITTAL INDICATOR</td> <td>MEDICAL REVIEW</td> </tr> </table>	RESUBMITTAL INDICATOR
RESUBMITTAL INDICATOR	MEDICAL REVIEW	

Seward General Hospital - Box 365 - Seward, Alaska 99664

PATIENT NAME McCall, Patrizia NMI

HOSPITAL NO. 72-25930

DATE ADMITTED 7-18-72

BILL TO NAME Divn. Family & Children's Serv PHONE

ADDRESS Box 158

SOCIAL SECURITY NO.

ADDRESS Box 3613

INSURANCE COMPANY

CITY, STATE Anchor Point, Alaska 99556

DOCTOR J. L. NOYES M.D.

CITY, STATE Kenai, Alaska 99611

DECS

DATE	DAILY HOSP. SERVICE	X-RAY		LABORATORY		CENTRAL SERVICE		MEDICATIONS AND DRUGS	Emergency Treatment or Delivery Room	MISCELLANEOUS		CREDITS	LAST AMOUNT IS BALANCE DUE
		CODE & AMOUNT	CODE & AMOUNT	CODE & AMOUNT	CODE & AMOUNT	CODE & AMOUNT	CODE & AMOUNT						
Jul 18	72 70.00	102	16.00										
Jul 18		102	16.00	105	131.00	110	22.90						
						112	27.00						
						114	50.00	64.95	145.00				
									7.50	121	120.00		
										123	10.00		680.35
Jul 19	70.00			105	69.00	110	2.00						
						112	12.00	34.00					867.35
Jul 20	70.00					112	16.00	34.00					987.35
Jul 21	70.00			105	32.00	110	1.75						
						112	6.00	34.00					1,131.10
Jul 22	70.00							34.00					1,235.10
Jul 23	70.00					112	6.00	34.00					1,345.10
Jul 24	70.00			105	17.00	110	1.75	34.00					1,467.85
Jul 25	70.00					112	6.00	34.00					1,577.85
Jul 26	70.00							25.00					1,672.85
Jul 27	70.00							21.00					1,763.85
Jul 28	72	DISCHARGED		2:50 PM									1,763.85

Accts. past 30 days interest at 1% PER MONTH or 12% PER YEAR is added to balance due.

Changes or credits not in the business office at time of dismissal will be billed to you at a later date. Sales Tax included on all items where applicable. Retain this statement for your records. A charge will be made for additional copies.

Note: See reverse side for code descriptions. These represent only hospital charges. Your doctor's charges are billed to you separately by him.

Seward General Hospital - Box 365 - Seward, Alaska 99664

PATIENT NAME

#2196

BILL TO NAME

ADDRESS

Box 365

HOSPITAL NO.

DATE ADMITTED

ADDRESS

CITY, STATE

Seward, Alaska

SOCIAL SECURITY NO.

DOCTOR

CITY, STATE

PHONE

INSURANCE COMPANY

DATE	DAILY HOSP. SERVICE	X-RAY		LABORATORY		CENTRAL SERVICE		MEDICATIONS AND DRUGS	Laboratory Treatment or Delivery Room	MISCELLANEOUS		CREDITS	LAST AMOUNT IS BALANCE DUE
		CODE & AMOUNT	CODE & AMOUNT	CODE & AMOUNT	CODE & AMOUNT	CODE & AMOUNT	CODE & AMOUNT						
	70.00	102	24.00	105	20.00								
				107	5.00	110	3.00	1.25	7.50				130.75
	70.00			105	14.00								251.45
	70.00			108	32.00			2.70					322.15
	70.00			105	2.00	110	2.75	2.25					400.30
	70.00							1.65					472.85
	70.00							1.65					548.10
	70.00			105	2.00			1.65					607.10
		108	56.00	DISCHARGED									667.10
								BETNA INS (EKG)				8.00	594.10
								MEDICARE CK				524.10	70.00

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

Signature
Signature

4-22-74

06-35-6-380-384
B-Digit

0AA 043579
Case or Med. Card No

Accrs. past 30 days interest at 1% PER MONTH or 12% PER YEAR is added to balance due.

Changes or credits not in the business office at time of discharge will be billed in your next bill. Retire tax included on all items where applicable. Retain this statement for your records. A charge will be made for additional copies.

Note: See reverse side for code descriptions. These represent only hospital charges. Your doctor's charges are billed to you separately by him.

Seward General Hospital - Box 365 - Seward, Alaska 99664 *2/19/76*

PATIENT NAME: THOMAS H. APPLETON
 ADDRESS: P. O. BOX 1292 SEWARD, ALASKA 99664
 CITY, STATE: _____

HOSPITAL NO. *#01-248*
 DATE ADMITTED: *2-17-76*
 SOCIAL SECURITY NO. _____
 DOCTOR: _____

BILL TO NAME: _____ PHONE: _____
 ADDRESS: _____
 INSURANCE COMPANY: _____
 CITY, STATE: _____

DATE	DAILY HOSP. SERVICE	X-RAY CODE & AMOUNT	LABORATORY CODE & AMOUNT	CENTRAL SERVICE CODE & AMOUNT	MEDICATIONS AND DRUGS	TEMP. TAKEN (Temperature in 24/24 HOURS)	SCENARIOS CODE & AMOUNT	CREDITS	LAST AMOUNT IS BALANCE DUE
	70.00			110 6.25					76.25
	70.00		105 95.00	112 12.00	7.00				277.25
	70.00			112 14.00	24.00				351.25
	70.00			110 2.00					407.15
	70.00			112 15.00	43.00				487.15
	70.00			110 1.75					623.90
	70.00			112 24.00	42.00				759.90
	70.00		107 21.00	112 25.00	37.00				876.90
	70.00			110 4.80					952.70
	70.00			112 31.00					1,081.70
	70.00		107 20.00	112 33.00	17.00				1,240.70
	70.00			112 31.00	14.00				1,385.70
	70.00			112 33.00					1,498.70
	70.00			110 1.20					1,573.90
	70.00			112 35.00	21.00				1,684.10
	70.00			110 1.20					1,884.10
	70.00			112 22.00	7.00				1,923.30
	70.00			110 6.30					1,984.10
	70.00			112 33.00	21.00				2,005.30
	70.00			110 2.40					2,007.70
	70.00	102 14.00	105 20.00	112 31.00	5.00				2,067.70
	70.00			110 1.00					2,068.70
	70.00			112 24.00	14.00				2,106.70
	70.00			110 3.70					2,171.20
	70.00			112 22.00	7.00				2,263.40
	70.00			110 0.25					2,263.40
				112 13.00					2,276.40
		EXPIRED 1.30 A.M.							2,263.40
				MEDICARE CK				2161.40	102.00

Accts. past 30 days interest at 1% PER MONTH or 12% PER YEAR is added to balance due.

Charges or credits not in the business office at time of discharge will be billed to you as a later date. Sales tax included on all items where applicable. Retain this statement for your records. A charge will be made for additional copies.

Note: See reverse side for code descriptions. These represent only hospital charges. Your doctor's charges are billed to you separately by him.

WRITE: State File
 CARRY: State Response
 FID: Provider's Copy

Send white &
 copy copies
 for payment.

15 Provider Ref

06

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES
 Outpatient Hospital-Practitioner-Home Health Agency Invoice

4280751 A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization number Crippled Children's Services		Place 0	Name of Provider Jack Arlyn Smith, M.D.	
Name of Patient KEITH, Kelly			3300 Providence Drive Anchorage, Alaska 99504	
Date of Birth 5 / 3 / 68	Sex <input type="checkbox"/> <input checked="" type="checkbox"/>	Elig. Code 30P	Provider ID No. G.A.S. 343	Category 05
Case No. 622-391	Resource 7	Employee ID No. (if different from above)		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First Chronic serous otitis media bilateral Chronic adno-tonsillitis.		Primary 351
		Secondary
Have all other payment sources been exhausted? <input type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) 03414
Referring or Consulting Physician		
Comments:		

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY		
4-29-72	SH	ENT exam	90010	12.00			
5-19-72	IH	T+A	42840	160.00			
5-19-72	IH	M+T	69430	60.00			
*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		Total Charge	232.00		
		M/Care Pd.	Other Paid	Total			
			Blue Cross	175.60	Less	175.60	
		M/Care CoIn	M/Care Ded.	Total			
				Unpaid Balance	56.40		

PROVIDER CERTIFICATION

<p>"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.</p>	Remarks:
	<p>Signature: Jack Arlyn Smith Date: 5-22-74</p>
Resubmittal Indicator	Medical Review

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

PHARMACY INVOICE

NO. 543975

30 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Varah, Jackie		RACE	Wright Drug Co.	
DATE OF BIRTH ____/____/____	SEX: M <input type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	PROVIDER ID NO. WDS 809	CATEGORY 09
CASE NUMBER		RESOURCE	PAYEE ID NO. (if different from above)	

HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO	SERVICE PREAUTHORIZATION NO. (if applicable)
COMMENTS:	

DRUGS DISPENSED

31 DATE OF SERVICE	PRESCRIPTION NUMBER	REFILL (X)	DRUG CODE	DRUG NAME AND STRENGTH	QTY.	PHYSICIAN *ID NUMBER	CHARGE
01-26-74	187-173		92252	Cleocin 150mg.	20	WDC 824	7.95
01-26-74	187-174		183100205	Novahistine DH	4 oz.	WDC 824	3.85

* INSERT NAME OF PHYSICIAN IF ID NOT KNOWN.

32 OTHER BENEFITS	MEDICARE	INSURANCE	TOTAL
-------------------	----------	-----------	-------

TOTAL CHARGE	11.80
LESS: INS. OR OTHER PAY.	
AMOUNT BILLED	

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 01-25-74

MEDICARE		
CO-INS.	DEDUCT	TOTAL

REMARKS:
This is being resubmitted because according to our records there has been no payment made.

RESUBMITTAL INDICATOR	
MEDICAL REVIEW	

WRITE: State File
 CASH: State Casework
 PING: Patient's Copy

Send 4 to 8
 copies copies
 for patient.

15 Provider Ref. *PRITCHARD*

06 ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES **Nº 125073 A**
 Outpatient Hospital-Practitioner-Home Health Agency Invoice

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number <i>76099994</i>		Name of Provider <i>DR. THOMAS B. PRITCHARD, M.D.</i>	Address <i>1000 W. 10th St. Anchorage, Alaska 99501</i>	
Name of Patient <i>Pritchard, Ruth E.</i>			Provider ID No. <i>HRP 919</i>	
Date of Birth <i>11/01/28</i>	Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Elig. Code <i>21 E</i>	Category <i>05</i>	
Case No. <i>715 28-02</i>	Resource <input checked="" type="checkbox"/>	Payee ID No. (if different from above)		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First <i>Post-operative status L5-S1 disc. total laminectomy L5. Dissected neuropathy L5, left</i>		Primary <i>728</i>
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable)
Comments:		Referring or Consulting Physician <i>Dr. Pritchard</i>

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY	
<i>9-14-72</i>	<i>IH</i>	<i>Orthopedic Consultation</i>	<i>90600</i>	<i>30-</i>	<i>1500</i>	<i>4 01</i>
*Place of Service		12 Coordination of Other Benefits	Total Charge	<i>30-</i>	<i>1500</i>	
DO Doctor's Office	IL Independent Lab	M/Care Pd. Other Paid Total	Less	<i>0</i>		
H Patient's Home	IH Inpatient Hospital	M/Care CoIn M/Care Ded. Total	Unpaid Balance	<i>30-</i>	<i>1500</i>	
OL Other Location	NH Nursing Home					
ECF Extended Care Fac.	OH Outpatient Hosp.					

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 *Thomas B. Pritchard, M.D.* Date *MAY 14 1974*

Remarks:
Thomas Pritchard
33-6-358-350

Resubmittal Indicator Medical Review

Revised 6/1/73 06 7014

February 20, 1975

February 20, 1975

The Honorable Bill Ray
Chairman
Senate Finance Committee
Pouch V
Juneau, Alaska 99811

Robert Dawson, Director

Attention: Senator George Hohman

Dear Senator Ray:

This is in response to a question raised by Senator Hohman at this morning's Senate Finance hearing concerning the Governor's requested supplemental appropriation for miscellaneous claims (SB 78).

After reviewing AS 37.25.010 (b) it is our interpretation that the claims associated with SB 78 are not legally payable with current year authorization. This is due to the fact that the provisions (1) and (2) of subsection (b) preclude such payment.

A copy of the proposed change to the SB 78 appropriated amount which I mentioned this morning is also attached. This alteration has the following effect:

Remove:	N.C. Machinery Claim	(\$935.58)
Add:	Spenard Builders (In. no. R27639)	18.04
Add:	Spenard Builders (In. no. C5972)	8.96
	Net effect of revision	<u>(\$908.58)</u>

We accordingly recommend that SB 78 be amended to reduce the appropriated amount from \$45,900 to \$44,992; a reduction of \$908.00. Within the bill the amount appropriated to the Department of Public Works should be reduced by a like amount: \$908.58.

February 20, 1975

To avoid miscellaneous claim supplemental appropriations in future fiscal years we have proposed that the General Appropriation Bill be footnoted to include the provision that it be allowable for the Governor's Contingency Fund to be used to pay obligations for any agency for any time period. HB 70 now includes that provision. We solicit your support in having such a provision included in the Senate's version of the budget bill this session!

Sincerely,



V. Kent Dawson, Director

cc: Jay Hogan, Director, Legislative Finance

Attachment:

VKD/bc

STATE
of ALASKA

MEMORANDUM

#6

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

DATE : 11-22-74

FROM: Ray Davidson
Fiscal Officer
Dept. of Health & Social Services

SUBJECT: 1975 Miscellaneous Claims

We are here with submitting prior year billings for Legislative approval.

The attached billings were not submitted for payment until after the statute of limitations expired (two years after service). We would appreciate legislative approval to enable us to make payment to these vendors.

Please Note:

This request contains two parts:

1. \$8661.65 billings presented for approval last year and not acted on to date.
2. \$618.85 presented for the first time this date.

9280.50

$$\begin{array}{r} 7302.51 \\ 9280.50 \\ \hline 24.01 \end{array}$$

Legislative Billings for year 1974-75

Submitted November 22, 1974

	Invoice #	Date of Service	Amount	Date ^{Received} Recieved	Code	Reason for Delay
Family & Children Services						
Alaska Children Services	69355	03-16-72	307.20	5-15-74	06-21-3-265-336	Vendor Inv. not rcvd.
Frank Chasley	482677	02-16-72	115.00	5-02-74	06-21-3-150-730	Wt. misplaced 2 yrs.
Anchorage Daily Times	L-79415	12-22-70	11.70	8-15-74	06-21-3-263-325	Vendor Inv. not rcvd.
Anchorage Daily Times	L-79156	6-24-71	67.20	5-30-74	06-21-3-263-325	" " " "
Anchorage Daily Times	L-79156	6-3-71	63.60	5-30-74	06-21-3-263-325	" " " "
Corrections						
Schmolsk Plumbing & Heating	12473	5-4-71	24.25	3-04-74	06-66-04-112-450	Vendor Inv. not rcvd.
Public Health						
National Academy of Engineers	266362	11-02-70	29.90	2-13-74	06-31-1-980-490	" " " "
TOTAL			618.85			

STATE OF ALASKA
DIVISION OF FAMILY AND CHILDREN SERVICES

1. DISTRICT NO. 21
2. CASE WORKER PCN NO. 270
(DISTRICT USE ONLY)

ACS 410

CHILD CARE INVOICES

INVOICE NUMBER

INVOICE MUST BE SUBMITTED WITHIN ONE MONTH FROM DATE OF SERVICE

MAIL TO:

LOCAL DISTRICT OFFICE

3. FOSTER HOME/INSTITUTION

HOME ADDRESS

4. CHILD CARE LICENSE NO.

ALASKA CHILDRENS SERVICES, INC. 4600 Abbott Rd Anchorage, Alaska 99507

5. COMMENTS OF FOSTER HOME/INSTITUTION

EMERGENCY SHELTER

6. CASE NUMBER (FOR DISTRICT USE ONLY)	7. PROGRAM INITIALS	8. NAMES OF CHILDREN	RECORD OF SERVICES RENDERED						11. NO. OF DAYS	12. RATE	13. CHARGE	14. (FOR DISTRICT USE ONLY)	
			9. BIRTH DATE			10. PERIOD OF SERVICE							
			MO	DAY	YR	MO	YR	FROM DAY	TO DAY				
69355	JCO	Klinger, Melinda	10	27	55	3	72	1	16	16	34.99	307.20	

Second Re Billing

RECEIVED
MAY 15 4 03 PM '74
FISCAL SERVICES
JUNEAU

15. FOSTER HOME/INSTITUTION CERTIFICATE

13A. TOTAL CHARGES 307.20

I HEREBY CERTIFY UNDER PENALTY OF FRAUD, THAT THE SERVICES RENDERED IS A CORRECT CHARGE AGAINST THE STATE OF ALASKA, THE CLAIM IS JUST AND DUE. THAT NO PART OF SAME HAS BEEN PAID AND I AM AUTHORIZED TO SIGN AS HEAD OF THE FOSTER HOME/INSTITUTION.

16. APPROVED AND ALLOWED IN THE ABOVE AMOUNT, OR AS CORRECTED

SUBSCRIBED THIS 22 DAY OF April 1974
R. E. Gilbert by
Wayne B. Santos - Director of Finance
FOSTER HOME/INSTITUTION HEAD SIGNATURE (IN INK)

(AUTHORIZED SIGNATURE)
(FOR DISTRICT USE ONLY)

17. COMMENTS (FOR DISTRICT USE ONLY)

• .00 T

3	0	7	.20	
1	1	5	.00	
	1	1	.70	
	6	7	.20	
	6	3	.60	
	2	4	.25	
	2	9	.90	
6	1	8	.85	T

JUNEAU, ALASKA

Wa# 482677
89-52
1252

DATE OF ISSUE
MO. DAY YR. AGENCY

02 16 72 063

482677
18077

PAY TO THE ORDER OF

CHARLEY, FRANK
CHISTOCHINA VILLAGE
GAKONA AK

99586

DOLLARS CENTS
\$ *****115 00

\$115.00

Joseph R. Henri
COMMISSIONER OF ADMINISTRATION

0000011500

125200521

Commissioner of Administration,

Dear Sir:

Due to faulty mechanism of
our cash register this check was caught
up in it and discovered when
it needed repair.

As it was only a month overdue
we tried to run it through the
bank but you can see we were
unsuccessful being outdated.

Could you replace this for us
with a new dated check?

Very truly yours.

Mrs. B. B. Paston
(owner)

May 2, 1974

Posty's Sinona Creek Trading Post
Mile 34.6 Tok Cuttoff
Gakona, Alaska 99586

Dear Sir:

We received your request to reissue warrant #482677 in the amount of \$115.00. Due to State Date Law 37.05.180 this warrant was invalid 02-16-84.

We are unable to pay any billing over 2 years old without special approval by the legislature. The renewal of this warrant will be filed with other billings two years old waiting approval by the legislators. We will be unable to submit this prior to 1975 legislation. Thanks for your patience.

Ray Davidson



Fiscal Officer
Health and Social Services

STATEMENT

Anchorage Times Publishing Co.

ALASKA'S LARGEST NEWSPAPER
POST OFFICE BOX 40
ANCHORAGE, ALASKA

NOV 23, 1970

ACCOUNT OF Dept. of Health & Welfare

#17415

TERMS ALL ACCOUNTS DUE THE FIRST OF EACH MONTH

ALASKA STATE PLAN FOR THE CONST.
OF MENTAL HEALTH CENTERS.....

Dec. 21

10 30 1970 10.20

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.....Clerk

STATEMENT

Anchorage Times Publishing Co.

ALASKA'S LARGEST NEWSPAPER

POST OFFICE BOX 40

ANCHORAGE, ALASKA

DEC 21 1970

ACCOUNT OF

DEPT. OF Health & Welfare

#1415

TERMS: ALL ACCOUNTS DUE THE FIRST OF EACH MONTH

ALASKA STATE PLAN FOR THE CONST. OF MENTAL HEALTH CENTERS.....

Dec. 21

30.00 1.70

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.....Clerk

STATEMENT

Reckly

Anchorage Daily Times

P. O. BOX 40

TELEPHONE 279-5622

ANCHORAGE, ALASKA 99510

TERMS

ALL ACCOUNTS DUE WHEN BILLED: DELINQUENT AFTER THE 15TH OF THE MONTH.
2% DISCOUNT ON DISPLAY ADVERTISING ALLOWABLE IF PAYMENT RECEIVED BY 15TH OF MONTH FOLLOWING PUBLICATION. X X X X X X X X X X

- LEGAL ADVERTISING STATEMENT.
- INVOICES AND PROOFS OF PUBLICATION
- WERE MAILED AT EXPIRATION OF AD.

Customer

COMMISSIONER/HEALTH & WELFARE
MCKAY BLDG RM 222
ANCHORAGE AK

L79156


04-12-74

TO INSURE PROPER CREDIT PLEASE RETURN THIS PORTION WITH YOUR REMITTANCE

AMOUNT ENCLOSED

--	--

BALANCE FORWARD AMOUNT →

DATE	DESCRIPTION	OUR REFERENCE
6-24-71	ORDER TO <i>Reckly</i> UNDER 18 <i>neabok children</i>	
		
	<i>Third Billing</i>	

67.20

Anchorage Daily Times

P. O. BOX 40
ANCHORAGE, ALASKA 99510

TOTAL BALANCE DUE

67.20

ALLOWABLE DISCOUNT
IF PAYMENT RECEIVED BY 15TH OF MONTH

--

SUPERIOR COURT
 STATE OF ALASKA
 JUDICIAL DISTRICT
 AT ANCHORAGE
 FAMILY DIVISION
 The Matter of:
 NEAKOK CHILDREN - DONNA,
 EVA MARIE and
 THOMAS,
 Minor Children under the
 Age of Eighteen (18)
 Years.
 No. CP 1088, 1089 and 1040
NOTICE TO ARSENT 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 hear-
 ing 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 ap-
 pointed 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. Ryan
 Deputy
 PUB.: June 2, 9, 16, 23, 1971

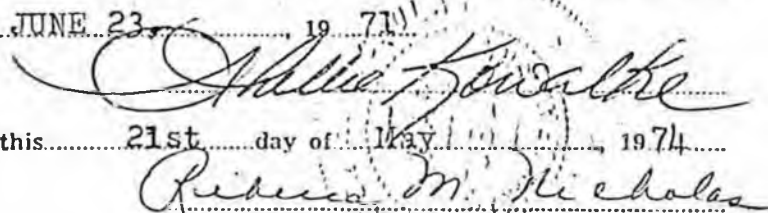
Proof of Publication

 PO Box 40
 Anchorage
 99510

ANCHORAGE DAILY TIMES

SHELLIE KOWALKE 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 Divi-
 sion, State of Alaska; that the notice of MATTER OF NEAKOK CHILDREN, MINORS
 UNDER 18 YRS. 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, 1971
 and ending with the issue of JUNE 23, 1971

Subscribed and sworn to before me this 21st day of May, 1971

 Notary Public for the State of Alaska.
 My Commission Expires 12-14, 1977

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

Marion Merrill 5-22-74
 Signature Date

06-21-3-263-325
 8-Digit Account Code 3-Digit Subject Code

JC 40324-102004 These have
 Case or Mand. Card No. Remarks
 not been paid.

0603565
 Need to approval
 signature. No pay
 for 1 yr.

STATEMENT

Anchorage Daily Times

P. O. BOX 40

TELEPHONE 279-5622

ANCHORAGE, ALASKA 99510

Reilly

- LEGAL ADVERTISING STATEMENT.
- INVOICES AND PROOFS OF PUBLICATION
- WERE MAILED AT EXPIRATION OF AD.

- TERMS
- ALL ACCOUNTS DUE WHEN BILLED: DELINQUENT AFTER THE 15TH OF THE MONTH.
 - 2% DISCOUNT ON DISPLAY ADVERTISING ALLOWABLE IF PAYMENT RECEIVED BY 15TH OF MONTH
 - FOLLOWING PUBLICATIONS XXXXXXXX

CUSTOMER

COMMISSIONER/HEALTH & WELFARE
 MCKAY BLDG RM 222
 ANCHORAGE AK

L79156

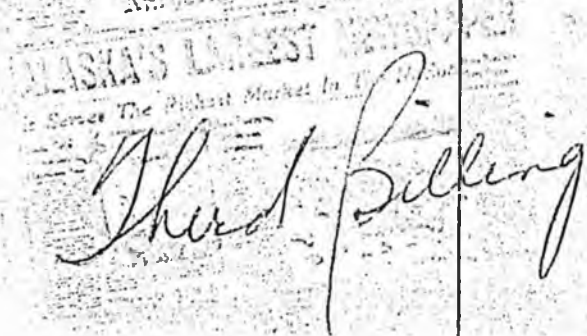
04-12-74

INSURE PROPER CREDIT PLEASE RETURN THIS PORTION WITH YOUR REMITTANCE

AMOUNT ENCLOSED

--	--

BALANCE FORWARD AMOUNT →

DATE	DESCRIPTION	OUR REFERENCE	
5/3/74	UNDER 18 Daniel Feenstra		63.60
5/24/74	UNDER 18		67.28
			63.60

Anchorage Daily Times

P. O. BOX 40
ANCHORAGE, ALASKA 99510

TOTAL BALANCE DUE

130.80*

ALLOWABLE DISCOUNT IF PAYMENT RECEIVED BY 15TH OF MONTH

--

Proof of Publication

Po Box #40
Anchorage
99510

ANCHORAGE DAILY TIMES

SHELLIE KOWALKE

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 DANIEL FEENSTRA... A MINOR CHILD UNDER 18 YRS OF AGE... a copy of which is hereto attached, was published

MAY 10 17 24 JUNE 1

in said Anchorage Daily Times, beginning with the issue of MAY 10 19 71 and ending with the issue of JUNE 1 19 71

Subscribed and sworn to before me this 21st day of MAY 19 74

Shellie Kowalke
Richard M. Nicholas
Notary Public for the State of Alaska

My Commission Expires 12-14 1977

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA THIRD JUDICIAL DISTRICT AT ANCHORAGE FAMILY DIVISION
In the Matter of: DANIEL FEENSTRA B.D. 3-21-67 A minor Child under the Age of Eighteen (18) Years. No. CP 2069
NOTICE TO ABSENT PARTY TO: Tatianna Feenstra
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 11th day of June, 1971, at the hour of 8:30 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 child.
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 7th day of May, 1971.
A. M. Vokacek
Clerk of the Superior Court
By: (s) B. Johnson
Deputy
Pub.: May 10, 17, 24; June 1, 1971

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

Merion Merrill 5-22-74
Signature Date

8-Digit Account Code: JC 52514-01
3-Digit Object Code: JC 52514-01

*These have not been paid.
3rd Billing!!*

June 7, 1974

Anchorage Daily Times
P. O. Box 40
Anchorage, Alaska 99510

Attention: Accounts Receivable

Gentlemen:

We have received for payment in our office two of your invoices from your legal advertising department dating back to the months of May and June of 1971. The attached proof of publication from you appears to be the original copy, and I can find no prior payment on your invoices in our records. Therefore, it is with regret that I must tell you that we are unable to pay the outstanding amounts as shown on your invoices at this time.

State law requires that any invoices over two years old must have legislative approval prior to payment. Your invoices for both publications; the matter of the Neakok children in the amount of \$67.20, and Daniel Feenstra in the amount of \$63.60 fall into this time restriction category.

We do not anticipate a problem regarding legislative approval, however, payment cannot be made to you until such approval is given sometime after the legislature reconvenes next year.

If you should have further questions regarding these invoices, please feel free to contact us. We certainly do regret any inconvenience this may cause to you.

Very truly yours,



Erna F. Morgan
Accounts Payable Supervisor
Fiscal Section

/cm

cc: Marion Merrill

24.25	TOTAL
5-	TAX
24.00	LABOR
25	TOTAL EARNINGS

25. Gordon Macdonald

Worked 1/2 hour after quitting
 Time to complete job.
 Tuesday 5/14/72
 Alaska State Pollution
 Dept. of Environmental Conservation
 @ Ketchikan, Alaska
 WORK PERFORMED
 ADDRESS
 BOX NO.

12472
 1514 1/2

P. O. BOX 1721 - KETCHIKAN, ALASKA 99901

125 STEWART STREET
 2. 4.15 PM
 10. 1. 21 AM

Gordon Macdonald

MEMORANDUM

State of Alaska

DEPT. Health and Social Services
DIV. Administration
SEC. Fiscal

TO: Mr. Robert Andrew
Ketchikan Correctional Institution

DATE : March 8, 1974

FROM: 
L. Hertz
Fiscal Services

SUBJECT: Schmolck Plumbing, Heating &
Sheetmetal

In regard to our previous correspondence regarding the subject past due account, I regret that we will be unable to pay the full amount at this time.

State law requires that any invoices over two years old must have Legislative approval prior to payment. Invoice No. 12473 is dated May 4, 1971 in the amount of \$24.25, which we will have to hold for approval. We have already submitted our list to the current session and do not know at this time if we will be able to make any additions. It may be next year before this invoice can be paid. We have processed invoice number 988 in the amount of \$148.27 with a "rush" tag to beat the two year deadline which will be March 12th. Sorry this was not caught before, but hopefully we can get most of it out of the way.

PUBLIC HEALTH RHO SCRO
 ELIZABETH A TOWER MD RHO SCRO
 RM 222 MACKAY BLDG
 338 DENALI ST ANCHORAGE AK 99501

PUBLIC HEALTH RHO SCRO
 ELIZABETH A TOWER MD RHO SCRO
 RM 222 MACKAY BLDG
 338 DENALI ST ANCHORAGE AK 99501

MO.	DAY	YEAR
11	02	70

INVOICE NO.
 266362

Make check or money order payable and return to National Academy of Sciences. Attn: ACCOUNTING OFFICE. Do not send cash. Please write invoice number on check or money order.

Secure permission before returning books for credit. A \$1.00 service charge is made for handling approved returns. No credit allowed for publications returned in unsaleable condition.

We provide only 2 copies of invoices, customer may reproduce additional copies.

Quantity	Publication ISBN: 09-0-	Title	List Price	Net Price	Amount
1	1607-X	HUMAN ECOLOGY ALASKA EARTHQUAK 70	29.50	29.50	29.50
1	8940-0	POSTAGE AND HANDLING	.40	.40	.40
Please remit amount due immediately to the Accounting Office at the address shown. Include invoice number. PAY LAST AMOUNT SHOWN — NO ADDITIONAL DISCOUNTS ALLOWED TOTAL ACCOUNTING OFFICE					29.90

JUL 26 1971
 STATEMENT
 ISSUED

REPLY MEMO

State of Alaska

MESSAGE

REPLY

TO Elizabeth Tower

DATE 2/15/74

TO

DATE

Public Health

We can find no record of ever paying this invoice nor ever receiving it. Unfortunately, due to the lapse of time since this was issued, we are unable to pay without Legislative approval since Alaska Law requires that any billing over two years old must have prior Legislative approval before payment. We have already submitted our list to the current Legislature it may be next year before we can obtain approval but we will do our best.

As requested

SIGNED I. Wertz, Fiscal Services

SIGNED

1. KEEP YELLOW COPY.

2. SEND WHITE AND PINK COPIES WITH CARBON INTACT.

1. WRITE REPLY.

2. DETACH STUB, KEEP PINK COPY. RETURN WHITE COPY TO SENDER.

Legislative Billings

~~Submitted 1-29-74~~

*Resubmitted
11-22-74
kel*

Corrections

<u>Vendor Name</u>	<u>Date</u>	<u>Invoice</u>	<u>Code</u>	<u>Amount</u>	<u>Total</u>
A & W Wholesale	1-7-71	18408	06-66-4-110-490	58.00	
"	2-15-71	12007	"	29.00	
"	5-10-71	9229	"	104.21	
"	5-11-71	6525	"	1.95	
"	5-17-71	10165	"	20.90	
"	5-20-71	1046	"	17.00	
"	5-27-71	2261	"	37.97	
"	5-28-71	2300	"	12.00	
"	6-7-71	1446	"	16.05	
"	8-9-71	25268	"	7.00	
					304.08

Pied Piper Pest Control	1-23-71	2740	06-66-4-110-390	95.00	
Pied Piper Pest Control	3-20-71	2854	"	95.00	
					190.00

Public Health Nursing

Bells Gen. Merchandise	10-21-70	23	06-31-1-480-490	24.93	
Samuelson Flying	9-19-67	25578	06-31-1-301-211	30.00	
					54.93

Medical Assistance

L. David Elvall, MD	8-1-68		06-33-3-800-	246.00	
T. S. Redmond, DDS	1-12-72		06-33-6-400-380	175.00	
D. B. Addington, MD	4-4-71		06-33-6-350-380	295.68	
Alaska Clinic	1-12-70		06-33-6-350-380	57.40	
G. B. Von Wichman MD	2-16-71		06-33-6-350-380	295.00	
Anch. Med & Surg.	6-18-71		06-33-6-350-380	10.00	
A. C. Chalmers MD	1-25-70		06-33-6-350-380	8.60	
"	2-2-71		"	20.60	
"	6-1-71		"	3.80	
City of Fairbanks	6-25-71		06-33-6-380-380	37.00	
Fbks Med & Surg	11-25-71		06-33-6-350-380	3583.00	
Fbks Men. Hosp.	4-13-71		06-33-6-310-380	60.00	
"	1-7-71		06-66-4-313-380	1985.89	
L. P. Ferucci MD	3-23-71		06-33-6-350-380	10.00	
G. O. Gould DDS	12-8-69		06-33-6-400-380	115.00	
Geo. Hale MD	6-19-72		06-33-6-350-380	120.92	
"	10-13-71		06-33-6-350-380	157.37	

Paul Jaeger MD	2-8-71	06-33-6-400-380	45.00
* N. Jones MD	11-17-70	06-33-6-390-470	42.60
B. D. Layman DDS	11-24-71	06-33-6-400-380	15.00
"	"	"	15.00
"	"	"	15.00
"	"	"	35.00
D. Leistikow MD	9-14-70	06-33-6-350-380	10.00
D. J. McIntyre	10-14-71	06-33-6-350-380	15.00
"	10-10-70	"	30.00
"	5-3-71	"	196.00
J. W. Mortensen MD	8-4-70	"	55.83
Providence Hosp.	7-13-71	06-33-6-310-380	112.15
"	1-3-72	"	68.00
W. S. Stover MD	8-24-72	06-33-6-350-380	240.00
Tanana Valley			
Med & Surg. Group	11-2-70	06-33-6-350-380	13.80
"	5-12-71	06-31-1-724-380	23.00
			<u>8112.64</u>

8661.65

*

	5	8.00	+
	2	9.00	+
1	0	4.21	+
		1.95	+
	2	0.90	+
	1	7.00	+
	3	7.97	+
	1	2.00	+
	1	6.05	+
		7.00	+
3	0	4.08	*

INVOICE NO.

1446

A&W WHOLESALE CO., INC.

BOX 688, FAIRBANKS, ALASKA 99707

1003 PIONEER ROAD - PHONE 452-2138

Only

eds

Supplies

ies

SOLD TO *State Jail*

ADDRESS *# 4778*

Date *6-7-71*

FILLED BY

SALESMAN

SHIP BY

PA

DESCRIPTION

DEPT. 1

DEPT. 2

DEPT. 4

DEPT. 4

cs 1/2 gal Purex

16 05

STATE CIGARETTE TAX

Miguel Larza

DEPARTMENT TOTALS

16 05

POSTAGE AND INS. →

INVOICE TOTAL

16 05

01

PIED PIPER PEST CONTROL

Box 2535
FAIRBANKS, ALASKA 99701
Phone 455-5640

<small>SOLD BY</small> <i>U Benson</i>	<small>DATE</small> <i>11/23</i> 19 <i>71</i>
<small>NAME</small> <i>State Jail</i>	
<small>ADDRESS</small>	
<small>CITY</small> <i>Fairbanks</i>	
<input type="checkbox"/> CASH <input type="checkbox"/> CHARGE <input type="checkbox"/> MDSE. RET'D <input type="checkbox"/> C.O.D. <input type="checkbox"/> PA'D OUT <input type="checkbox"/> PD. ON ACCT.	

QUAN.	DESCRIPTION	AMOUNT
	<i>4445</i>	<i>95.00</i>
<small>RECEIVED BY</small> <i>U Benson</i>		<small>TOTAL</small> <i>95.00</i>

2 2740

Thank You

*

95.00 +
95.00 +
190.00 *

*

24.95 +
30.00 +
54.95

Bello General Merchandise
Kobe, Alaska

Date 10-21-1970

Health Center
Address Kobe, Alaska

Req. No.	Clerk	Account Forward	
1	U. Pitt (for motor)		235
2	3 Gal. Pink Clay		
3	Labor \$5.99		
4	by Youth Camps		11.98
5	Painting around health		
6	at Masquah Bay Center		
7	Paint		
8	Paint		
9	Paint (Aug 8)		1.46
10	Paint		1.5
11	Paint		5.99
12	Paint		1.50
13	Paint		1.50
14	Paint with 2 Stamps		24.93
15	Paint		

Your Account Stated to Date - If Error Is Found Return at Once

PLEASE PRESS DOWN HARD FOR CLEAR COPIES

FLIGHT RECORD AND INVOICE

5A-05

FROM: Samuelson Flying TO: STATE OF ALASKA
 NAME: Bob 498 DEPT: Health & Welfare
 ADDRESS: Bethel Alaska DIVISION: 78 Central
 AIRCRAFT TYPE & MODEL: P-185 NUMBER: 1198164 DATE: 9-19-67 CONTRACT NUMBER: -

1. DPT.	TIME	ARR.	TIME	FLIGHT TIME	2. DPT.	TIME	ARR.	TIME	FLIGHT TIME
Bethel	11:00	Sam Bay	12:15	1:15	Bethel	12:30	Sam Bay	12:50	1:20
Sam Bay	12:30	Sam Bay	12:50	1:20	Bethel	1:00	Sam Bay	1:50	1:50
Bethel	1:00	Sam Bay	1:30	1:30	Bethel	2:00	Bethel	3:25	1:25
Sam Bay	1:30	Sam Bay	1:50	1:50					
Bethel	2:00	Bethel	3:25	1:25					

PASSENGER(S): Steve Peterson FLIGHT TIME: 3 HRS: 41 1/10THS @ 1750 \$ 27500
 STAND BY TIME: 1 HRS: 15 1/10THS @ 1500 \$ 24500

CARGO: _____ TOTAL DUE \$ 3000

CUSTOMER'S SIGNATURE: [Signature] FOR STATE COOKING ONLY: _____ PILE: MTT

No. 25578

1-12-72

Ms. Beth Heron
1080 W Fireweed Ln
Anchorage AK
Dentist T.S. Redmond D.D.S.

Dr. Redmond

BILLING for Beth Heron

12-16-70	# 2 OL	Amalgam Filling	\$20.00
	# 20	" "	15.00
	# 30	" "	15.00
2-15-71	# 14 0	" "	15.00
	# 14 OL	" "	20.00
	# 15 0	" "	15.00
	# 15 CL	" "	20.00
	# 18 0	" "	15.00
	# 31 0	" "	15.00
	Prophylaxis + fluoride		25.00

Total

RECEIVED

DEC 7 1972

MEDICAL ASSISTANCE

T.S. Redmond D.D.S.

3-10-73 sent 2nd billing

THOMAS S. REDMOND, DDS
1080 W FIREWEED LN
ANCHORAGE AK

06-33-6-400-380



EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE BENEFIT TAKEN OFF YOUR MEDICARE CLAIM

Prepared By:

Aetna Life & Casualty
Medicare Claim Administration
Yeon Building
522 S. W. 5th Avenue
Portland, Oregon 97204
Telephone Nos. 222 6871

DATE

9 28 72

HEALTH MAINTENANCE CLAIM NUMBER

574-01 6589A

IMPORTANT

SEE REVERSE SIDE FOR GENERAL INFORMATION.

BENEFICIARY'S NAME AND ADDRESS

CARLOS PEREGRINO

KENAI, AK 99611

LOCATION OF SERVICE CODES

SERVICES

DESCRIPTION OF SERVICE CODES

The following will explain the codes shown in the "Location of" column to the right.

SERVICES	FIRST DATE		LAST DATE		EXTENSION CODE	RENDERED BY	NUMBER OF SERVICES
	MO	DAY	MO	DAY			
1	04	04	06	05	TH		20
2					TH		1
3							
4							
5							
6							
7							
8							
9							
10							

The following will explain the number shown in the "Description of" column at left.

- O Doctor's Office
- HI Inpatient Hospital
- IL Independent Lab
- ICF Extended Care Facility
- PH Patient's Home
- OH Outpatient Hospital
- OL Other Location
- NH Nursing Home

- 1. Medical Care
- 2. Surgery
- 3. Consultation
- 4. Diagnostic X-ray
- 5. Diagnostic Lab
- 6. Radiation Therapy
- 7. Anesthesia
- 8. Assistant Surgeon
- 9. Other Service
- 0. Whole Blood or Packed Red Blood Cells

an amount is shown in the "Not Allowed" column at right, the paragraph checked below will explain.

The Allowed Charge is less than the actual charge for psychiatric service, because only 62 1/2% of such expenses are allowed under the law.

The Allowed Charge is less than the actual charge for psychiatric service, because the \$250.00 maximum payable in one calendar year has been reached.

The charges have been reduced to the amount indicated, because they have been determined to be higher than we can consider as covered expense under the Medicare Program.

Your \$50.00 deductible has been met for 19 71

D. B. ADDINGTON, MD
3300 PROVIDENCE DR, ST. 205
ANCHORAGE, AK 99504
06-33-6-350-380

	TOTAL	NOT ALLOWED	ALLOWED
1	1383.90		1383.90
2	94.50		94.50
3			
4			
5			
6			
7			
8			
9			
10			
TOTAL ALLOWED CHARGES			1478.40
LESS DEDUCTIBLE			
BALANCE OF ALLOWED CHARGES			1478.40
LESS 20% COINSURANCE			295.68
MEDICARE PAYS			1182.72

BENEFITS TO



EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM

Reported By: _____ DATE: _____

Aetna Life & Casualty
Medicare Claim Administration
Yeon Building
522 S. W. 5th Avenue
Portland, Oregon 97204
Telephone No. 222-6831

HEALTH INSURANCE CLAIM NUMBER

121 71
554-28-5570

IMPORTANT

I certify that this is a just and proper bill and hereby authorize the Department Certifying Officer to effect **SEE REVERSE SIDE FOR GENERAL INFORMATION.**

Murray Hewitt 3-5-73
Signature Date

06-22-3-370-375-71-0070

8-Digit Account Code 3-Digit Object Code

CAA 36645-01

Case or Med. Card No.

BENEFICIARY'S NAME AND ADDRESS

Emma Petreff
D. Petreff
By 246
Chugiak Alaska

LOCATION OF SERVICE CODES	SERVICES						DESCRIPTION OF	REMARKS	
	FIRST DATE	LAST DATE	LOCATION OF	NUMBER OF	RENDERED BY				
	MO	DAY	MO	DAY					
	1	12	11	23	I.H.	01	D. Petreff	1	<p>The following will explain the number shown in the "Description of" column at left.</p> <ol style="list-style-type: none"> Medical Care Surgery Consultation Diagnostic X-ray Diagnostic Lab Radiation Therapy Anesthesia Assistant Surgeon Other Service Whole Blood or Packed Red Blood Cells
	2	17	10		I.H.	01	MD	1	
	3				I.H.	10		1	
	4				I.H.	01		1	
	5				I.H.	01		5	
	6				I.H.	02		4	
	7				I.H.	01		1	
	8								
	9								
	10								

If an amount is shown in the "Not Allowed" column at right, the paragraph checked below will explain.

- The Allowed Charge is less than the actual charge for psychiatric service, because only 62½% of such expenses are allowed under the law.
- The Allowed Charge is less than the actual charge for psychiatric service, because the \$250.00 maximum payable in one calendar year has been reached.
- The charges have been reduced to the amount indicated, because they have been determined to be higher than we can consider as covered expense under the Medicare Program.

Still Date

	TOTAL	NOT ALLOWED	ALLOWED
1	70.00	30.00	40.00
2	50.00	10.00	40.00
3	120.00	30.00	90.00
4	48.00	8.00	40.00
5	8.00		8.00
6	48.00	10.00	38.00
7	30.00	15.00	15.00
8			
9			
10			

Your \$50.00 deductible has been met for 19 70

BENEFITS PAID TO

ALASKA CLINIC
D. M. Dietz MD
825 4th St
Anchorage AK
06-33-6-350-380

TOTAL ALLOWED CHARGES 287.00
 LESS DEDUCTIBLE 25.00
 BALANCE OF ALLOWED CHARGES 262.00
 LESS 20% COINSURANCE 54.90
 MEDICARE PAYS 207.10

STATEMENT

GEORGE B. VON WICHMAN M.D. ORTHOPEDIC SURGEON
~~XX~~
~~XX~~

Anchorage Fracture and Orthopedic
 A Professional Corporation
 3543 Latouche Street
 Anchorage, Alaska 99508

George B. vonWichman

IN
ACCOUNT
WITH

Department of Health & Social Services
 P.O.Box 3613
 Kenai, Alaska 99611

DATE	NAME CODE	OFFICE EXAM A	EMERGENCY CARE B	SURGERY MINOR SURGERY C	X-RAYS D	CODE	OTHER SERVICE	CREDITS		BALANCE
								ON ACCOUNT	ADJUSTMENTS	
		RE: Simon, Karla BD 3-5-65								
		Diagnosis: Fracture displaced lower third right tibia .								
16-71		Hospital admitted								25.
17-71		Surgery Closed reduction right tibia								+ 270.
									TOTAL	295.
		This is a re-billing of June and August, 1972					33.6 - 350.380			

Admin

- | | |
|----|----|
| 1. | 7. |
| 2. | 8. |
| 3. | 9. |
| 4. | |
| 5. | |
| 6. | |

- | | | |
|---|---|--|
| A. - IN OFFICE SERVICE
PRE-OP OR POST-OP | K. - CAST WITH MATERIALS | XT. - X-RAY THORATIC SPINE/CHEST |
| B. - BACK EXAMINATION | L. - LOCAL ANESTHETIC
ASPIRATION/INJECTION | XV. - X-RAY ARM/LEG |
| C. - COMPLETE EVALUATION | M. - MISCELLANEOUS & DRESSING | XD. - X-RAY DIGITS |
| PV. - IN PROVIDENCE HOSP. | Q. - CONSULTATION/REPORTS | S. - SUPPORTS/SPECIAL SERVICE |
| PY. - IN PRESBYTERIAN HOSP. | XI. - X-RAY NECK/SHOULDERS | Y. - LAB CHARGE HERE
MEDICATIONS/INJECTIONS |
| H. - HOSPITAL CARE | XP. - X-RAY LUMBAR SPINE/PELVIS/HIPS | Z. - PRESCRIPTIONS CHARGED HERE |

PLEASE PA
AMOUNT II
COLUM

IN ACCOUNT WITH
ANCHORAGE MEDICAL AND SURGICAL CLINIC

718 K ST.
ANCHORAGE, ALASKA 99501

Alaska Dept. of Welfare
Room 222 McKay Building
Denali 338
Anchorage, Alaska

DATE	PROFESSIONAL SERVICE RENDERED
6-18-71	<p data-bbox="784 519 900 553">3-26-73</p> <p data-bbox="244 718 574 752">RE: Sternhagen, Erika</p> <p data-bbox="244 818 429 851">Office Call</p> <p data-bbox="817 818 900 851">10.00</p> <p data-bbox="244 1050 925 1117">This has been billed several times, please check into this. Thank you.</p> <p data-bbox="239 1338 503 1371">IRS# 92-001-8977</p> <p data-bbox="338 1404 941 1470">06-33-6-350-380</p> <p data-bbox="735 1515 949 1581"><i>Alma</i></p>

NO RECEIPTS SENT UNLESS REQUESTED.
ACCOUNTS ARE PAYABLE WITHIN 30 DAYS.



EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM

Prepared By:

Aetna Life & Casualty
Medicare Claim Administration
Yeon Building
522 S. W. 5th Avenue
Portland, Oregon 97204
Telephone No. 222-6831

DATE

4/1/71

IMPORTANT

HEALTH INSURANCE CLAIM NUMBER

517-09-0162A

FOR GENERAL INFORMATION, SEE THE REVERSE SIDE.

The enclosed Request for Medicare Payment form (SSA-1490) is for your use in submitting future claims.

BENEFICIARY'S NAME AND ADDRESS

B. B. Bolden
408 N. Park
Mt. View, Alaska 99504

LOCATION OF SERVICE CODES

SERVICES

DESCRIPTION OF SERVICE CODES

The following will explain the codes shown in the "Location of" column to the right.

The following will explain the number shown in the "Description of" column at left.

- O Doctor's Office
- IH Inpatient Hospital
- IL Independent Lab
- ECF Extended Care Facility
- H Patient's Home
- OH Outpatient Hospital
- OL Other Location
- NH Nursing Home

- 1 Medical Care
- 2 Surgery
- 3 Consultation
- 4 Diagnostic X-ray
- 5 Diagnostic Lab
- 6 Radiation Therapy
- 7 Anesthesia
- 8 Assistant Surgeon
- 9 Other Service
- 10 Whole Blood or Packed Red Blood Cells

LOCATION OF SERVICE CODES	FIRST DATE		LAST DATE		LOCATION OF	NUMBER OF	DESCRIPTION OF
	MO	DAY	MO	DAY			
	11	25	12	29	A.C. Chalmers	2	1
						1	2
						1	3
						1	4
						1	5
						1	6
						1	7
						1	8
						1	9
						1	10

Case or Med. Card No.

Remarks

If an amount is shown in the "Not Allowed" column at right, the paragraph checked below will explain.

- The Allowed Charge is less than the actual charge for psychiatric service, because only 62½% of such expenses are allowed under the law.
- The Allowed Charge is less than the actual charge for psychiatric service, because the \$250.00 maximum payable in one calendar year has been reached.
- The charges have been reduced to the amount indicated, because they have been determined to be higher than we can consider as covered expense under the Medicare Program.

06-33-6-350-380

Your \$50.00 deductible has been met for 19 70

BENEFITS PAID TO

Ben B. Bolden
AC CHALMERS, MD.
3300 PROVIDENCE
ANCH AK 99504

CHARGE	TOTAL	NOT ALLOWED	ALLOWED
	1	30.00	
2	5.00		5.00
3	10.00	2.00	8.00
4			
5			
6			
7			
8			
9			
10			

TOTAL ALLOWED CHARGES 4300

LESS DEDUCTIBLE

BALANCE OF ALLOWED CHARGES 4300

LESS 20% COINSURANCE 360

MEDICARE PAYS 3940

EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM

Prepared By: *JK*

Aetna Life & Casualty
Medicare Claim Administration
Yeon Building
522 S. W. 5th Avenue
Portland, Oregon 97204
Telephone No. 222-6831

DATE

4/1/71

IMPORTANT

HEALTH INSURANCE CLAIM NUMBER

517-09-0162A

FOR GENERAL INFORMATION, SEE THE REVERSE SIDE.

The enclosed Request for Medicare Payment form (SSA-1490) is for your use in submitting future claims.

BENEFICIARY'S NAME AND ADDRESS

B. B. Bolden

Ben Bolden

LOCATION OF SERVICE CODES

SERVICES

DESCRIPTION OF SERVICE CODES

The following will explain the codes shown in the "Location of" column to the right.

FIRST DATE	LAST DATE	LOCATION OF	NUMBER OF	RENDERED BY	DESCRIPTION OF
12	12	13	15	6	Dr. C. Chalmers

The following will explain the number shown in the "Description of" column at left.

- O Doctor's Office
- IH Inpatient Hospital
- IL Independent Lab
- ECF Extended Care Facility
- H Patient's Home
- OH Outpatient Hospital
- L Other Location
- H Nursing Home

- 1. Medical Care
- 2. Surgery
- 3. Consultation
- 4. Diagnostic X-ray
- 5. Diagnostic Lab
- 6. Radiation Therapy
- 7. Anesthesia
- 8. Assistant Surgeon
- 9. Other Service
- 0. Whole Blood or Packed Red Blood Cells

MISSISSIPPI

NO. 1

OFFICER TO EFFECT PAYMENT OF BENEFITS

Signature

06-22-3-370-385-71-0070

8-Digit Account Code

2-7-73

06A 55158-01

If an amount is shown in the "Not Allowed" column, the actual charge and the amount graph checked below will explain.

- The Allowed Charge is less than the actual charge for psychiatric service, because only 62 1/2% of such expenses are allowed under the law.
- The Allowed Charge is less than the actual charge for psychiatric service, because the \$250.00 maximum payable in one calendar year has been reached.
- The charges have been reduced to the amount indicated, because they have been determined to be higher than we can consider as covered expense under the Medicare Program.

06-33-6-350-380

Your \$50.00 deductible has been met for 19 *71*

BENEFITS PAID TO

Ben B. Bolden
AC CHALMERS, M.D.
3300 PROVIDENCE
ANCH. AK. 99504

	TOTAL	NOT ALLOWED	ALLOWED
1	30.00		30.00
2	5.00		5.00
3	10.00	2.00	8.00
4			
5			
6			
7			
8			
9			
10			

TOTAL ALLOWED CHARGES *4300*
LESS DEDUCTIBLE *1500*
BALANCE OF ALLOWED CHARGES *2800*
LESS 20% COINSURANCE *560*
MEDICARE PAYS *2240*



EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM

Prepared By:

Aetna Life & Casualty
Medicare Claim Administration
Yeon Building
522 S. W. 5th Avenue
Portland, Oregon 97204
Telephone No. 222-6831

DATE

8-9-71

IMPORTANT

HEALTH INSURANCE CLAIM NUMBER

517-09-0162A

FOR GENERAL INFORMATION, SEE THE REVERSE SIDE.

The enclosed Request for Medicare Payment form (SSA-1490) is for your use in submitting future claims.

BENEFICIARY'S NAME AND ADDRESS

B. B. Bolden
408 N. Park
Mt. View, AK Ben Bolden

LOCATION OF SERVICE CODES

The following will explain the codes shown in the "Location of" column to the right.

- O Doctor's Office
- IH Inpatient Hospital
- IL Independent Lab
- ECF Extended Care Facility
- H Patient's Home
- OH Outpatient Hospital
- OL Other Location
- NH Nursing Home

SERVICES

FIRST DATE	LAST DATE	LOCATION OF	NUMBER OF	RENDERED BY	DESCRIPTION OF
06	01	06	01	A.C. Chalmers	

DESCRIPTION OF SERVICE CODES

The following will explain the number shown in the "Description of" column at left.

- 1. Medical Care
- 2. Surgery
- 3. Consultation
- 4. Diagnostic X-ray
- 5. Diagnostic Lab
- 6. Radiation Therapy
- 7. Anesthesia
- 8. Assistant Surgeon
- 9. Other Service
- 0. Whole Blood or Packed Red Blood Cells

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- The Allowed Charge is less than the actual charge for psychiatric service, because the \$250.00 maximum payable in one calendar year has been reached.
- The charges have been reduced to the amount indicated, because they have been determined to be higher than we can consider as covered expense under the Medicare Program.

06-33-6-350-380

Your \$50.00 deductible has been met for 1971

BENEFITS PAID TO

Ben B. Bolden
A.C. CHALMERS, M.D.
3300 PROVIDENCE
ANCH. AK 99504

	TOTAL	NOT ALLOWED	ALLOWED
1	15.00	—	15.00
2	5.00	7.10	4.00
3			
4		5	
5		3	
6			
7			
8			
9			
10			

TOTAL ALLOWED CHARGES 19.00
 LESS DEDUCTIBLE —
 BALANCE OF ALLOWED CHARGES 19.00
 LESS 20% COINSURANCE 3.80
 MEDICARE PAYS 15.20

STATEMENT
AMBULANCE SERVICE
CITY OF FAIRBANKS

No. 3455

Date June 25, 1971

Requested by Leona Allridge

Address 4444 Woodriver

Phone No. 479-2034

Patient's Name Bernice Allridge

Home Address 4444 Woodriver Drive

From 4444 Woodriver Drive

To Fairbanks Community Hospital

Mileage 16

Nature of Service: Injury, Illness **xx** Transportation

Time Rec 1827

25.00

Aid Performed routine

Out 1828

12.00

Driver Willis

In 1907

First Aider Cherg

BILLING ADDRESS

Bernice Allridge

4444 Woodriver Drive

Fairbanks, Alaska 99701

DIVISION OF
PUBLIC WELFARE

FEB 12 1973

Statement to be returned to:

Revised Payment:

Cash Receipt:

Statement Must Be Returned With Remittance

33-6-380-380

37.00
Adm

FAIRBANKS MEDICAL & SURGICAL CLINIC • P. O. BOX 1330 • FAIRBANKS, ALASKA
 Internal Medicine General Surgery Pediatrics Orthopedics
 61 A. J. Straatsma, MD 61 A. J. Straatsma, MD 61 A. J. Straatsma, MD 61 A. J. Straatsma, MD
 62 G. W. Walkup, MD 62 G. W. Walkup, MD 62 G. W. Walkup, MD 62 G. W. Walkup, MD
 63 G. W. Walkup, MD 63 G. W. Walkup, MD 63 G. W. Walkup, MD 63 G. W. Walkup, MD
 64 G. W. Walkup, MD 64 G. W. Walkup, MD 64 G. W. Walkup, MD 64 G. W. Walkup, MD
 65 G. W. Walkup, MD 65 G. W. Walkup, MD 65 G. W. Walkup, MD 65 G. W. Walkup, MD
 66 G. W. Walkup, MD 66 G. W. Walkup, MD 66 G. W. Walkup, MD 66 G. W. Walkup, MD
 67 G. W. Walkup, MD 67 G. W. Walkup, MD 67 G. W. Walkup, MD 67 G. W. Walkup, MD
 68 G. W. Walkup, MD 68 G. W. Walkup, MD 68 G. W. Walkup, MD 68 G. W. Walkup, MD
 69 G. W. Walkup, MD 69 G. W. Walkup, MD 69 G. W. Walkup, MD 69 G. W. Walkup, MD
 70 G. W. Walkup, MD 70 G. W. Walkup, MD 70 G. W. Walkup, MD 70 G. W. Walkup, MD
 71 G. W. Walkup, MD 71 G. W. Walkup, MD 71 G. W. Walkup, MD 71 G. W. Walkup, MD
 72 G. W. Walkup, MD 72 G. W. Walkup, MD 72 G. W. Walkup, MD 72 G. W. Walkup, MD

DATE	CODE	DR.	PL.	CHARGES	REVERSE SIDE	BALANCE
						09 G. Straatsma, MD
						10 G. Walkup MD
						18 G. Murphy M.D.
						39 H. Sexton MD
11-25-71	09			90275 INTENSIVE CARE (12-2)		60.00 ✓
11-25-71	10			90250 LIMITED EET-2 @ 20.00 (12-10, 12-11)		40.00 ✓
11-25-71	09			90275 INTENSIVE CARE (12-3)		60.00 ✓
11-25-71	09			90250 LIMITED EET-15 @ 20.00 (12-3 thru 12-20)		300.00 ✓
11-25-71	09			90630 COMPLEX (12-1)		100.00 ✓
11-25-71	10			90610 CONSULT-EXTENSIVE (12-12)		50.00 ✓
11-25-71	39			47360 SURGERY ASSIST		80.00 ✓
11-25-71	39			39540 SURGERY ASSIST		90.00 ✓
11-25-71	18			32500 SURGERY		495.00 ✓
11-25-71	39			32500 SURGERY ASSIST		45.00 ✓
11-25-71	18			39540 SURGERY		900.00 ✓
11-25-71	18			13300 SURGERY		200.00 ✓
12-9-71	18			16015 SURGERY		180.00 ✓
11-25-71	18			47360 SURGERY		800.00 ✓
11-29-71	18			10121 SURGERY		100.00 ✓
12-1-71	18			31600 SURGERY		243.00 ✓
11-25-71	39			13300 SURGERY ASSIST		20.00 ✓
12-23-71	18			85010 BLOOD COUNT, COMPLETE		9.60 ✓
1-4-72	18			97003 PT-EXERCISE		12.00 ✓
1-4-72	18			97000 PT-1 MODALITIE		12.00 ✓
1-4-72	18			85010 BLOOD COUNT, COMPLETE		9.60 ✓

FAIRBANKS MEDICAL & SURGICAL CLINIC Continued
 P.O. BOX 1330 • FAIRBANKS, ALASKA 99701

STATEMENT

PLEASE DETACH AND RETURN WITH YOUR REMITTANCE AMOUNT PAID \$

FAIRBANKS MEDICAL & SURGICAL CLINIC • P. O. BOX 1330 • FAIRBANKS, ALASKA
 Internal Medicine General Surgery Pediatrics Orthopedics
 61 A. J. Straatsma, MD 61 A. J. Straatsma, MD 61 A. J. Straatsma, MD 61 A. J. Straatsma, MD
 62 G. W. Walkup, MD 62 G. W. Walkup, MD 62 G. W. Walkup, MD 62 G. W. Walkup, MD
 63 G. W. Walkup, MD 63 G. W. Walkup, MD 63 G. W. Walkup, MD 63 G. W. Walkup, MD
 64 G. W. Walkup, MD 64 G. W. Walkup, MD 64 G. W. Walkup, MD 64 G. W. Walkup, MD
 65 G. W. Walkup, MD 65 G. W. Walkup, MD 65 G. W. Walkup, MD 65 G. W. Walkup, MD
 66 G. W. Walkup, MD 66 G. W. Walkup, MD 66 G. W. Walkup, MD 66 G. W. Walkup, MD
 67 G. W. Walkup, MD 67 G. W. Walkup, MD 67 G. W. Walkup, MD 67 G. W. Walkup, MD
 68 G. W. Walkup, MD 68 G. W. Walkup, MD 68 G. W. Walkup, MD 68 G. W. Walkup, MD
 69 G. W. Walkup, MD 69 G. W. Walkup, MD 69 G. W. Walkup, MD 69 G. W. Walkup, MD
 70 G. W. Walkup, MD 70 G. W. Walkup, MD 70 G. W. Walkup, MD 70 G. W. Walkup, MD
 71 G. W. Walkup, MD 71 G. W. Walkup, MD 71 G. W. Walkup, MD 71 G. W. Walkup, MD
 72 G. W. Walkup, MD 72 G. W. Walkup, MD 72 G. W. Walkup, MD 72 G. W. Walkup, MD

DATE	CODE	DR.	PL.	CHARGES	REVERSE SIDE	BALANCE
						Dr.
1-4-72	90040			BRIEF ET-EST	18	12.00 ✓
1-7-72	97000			PT-1 MODALITIE	17	12.00 ✓
1-7-72	97003			PT-EXERCISE	17	
1-18-72	90040			BRIEF ET-EST	18	12.00 ✓
1-25-72	85050			HEMOGLOBIN, colorimetric	18	3.20 ✓
2-1-72	90040			BRIEF ET-EST	18	12.00 ✓
2-1-72	99105			ABDOMINAL BELT	18	30.00 ✓
						3,875.40

PAID 12/4/73 292.40

STATE DATED BALANCE 3583.00

ANY TRANSACTION AFTER THE 25th WILL APPEAR ON YOUR NEXT MONTHLY STATEMENT.

FAIRBANKS MEDICAL & SURGICAL CLINIC
 P.O. BOX 1330 • FAIRBANKS, ALASKA 99701

STATEMENT

PLEASE DETACH AND RETURN WITH YOUR REMITTANCE AMOUNT PAID \$

06-33-6-350-380

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

Send white & canary copies for payment.

25 Provider Ref 009-934

06

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Health Care Facility Invoice

Nº 507685 B

20 PATIENT INFORMATION		STAFF USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number DPW OAA 32037		RACE	Name of Provider Fairbanks Memorial Hospital	
Name of Patient ANDERSON, Peter A.			Provider ID Number FMH 280	Category 01
Date of Birth 06 / 28 / 02	Sex: M <input type="checkbox"/> F <input checked="" type="checkbox"/>	Resources	Payee ID Number (if different from above)	
Case Number		Attending Physician Raymond Evans, MD		ID Number
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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. Supplied	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					170.90
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					

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.

Signature: *Raymond Evans* Date: 10/24/73

Remarks:
see attached ledger copy

Resubmittal Indicator	Medical Review
-----------------------	----------------

23 COORDINATION OF OTHER BENEFITS

Other Benefits	Medicare
Medicare Paid 993.55	Co-Ins. 0
Ins. or Other Pd 0	Ded. 60.00
Total 993.55	Total 60.00

Total Charge	1053.55	Less	993.55	Amount Billed	60.00
--------------	---------	------	--------	---------------	-------

FROM

Mr. David R. Meek
Northern Regional Correctional Inst.
P.O. Box 317
Fairbanks, Alaska 99707

RETURN TO

Ms. Carolyn Hieb, Credit Mgr.
FAIRBANKS MEMORIAL HOSPITAL
1650 Cowles Street
Fairbanks, Alaska 99701

SUBJECT Kay Cupp - Deceased 1-21-72 005-444
State Jail to pay for 2 days only - Hospitalization

DATE 9 / 28 / 73

MESSAGE

Enclosed you will find the copies of all charges for the above named Kay Cupp. Total charges now stand at \$ \$ 2,234.50. Please adjust the balance due that was presented to you on 9-26-73 from \$ 1,924.34 to the outstanding balance of \$ 1,985.89.

Your assistance in this problem is greatly appreciated. If there is anything that I can do to be of any further assistance, please do not hesitate in contacting me at once.

Sincerely,

Carolyn Hieb
Carolyn Hieb / SIGNED

Credit Mgr.

REPLY

RECEIVED
OCT 9 / 1973
FISCAL SERVICES
BUREAU

SIGNED

DATE

Rediform 45-471

SEND PARTS 1 AND 3 WITH CARBON INTACT - PART 3 WILL BE RETURNED WITH REPLY

DEPT. Lab PTS. NO. 5-444 DATE 1/18/72 TIME 3 P.M. E 23969

PRINT NAME Cupp Kay

O.P. EMG. AGE 7 # 1041

DOCTOR Carter

DEPARTMENTAL CHARGES	
Hct	4 -

LAB. WANTED → TODAY STAT IN A.M. REC'D BY TIME A.M. P.M.

CENT. SUP. REC'D BY GIVEN BY RET'D BY

DEL. RM M F B. DATE / / TIME OF BIRTH A.M. P.M. TOTAL

X-RAY CLIN. IND. FOR EXAM. TAX

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X RAY CASE NO. PREVIOUS X RAY YES NO NURSE J. Thompson CHART DESK

DEPT. Lab PTS. NO. 5-444 DATE 1/18/72 TIME 9 A.M. E 23954

PRINT NAME Cupp Kay

O.P. EMG. AGE # 1041-4

DOCTOR Carter

DEPARTMENTAL CHARGES	
Na	10
K	10
Cl	10
HCO ₃	10
Ca	10

LAB. WANTED → TODAY STAT IN A.M. REC'D BY TIME A.M. P.M.

CENT. SUP. REC'D BY GIVEN BY RET'D BY

DEL. RM M F B. DATE / / TIME OF BIRTH A.M. P.M. TOTAL

X-RAY CLIN. IND. FOR EXAM. TAX

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X RAY CASE NO. PREVIOUS X RAY YES NO NURSE J. Collins CHART DESK

X

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. Lab	PTS. NO. 5-444	DATE 1/8/72	TIME 3	A.M. P.M.	E 23963
PRINT P.T.S. NAME Cupp Kay	LAST FIRST INITIAL	DOCTOR Carter		O.P. <input type="checkbox"/> EMG. <input type="checkbox"/>	AGE 77
LAB. WANTED → TODAY <input checked="" type="checkbox"/> STAT <input type="checkbox"/> IN A.M. <input checked="" type="checkbox"/>					TIME A.M. P.M.
CENT. SUP.	REC'D BY	GIVEN BY	RET'D BY		
DEL. RM. M <input type="checkbox"/> F <input type="checkbox"/>	B. DATE / /	TIME OF BIRTH	A.M. P.M. <input type="checkbox"/>	TOTAL	
X-RAY: CLIN. IND. FOR EXAM.	WHEEL CHAIR			TOTAL	
	BEDSIDE	CARRIER	PT. CAN STAND		
X-RAY CASE NO.	PREVIOUS X-RAY	YES <input type="checkbox"/> NO <input type="checkbox"/>	NURSE	CHART DESK	

Na, K, Cl HCO₃ Calcium 50 -

S. Thompson

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. Lab.	PTS. NO. 5-444	DATE 1/8/72	TIME	A.M. P.M.	E 23925
PRINT P.T.S. NAME Cupp Kay	LAST FIRST INITIAL	DOCTOR Murphy Carter		O.P. <input type="checkbox"/> EMG. <input type="checkbox"/>	AGE 77
LAB. WANTED → TODAY <input checked="" type="checkbox"/> STAT <input type="checkbox"/> IN A.M. <input type="checkbox"/>					TIME A.M. P.M.
CENT. SUP.	REC'D BY	GIVEN BY	RET'D BY		
DEL. RM. M <input type="checkbox"/> F <input type="checkbox"/>	B. DATE / /	TIME OF BIRTH	A.M. P.M. <input type="checkbox"/>	TOTAL	
X-RAY: CLIN. IND. FOR EXAM.	WHEEL CHAIR			TOTAL	
	BEDSIDE	CARRIER	PT. CAN STAND		
X-RAY CASE NO.	PREVIOUS X-RAY	YES <input type="checkbox"/> NO <input type="checkbox"/>	NURSE	CHART DESK	

Na, K, Cl at 6PM 1-8-72 30 -
+ Het 4 -
Cupp 5 -

G. Lincoln R.N.

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA

DEPARTMENTAL CHARGES

DEPT. *Lab* P.T.S. NO. *005-444* DATE *7/8/72* TIME *9:00* A.M. P.M. **E 24068**

PRINT P.T.S. NAME *Cupp, Kay* LAST FIRST INITIAL

O.P. A.G.E. I.C.U.-4
EMG.

DOCTOR *Carter*

Credit Sero. on min. cult 1/7 **(10)**

LAB WANTED → TODAY STAT IN A.M. REC'D BY TIME A.M. P.M.

CENT. SUP. REC'D BY GIVEN BY RET'D BY

DEL. RM. M F B. DATE / / TIME OF BIRTH A.M. P.M. TOTAL

X-RAY CLIN. IND. FOR EXAM TAX

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X-RAY CASE NO. PREVIOUS X-RAY YES NO NURSE CHART DESK *Lab*

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA

DEPARTMENTAL CHARGES

DEPT. *Lab* P.T.S. NO. *5-444* DATE *7/8/72* TIME *9:00* A.M. P.M. **E 23955**

PRINT P.T.S. NAME *Cupp, Kay* LAST FIRST INITIAL

O.P. A.G.E. I.C.U.-4
EMG.

DOCTOR *Carter*

Net **4** **X**

LAB WANTED → TODAY STAT IN A.M. REC'D BY TIME A.M. P.M.

CENT. SUP. REC'D BY GIVEN BY RET'D BY

DEL. RM. M F B. DATE / / TIME OF BIRTH A.M. P.M. TOTAL

X-RAY CLIN. IND. FOR EXAM TAX

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X-RAY CASE NO. PREVIOUS X-RAY YES NO NURSE CHART DESK *Lab*

DEPT. C.S. PTS. NO. 5-444 DATE 1/16/72 TIME 8 A.M. P.M. E 23924

PRINT NAME Cupp Kay INITIAL KC O.P. EMG. 1/16-4

DOCTOR Carter

<u>Metriostat</u>		<u>2</u>	<u>50</u>

LAB WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME A.M. P.M.

CENT SUP REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL RM M F B. DATE 1/1 TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY CLIN. IND. FOR EXAM. TAX _____

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL _____

X RAY PREVIOUS YES NO NURSE J. Thompson CHART DESK _____

CASE NO _____

DEPT. CS PTS. NO. 5-444 DATE 1/18/72 TIME _____ A.M. P.M. E 23723

PRINT NAME Cupp, Kay INITIAL KC O.P. EMG. 1/18

DOCTOR Carter

<u>1 Residue pressure manometer</u>		<u>4</u>	<u>00</u>
<u>My place ICU</u>			

LAB WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME A.M. P.M.

CENT SUP REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL RM M F B. DATE 1/1 TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY CLIN. IND. FOR EXAM. TAX _____

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL _____

X RAY PREVIOUS YES NO NURSE M. Jennings, JUN CHART DESK 100

CASE NO _____

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. CS | PTS. NO. 5-444 | DATE 1/18/72 | TIME 6 P.M. | E 23921

PRINT NAME CUPP KAY

O.P. ENG. AGE 40 SEX F

DOCTOR Can Taw/Murphy

<u>1 PA Tests -</u>	<u>6</u>	<u>50</u>

LAB WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME A.M. _____ P.M. _____

CENT. SUP. REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM. M F B. DATE / / TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY: CLIN. IND. FOR EXAM. _____ TAX _____

WHEEL CHAIR _____ BEDSIDE _____ CARRIER _____ PT. CAN STAND _____ TOTAL _____

X-RAY CASE NO. _____ PREVIOUS X-RAY _____ YES NO NURSE _____ CHART DESK H. Sullivan

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. Office | PTS. NO. 5-444 | DATE 1/18/72 | TIME 11 P.M. | E 23935

PRINT NAME CUPP KAY

O.P. ENG. AGE 40 SEX F

DOCTOR Carter

<u>3R-11P</u>	<u>RM Charge</u>	
<u>Total 8 hours</u>		<u>66.00</u>

LAB WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME A.M. _____ P.M. _____

CENT. SUP. REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM. M F B. DATE / / TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY: CLIN. IND. FOR EXAM. _____ TAX _____

WHEEL CHAIR _____ BEDSIDE _____ CARRIER _____ PT. CAN STAND _____ TOTAL _____

X-RAY CASE NO. _____ PREVIOUS X-RAY _____ YES NO NURSE _____ CHART DESK 1/18/72

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. Office PTS. NO. 5-444 DATE 1/18/72 TIME 7 A.M. P.M. E 23653

PRINT NAME Cupp, Kay LAST FIRST INITIAL

O.P. EMG. AGE 46 LOG # 100 ICU # 4

DOCTOR Carter

ICU Charge 7A-3P

Total = 8 hrs. 66.00

LAB WANTED → TODAY STAT IN A.M. REC'D BY

SENT BY REC'D BY GIVEN BY RET'D BY

DEL. PM M F B. DATE 1/1 TIME OF BIRTH A.M. P.M. TOTAL

X-RAY CLIN. IND. FOR EXAM. TAX

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X-RAY CASE NO. PREVIOUS X RAY YES NO REFUSE M. Jennings, LUN CHART DESK 100

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. Office PTS. NO. 5-444 DATE 1/18/72 TIME 7 A.M. P.M. E 23651

PRINT NAME Cupp, Kay LAST FIRST INITIAL

O.P. EMG. AGE 46 LOG # 100 ICU # 4

DOCTOR Carter

ICU Charge 11-7

Total Charge 66.00

LAB WANTED → TODAY STAT IN A.M. REC'D BY

SENT BY REC'D BY GIVEN BY RET'D BY

DEL. PM M F B. DATE 1/1 TIME OF BIRTH A.M. P.M. TOTAL

X-RAY CLIN. IND. FOR EXAM. TAX

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X-RAY CASE NO. PREVIOUS X RAY YES NO REFUSE Margaret CHART DESK 100

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

PRINT P.T.S. NAME: Cupp, Kay P.T.S. NO: 005-444 DATE: 7/3/72 TIME: 12 A.M. P.M. 12 E 14930

DOCTOR: Roth

DEPT.	PTS. NO.	DATE	TIME	A.M.	P.M.	E	NO.
<u>ICU</u>	<u>005-444</u>	<u>7/17/71</u>					<u>23908</u>

DEPT. NAME: Cupp, Kay INITIAL: K

O.P. EMG. A.C. E.C. SUG. EX

LAB. WANTED → TODAY <input type="checkbox"/> STAT <input type="checkbox"/> IN A.M. <input type="checkbox"/>	REC'D BY	GIVEN BY	RET'D BY	TIME	A.M.	P.M.	
CENT. SUP.	REC'D BY	GIVEN BY	RET'D BY				
DEL. RM.	M <input type="checkbox"/> F <input type="checkbox"/>	B. DATE	TIME OF BIRTH	A.M. <input type="checkbox"/>	P.M. <input type="checkbox"/>	TOTAL	
X-RAY: CLIN. IND. FOR EXAM.						TAX	
WHEEL CHAIR	BEDSIDE	CARRIER	PT. CAN STAND			TOTAL	
X RAY CASE NO.	PREVIOUS X-RAY	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	NURSE			CHART DESK	
			<u>B McDonald</u>				

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. ICU P.T.S. NO. 005-444 DATE: 7/17/71 TIME: 12 A.M. P.M. 12 E 23908

DEPT. NAME: Cupp, Kay INITIAL: K

O.P. EMG. A.C. E.C. SUG. ICU #4

DOCTOR: Chen

DEPT.	PTS. NO.	DATE	TIME	A.M.	P.M.	E	NO.
<u>ICU</u>	<u>005-444</u>	<u>7/17/71</u>					<u>23908</u>

DEPT. NAME: Cupp, Kay INITIAL: K

O.P. EMG. A.C. E.C. SUG. ICU #4

LAB. WANTED → TODAY <input type="checkbox"/> STAT <input type="checkbox"/> IN A.M. <input type="checkbox"/>	REC'D BY	GIVEN BY	RET'D BY	TIME	A.M.	P.M.	
CENT. SUP.	REC'D BY	GIVEN BY	RET'D BY				
DEL. RM.	M <input type="checkbox"/> F <input type="checkbox"/>	B. DATE	TIME OF BIRTH	A.M. <input type="checkbox"/>	P.M. <input type="checkbox"/>	TOTAL	
X-RAY: CLIN. IND. FOR EXAM.						TAX	
WHEEL CHAIR	BEDSIDE	CARRIER	PT. CAN STAND			TOTAL	
X RAY CASE NO.	PREVIOUS X-RAY	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	NURSE			CHART DESK	
			<u>K. Franko</u>			<u>ICU</u>	

FAIRBANKS COMMUNITY HOSPITAL

DEPT. Lab | PTS. NO. 055-444 | DATE 1/17/71 | TIME 8:15 A.M. / P.M. 55
 PRINT NAME Cupp, Kay | FIRST Kay | INITIAL K

O.P. | EMG. | A.C. | P.O. | ROOM ICU-4

DOCTOR Carter

DEPARTMENTAL CHARGES

Relative UA (STAT)
Serology
Culture + Sensitivity

6
37

LAB: WANTED → TODAY STAT IN A.M. REC'D BY

CENT. SUP. REC'D BY GIVEN BY RET'D BY

DEL. RM. M F B. DATE 1/1 TIME OF BIRTH A.M. P.M. TOTAL

X-RAY: CLIN. IND. FOR EXAM. Unnecessary TAX

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X-RAY CASE NO. PREVIOUS X-RAY YES NO NURSE K Freeman CHART DESK ICU

FAIRBANKS COMMUNITY HOSPITAL

DEPT. Lab | PTS. NO. 5-404 | DATE 1/17/72 | TIME 3:45 A.M. / P.M. 11
 PRINT NAME Cupp, Kay | FIRST Kay | INITIAL K

O.P. | EMG. | A.C. | P.O. | ROOM ICU-4

DOCTOR Carter / Murphy

DEPARTMENTAL CHARGES

Type + cross for 3 Units Blood
type rh

81
132

LAB: WANTED → TODAY STAT IN A.M. REC'D BY

CENT. SUP. REC'D BY GIVEN BY RET'D BY

DEL. RM. M F B. DATE 1/1 TIME OF BIRTH A.M. P.M. TOTAL

X-RAY: CLIN. IND. FOR EXAM. TAX

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X-RAY CASE NO. PREVIOUS X-RAY YES NO NURSE bloodins CHART DESK ICU

FAIRBANKS COMMUNITY HOSPITAL
FAIRBANKS, ALASKA

DEPT. X-Ray PTS. NO. 005-444 DATE 1/7/71 TIME 1:20 (P.M.) E 5070

PRINT NAME Cuppa Kay FIRST Cuppa LAST Kay INITIAL CK O.P. P.M.S. A.G.E. 24 ROOM ICU

DOCTOR Reith

<u>skull films</u>	<u>45</u>	<u>-</u>

LAB. WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME _____ A.M. _____ P.M. _____

CENT. SUP. REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM. M F B. DATE / / TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY: CLIN. IND. FOR EXAM. _____ TAX _____

WHEEL CHAIR _____ BEDSIDE _____ CARRIER _____ PT. CAN STAND _____ TOTAL _____

X-RAY CASE NO. 72-119 PREVIOUS X-RAY YES NO NURSE B. McDonald CHART DESK _____

DEPT. X-ray PTS. NO. 005-444 DATE 1/7/72 TIME _____ A.M. _____ P.M. _____ E 15907

PRINT NAME Cuppa Kay FIRST Cuppa LAST Kay INITIAL CK O.P. P.M.S. A.G.E. 44 ROOM ICU

DOCTOR Murphy

<u>Dist. Central Arteriosclerosis</u>	<u>50</u>	<u>00</u>

LAB. WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME _____ A.M. _____ P.M. _____

CENT. SUP. REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM. M F B. DATE / / TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY: CLIN. IND. FOR EXAM. _____ TAX _____

WHEEL CHAIR _____ BEDSIDE _____ CARRIER _____ PT. CAN STAND _____ TOTAL _____

X-RAY CASE NO. 72-132 PREVIOUS X-RAY YES NO NURSE A. Johnson CHART DESK OR

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA

DEPARTMENTAL CHARGES

PRINT P.T.S. NAME *Cupp, Kay* INITIAL *CC* (P.M.) *10010*

DOCTOR *Carter / Murphy*

O.P. A.M. EMG. E.T. 10010

<i>Spiral fluid for:</i>	<i>Cells</i>	<i>4</i>	<i>—</i>
	<i>Cultures</i>	<i>20</i>	<i>—</i>
	<i>Protein</i>	<i>10</i>	<i>—</i>
	<i>CPK</i>	<i>5</i>	<i>—</i>
	<i>SHIPPING (Per ice)</i>	<i>10</i>	<i>—</i>

LAB. WANTED → TODAY STAT IN A.M. REC'D BY

CENT. SUP. REC'D BY GIVEN BY RET'D BY TIME A.M. P.M.

DEL. RM. M B. DATE / / TIME OF BIRTH A.M. P.M. TOTAL TAX TOTAL

X-RAY: CLIN. IND. FOR EXAM. WHEEL CHAIR X RAY CASE NO. BEDSIDE PREVIOUS X-RAY CARRIER YES NO NURSE PT. CAN STAND CHART DESK *CC*

Collins

DEPT. *IT* PTS. NO. *665444* DATE *1/1* TIME *9* A.M. P.M. *E 13520*

PRINT P.T.S. NAME *Cupp Kay* INITIAL *CC* O.P. A.M. EMG. E.T. 10010

DOCTOR *Murphy*

<i>Wanted Normal 24 hrs</i>	<i>60</i>	<i>00</i>
<i>New set up</i>	<i>5</i>	<i>00</i>

LAB WANTED → TODAY STAT IN A.M. REC'D BY TIME A.M. P.M.

CENT. SUP. REC'D BY GIVEN BY RET'D BY TIME A.M. P.M. TOTAL *65* *00*

DEL. RM. M B. DATE / / TIME OF BIRTH A.M. P.M. TAX TOTAL

X-RAY: CLIN. IND. FOR EXAM. WHEEL CHAIR X RAY CASE NO. BEDSIDE PREVIOUS X-RAY CARRIER YES NO NURSE PT. CAN STAND CHART DESK *CC*

Collins

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA

DEPARTMENTAL CHARGES

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. IT PTS. NO. 5-444 DATE 1/7/72 TIME 6 A.M. P.M. E 23912

PRINT NAME Cupp, Ray INITIAL R

O.P. AGE 100-9
EMG

DOCTOR Murphy

<u>7.3m Endotrach tube</u>	<u>5</u>	<u>50</u>
<u>36 F6 9m Endotrach tube</u>	<u>12</u>	<u>50</u>
<u>Continuous Respiration 3 hrs on 1/7/72 - Daily Max 1/8/72</u>	<u>80</u>	<u>50</u>
<u>O₂ 1 1/2 hrs</u>	<u>27</u>	<u>50</u>
<u>Heated Aerosol O₂ x 27 hrs. + set up</u>	<u>97</u>	<u>50</u>

LAB WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME _____ A.M. P.M. _____

CENT NO. _____ REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL RM _____ M F B DATE 1/1 TIME OF BIRTH _____ A.M. P.M. TOTAL 222

X-RAY CLIN. IND. FOR EXAM. _____ TAX _____

WHEEL CHAIR _____ REOSIDE _____ CARRIER _____ PT. CAN STAND _____ TOTAL _____

X-RAY PREVIOUS YES NO NURSE _____ CHART DESK (P2)

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. Surg. PTS. NO. 005-444 DATE 1/7/72 TIME _____ A.M. P.M. E 15761

PRINT NAME Cupp, Ray INITIAL R

O.P. AGE 44
EMG

DOCTOR Murphy

Head injury (Subdural Hemorrhage) Murphree

<u>Artes. 4.50</u>	<u>(2) 3M Staples - Pelham</u>	<u>10.00</u>
<u>Surg. 4.00</u>	<u>Arteriosgrams</u>	<u>350.00</u>
<u>Surg. 8.40</u>		
<u>Artes. 8.50</u>	<u>Craniotomy - Tracheostomy</u>	
	<u>Artes. Arter.</u>	<u>80 -</u>
	<u>Artes. Admin.</u>	<u>340 -</u>

HAT 61310

LAB WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME _____ A.M. P.M. _____

CENT NO. _____ REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL RM _____ M F B DATE 1/1 TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY CLIN. IND. FOR EXAM. _____ TAX _____

WHEEL CHAIR _____ REOSIDE _____ CARRIER _____ PT. CAN STAND _____ TOTAL _____

X-RAY PREVIOUS YES NO NURSE _____ CHART DESK O.R.

Dr. Qureshi Ben.

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT.	P.S.	PTS. NO.	5-444	DATE	1/17/72	TIME	A.M. P.M.	3751	
PRINT PTS. NAME	Cups, Kay		LAST	FIRST	MIDDLE				
						O.P. EMG.	<input type="checkbox"/>	A G E	100
						DOCTOR			Carter - Murphy
1000 w NS for mg						AS		175	
Refuse to fill, please									
LAB WANTED → TODAY <input type="checkbox"/> STAT <input type="checkbox"/> IN A.M. <input type="checkbox"/>						REC'D BY	TIME	A.M. P.M.	
CENT. SLIP	REC'D BY	GIVEN BY		RET'D BY					
DEL. RM	M <input type="checkbox"/> F <input type="checkbox"/>	B. DATE	/ /	TIME OF BIRTH		A.M. <input type="checkbox"/> P.M. <input type="checkbox"/>	TOTAL		
X-RAY	CLIN. IND. FOR EXAM					TAX			
WHEEL CHAIR	BEDSIDE	CARRIER	PT. CAN STAND		TOTAL				
X-RAY CASE NO.	PREVIOUS X-RAY	YES <input type="checkbox"/> NO <input type="checkbox"/>	NURSE		CHART DESK				

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT.	C.S.	PTS. NO.	005-444	DATE	1/17/72	TIME	A.M. P.M.	17618	
PRINT PTS. NAME	Cups, Kay		LAST	FIRST	MIDDLE				
						O.P. EMG.	<input type="checkbox"/>	A G E	100
						DOCTOR			Carter - Murphy
90 lbs. elements (used in planning)								20.00	
LAB WANTED → TODAY <input type="checkbox"/> STAT <input type="checkbox"/> IN A.M. <input type="checkbox"/>									
CENT. SLIP	REC'D BY	GIVEN BY		RET'D BY					
DEL. RM	M <input type="checkbox"/> F <input type="checkbox"/>	B. DATE	/ /	TIME OF BIRTH		A.M. <input type="checkbox"/> P.M. <input type="checkbox"/>	TOTAL		
X-RAY	CLIN. IND. FOR EXAM					TAX			
WHEEL CHAIR	BEDSIDE	CARRIER	PT. CAN STAND		TOTAL				
X-RAY CASE NO.	PREVIOUS X-RAY	YES <input type="checkbox"/> NO <input type="checkbox"/>	NURSE		CHART DESK				

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. CS PTS. NO. 5-444 DATE 1/7/72 TIME 3 A.M. P.M.

PRINT P.T.S. NAME Cupp, Kay LAST FIRST INITIAL

DOCTOR Carter

1 50cc Omni Syringes		1	00
7 Sterile Bedset			25
7 Sterile Bedset			
Replace to room			

LAB WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME A.M. _____ P.M. _____

CENT SUP REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM M F B. DATE 1/1 TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY: CLIN. IND. FOR EXAM. _____ TAX _____

WHEEL CHAIR BEESIDE CARRIER PT. CAN STAND TOTAL _____

X RAY CASE NO. PREVIOUS X RAY YES NO NURSE Eden CHART DESK Eden

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. CS PTS. NO. 005-444 DATE 1/7/72 TIME _____ A.M. _____ P.M. _____

PRINT P.T.S. NAME Cupp, Kay LAST FIRST INITIAL

DOCTOR Carter

menstrual - 7			7.00
replace to room			

LAB WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME A.M. _____ P.M. _____

CENT SUP REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM M F B. DATE 1/1 TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY: CLIN. IND. FOR EXAM. _____ TAX _____

WHEEL CHAIR BEESIDE CARRIER PT. CAN STAND TOTAL _____

X RAY CASE NO. PREVIOUS X RAY YES NO NURSE K. Riley CHART DESK _____

8141

C. 39493

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. <i>OS</i>	PTS. NO. <i>005-444</i>	DATE <i>7/1/72</i>	TIME	A.M. <input type="checkbox"/>	P.M. <input checked="" type="checkbox"/>	E 20756
PRINT PTS. NAME <i>Cupp Kay</i>	INITIAL		O.P. <input type="checkbox"/>	EMG. <input type="checkbox"/>	AGE	ROOM NO. <i>9.004</i>
DOCTOR <i>Carter</i>						
<i>1 - X-ray Paranasal Sin</i>					<i>4.00</i>	
<i>Referral to ICU</i>						
LAB. WANTED → TODAY <input type="checkbox"/> STAT <input type="checkbox"/> IN A.M. <input type="checkbox"/>			REC'D BY	TIME	A.M.	P.M.
CENT SUP.	REC'D BY	GIVEN BY	RET'D BY			
DEL. RM. M <input type="checkbox"/> F <input type="checkbox"/>	B. DATE <i>1/1</i>	TIME OF BIRTH	A.M. <input type="checkbox"/>	P.M. <input type="checkbox"/>	TOTAL	
X-RAY CLIN. IND. FOR EXAM.					TAX	
WHEEL CHAIR	BEDSIDE	CARRIER	PT. CAN STAND	TOTAL		
X-RAY CASE NO.	PREVIOUS X-RAY	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	NURSE	CHART DESK	
<i>M. Riley RN</i>					<i>ICU</i>	

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. <i>OS</i>	PTS. NO. <i>005-444</i>	DATE <i>7/1/72</i>	TIME	A.M. <input type="checkbox"/>	P.M. <input checked="" type="checkbox"/>	E 20890
PRINT PTS. NAME <i>Cupp Kay</i>	INITIAL		O.P. <input type="checkbox"/>	EMG. <input type="checkbox"/>	AGE	ROOM NO. <i>9.004</i>
DOCTOR <i>Carter</i>						
<i>2-114</i>					<i>5.00</i>	
<i>Referral to ICU</i>						
LAB. WANTED → TODAY <input type="checkbox"/> STAT <input type="checkbox"/> IN A.M. <input type="checkbox"/>			REC'D BY	TIME	A.M.	P.M.
CENT SUP.	REC'D BY	GIVEN BY	RET'D BY			
DEL. RM. M <input type="checkbox"/> F <input type="checkbox"/>	B. DATE <i>1/1</i>	TIME OF BIRTH	A.M. <input type="checkbox"/>	P.M. <input type="checkbox"/>	TOTAL	
X-RAY CLIN. IND. FOR EXAM.					TAX	
WHEEL CHAIR	BEDSIDE	CARRIER	PT. CAN STAND	TOTAL		
X-RAY CASE NO.	PREVIOUS X-RAY	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	NURSE	CHART DESK	
<i>M. Riley RN</i>					<i>ICU</i>	

FAIRBANKS COMMUNITY HOSPITAL
FAIRBANKS, ALASKA

DEPARTMENTAL CHARGES

DEPT. *C.S.* PTS. NO. *005-444* DATE *1/7/62* TIME *E 23821*

PRINT NAME *Cupp Kay* INITIAL *K*

DOCTOR *Carter*

O.P. A.G.E. E. BOOK NO. *5014*

1 - Closed drainage unit	1	25
1 - IV Sundry supplies		25
<i>Replace to ICU</i>		

LAB. WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME _____ A.M. _____ P.M. _____

CENT. SUP. REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM. M F B. DATE *1/1* TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY CLIN. IND. FOR EXAM. _____ TAX _____

WHEEL CHAIR _____ BEDSIDE _____ CARRIER _____ PT. CAN STAND _____ TOTAL _____

X-RAY PREVIOUS X-RAY YES NURSE NO CHART DESK *D. Riley RN*

FAIRBANKS COMMUNITY HOSPITAL
FAIRBANKS, ALASKA

DEPARTMENTAL CHARGES

DEPT. *C.S.* PTS. NO. *005-444* DATE *1/7/71* TIME *D190448*

PRINT NAME *Cupp Kay* INITIAL *K*

DOCTOR *Carter*

O.P. A.G.E. E. BOOK NO. *5014*

1 - Foley cath set	7	25
1 - ...	3	00
1 - P. Run	15	00

LAB. WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME _____ A.M. _____ P.M. _____

CENT. SUP. REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM. M F B. DATE *1/1* TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY CLIN. IND. FOR EXAM. _____ TAX _____

WHEEL CHAIR _____ BEDSIDE _____ CARRIER _____ PT. CAN STAND _____ TOTAL _____

X-RAY PREVIOUS X-RAY YES NURSE NO CHART DESK *D. Riley RN*

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. CS PTS. NO. 005-444 DATE 1/7/72 TIME _____ A.M. _____ P.M. E 23731

PRINT PTS. NAME Cobb Kay LAST FIRST INITIAL

DOCTOR Porter

<u>Wentworth #18</u>		<u>2</u>	<u>00</u>
<u>Raymond To DCU</u>			

LAB. WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME _____ A.M. _____ P.M.

CENT. SUP. REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM. M F B. DATE 1/1 TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY: CLIN. IND. FOR EXAM. _____ TAX _____

WHEEL CHAIR _____ BEDSIDE _____ CARRIER _____ PT. CAN STAND _____ TOTAL _____

X-RAY CASE NO. _____ PREVIOUS X-RAY _____ YES NO NURSE D. Kelly RN CHART DESK JCU

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. R PTS. NO. 005-444 DATE 1/7/72 TIME _____ A.M. _____ P.M. E 23904

PRINT PTS. NAME Cupp Kay LAST FIRST INITIAL

DOCTOR _____

<u>Pain control 5-0 mg</u>	<u>Drug</u>	<u>25</u>	<u>25</u>
<u>1000 cc Normal saline</u>	<u>IV</u>	<u>6</u>	<u>50</u>
<u>1000 cc Post Anqer</u>	<u>IV</u>	<u>8</u>	<u>00</u>

LAB. WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME _____ A.M. _____ P.M.

CENT. SUP. REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM. M F B. DATE 1/1 TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY: CLIN. IND. FOR EXAM. _____ TAX _____

WHEEL CHAIR _____ BEDSIDE _____ CARRIER _____ PT. CAN STAND _____ TOTAL _____

X-RAY CASE NO. _____ PREVIOUS X-RAY _____ YES NO NURSE None CHART DESK _____

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA

DEPARTMENTAL CHARGES

DEPT. *ICU* HTS. NO. *025-444* DATE *7/7/71* TIME *E* A.M. *3620*
P.M.

PRINT NAME *Rupp, Kay*
LAST FIRST INITIAL

O.P. A.C.E. ENG. *2 1/2* *ICU #4*

DOCTOR *Carter*

<i>Provision</i>	<i>120/100</i>	<i>10</i>
<i>Out</i>	<i>25</i>	<i>-</i>

LAB. WANTED → TODAY STAT IN A.M. REC'D BY TIME A.M. P.M.

CENT. SUP. REC'D BY GIVEN BY RET'D BY

DEL. RM. M B. DATE */ /* TIME OF BIRTH A.M. P.M. TOTAL

X-RAY: CLIN. IND. FOR EXAM. TAX

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X-RAY CASE NO. PREVIOUS X-RAY YES NO NURSE *X Freeman* CHART DESK *Jen*

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. ICU | PTS. NO. 005-444 | DATE 7/7/71 | TIME | A.M. | P.M. | E 23907

PRINT NAME Cupp, Ray | LAST Cupp | FIRST Ray | INITIAL

O.P. ENG. | A.G.E. 44 | ROOM ICU #4

DOCTOR Carter

Pro Time	8	-	
Waiting Time	15	-	

LAB WANTED → TODAY STAT IN A.M. REC'D BY TIME A.M. P.M.

CENT. SUP. REC'D BY GIVEN BY RET'D BY

DEL RM M F B. DATE / / TIME OF BIRTH A.M. P.M. TOTAL

X-RAY CLIN. IND. FOR EXAM. Unconscious TAX

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X-RAY CASE NO. PREVIOUS X-RAY YES NO NURSE CHART DESK

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT. Office | PTS. NO. 5-044 | DATE 7/7/72 | TIME 3 | A.M. | P.M. | E 23913

PRINT NAME Cupp, Ray | LAST Cupp | FIRST Ray | INITIAL

O.P. ENG. | A.G.E. 37 | ROOM 104-4

DOCTOR Carter / Murphy

10M Charge			
1:30P → 3P			
Total - 10 Ms	Total Hour, 30 min	14.00	70.00

LAB WANTED → TODAY STAT IN A.M. REC'D BY TIME A.M. P.M.

CENT. SUP. REC'D BY GIVEN BY RET'D BY

DEL RM M F B. DATE / / TIME OF BIRTH A.M. P.M. TOTAL

X-RAY CLIN. IND. FOR EXAM. TAX

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X-RAY CASE NO. PREVIOUS X-RAY YES NO NURSE CHART DESK

FAIRBANKS COMMUNITY HOSPITAL

DEPARTMENTAL CHARGES

DEPT. Pharm. | PTS. NO. 005-444 | DATE 1/7/72 | TIME 15734 A.M. P.M.

PRINT NAME Cupt. Kay | INITIAL SK | O.P. | EMG. | AGE 46 | SEX SCU

DOCTOR

<u>Drug</u>	<u>Thrombin</u>	<u>2 vials</u>	<u>7</u>	<u>10</u>
<u>CS</u>	<u>CV P act</u>		<u>4</u>	<u>25</u>
<u>OR</u>	<u>EKG monitor</u>		<u>10</u>	<u>50</u>
<u>CS</u>	<u>Urea</u>		<u>20</u>	<u>00</u>
<u>Drug</u>	<u>Chloramphenicol</u>	<u>3 grams</u>	<u>17</u>	<u>50</u>

LAB WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME A.M. P.M.

CENT. SUP. REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM. M F B. DATE / / TIME OF BIRTH A.M. P.M. TOTAL

X-RAY CLIN. IND. FOR EXAM. TAX TOTAL

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X RAY CASE NO. PREVIOUS X RAY YES NO NURSE E. Shesgo CHART DFSK OR.

FAIRBANKS COMMUNITY HOSPITAL

DEPARTMENTAL CHARGES

DEPT. Lab. | PTS. NO. 005-444 | DATE 1/7/72 | TIME 15762 A.M. P.M.

PRINT NAME Cupt. Kay | INITIAL SK | O.P. | EMG. | AGE 46 | SEX SCU

DOCTOR Murphy

	<u>Blood</u>	<u>1 unit Admin</u>	<u>15</u>	<u>—</u>
		<u>Processing</u>	<u>18</u>	<u>—</u>
		<u>Replenishment</u>	<u>25</u>	<u>—</u>
		<u>HAB testing</u>	<u>5</u>	<u>—</u>

LAB WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME A.M. P.M.

CENT. SUP. REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM. M F B. DATE / / TIME OF BIRTH A.M. P.M. TOTAL

X-RAY CLIN. IND. FOR EXAM. TAX TOTAL

WHEEL CHAIR BEDSIDE CARRIER PT. CAN STAND TOTAL

X RAY CASE NO. PREVIOUS X RAY YES NO NURSE E. Shesgo CHART DFSK OR.

FAIRBANKS COMMUNITY HOSPITAL

FAIRBANKS, ALASKA
DEPARTMENTAL CHARGES

DEPT Lab. | PTS. NO. 005-444 | DATE 1/7/72 | TIME 15970
A.M. P.M.

PRINT
PTS.
NAME Cupak, Kay

OP. A.G. 46
EMG. E.Y. 30

DOCTOR Murphy

	<u>Adminis</u>	<u>15</u>	<u>-</u>
	<u>Blood 1 unit</u>		
	<u>Processing</u>	<u>18</u>	<u>-</u>
	<u>Replacement</u>	<u>25</u>	<u>-</u>
	<u>HAA Testing</u>	<u>5</u>	<u>-</u>

LAB. WANTED → TODAY STAT IN A.M. REC'D BY _____ TIME A.M. P.M.

CENT. SUP. REC'D BY _____ GIVEN BY _____ RET'D BY _____

DEL. RM. M F B. DATE / / TIME OF BIRTH _____ A.M. P.M. TOTAL _____

X-RAY: CLIN. IND. FOR EXAM. TAX _____

WHEEL CHAIR BEDSIDE CARRIER IT. CAN STAND TOTAL _____

X-RAY CASE NO. PREVIOUS X-RAY YES NO NURSE E. Shaffer CHART DESK O.R.

Cupp, KAY (46)

303

005-444 25 1/7/72 12:20pm

Dot

Page 2

Kay Cupp
916 23rd Street
Fairbanks, Alaska 99701

FAIRBANKS COMMUNITY HOSPITAL

119 N. CUSHMAN STREET - PHONE: 456-6655
FAIRBANKS, ALASKA 99701

SELF PAY

DATE TIME DISCHARGE

21-72

EXPIRED 8:45 AM

DESCRIPTION	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
									5,292.45
								BALANCE FORWARDED	
19 OR	95.00		12.00	40.00					
19 ORS OZ	20.00		113.00						
19 ORS	40.00					64.00		5,676.45	5,676.45
20 ORS	8.50	294.25	71.30		44.00	64.00		6,158.50	6,158.50
21		31.90	4.45						
21		77.50						6,272.35	6,272.35
			77.50					6,272.35	
						05-05-72			6,234.85*
						05-24-72			
									6,222.35*
						05-24-72			6,222.35*
21818 ST OF AK						10-30-72	24.00	5,973.74*	
SUB TOTALS	163.50	403.65	900.75	40.00		128.00			
							TOTAL CHARGES		
							LESS: COVERAGE		
							DUE FROM PATIENT		

EXPLANATION OF SYMBOLS

- ANESTHESIA
- EKG ELECTROCARDIOGRAM
- EMERGENCY SURGERY OR SERVICES
- EMERGENCY SURGERY
- LABORATORY
- NEUROLOGY
- DEPARTMENTAL CREDIT
- OPERATING ROOM
- OXYGEN
- PHYSIOTHERAPY
- PLASMA
- REFUND
- TELEPHONE
- TENSOR
- TRANSFUSION
- X-RAY

CUPP, Kay NMI (46)

Er 005-444 1-7-72 @12:20pm
 ICU 1/15/72
 303 1-7-72 @1:10pm

Kay Cupp
 916 23rd
 Fairbanks, Alaska
 99701

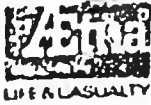
FAIRBANKS COMMUNITY HOSPITAL
 119 N. CUSHMAN STREET - PHONE: 456-6655
 FAIRBANKS, ALASKA 99701

DATE & TIME
 DISCHARGE

DATE	DESCRIPTION	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
7							70.00		70.00	70.00
8							168.00		238.00	238.00
9	ES	8.50	52.85	179.25	127.00	497.00				
9	IV	360.00	14.50							
9	WES TR	80.00		30.00						
9	WES 3B	340.00				36.00				
9	WES 02	650.00		222.00		30.00	168.00		2,433.10	2,433.10
10				13.60		351.00				
10	PHY 02	17.00		65.00			168.00		3,030.70	3,030.70
10	PHY 02	17.00		42.00			168.00		3,257.70	3,257.70
12	PHY 02	8.50	404.95	11.50	26.00	50.00			3,991.65	3,991.65
12	PHY 02	17.00		65.00			168.00		4,290.70	4,290.70
13	PHY 02	17.00		24.05		30.00			4,450.70	4,450.70
13	PHY 02	17.00		60.00			168.00		4,616.50	4,616.50
14	PHY 02	17.00					168.00		4,784.50	4,784.50
15	PHY 02	17.00					147.00		4,931.50	4,931.50
16	PHY 02	8.50	68.35	43.20		45.00			5,030.05	5,030.05
16	PHY 02	8.50		57.50			64.00		5,093.05	5,093.05
17	PHY 02	8.50		33.80					5,201.35	5,201.35
17	PHY 02	8.50		202.00			64.00		5,292.45	5,292.45
18	PHY 02	8.50		18.60			64.00		5,292.45	5,292.45
SUB TOTALS								TOTAL CHARGES		
								LESS COVERAGE		
								DUE FROM PATIENT		

EXPLANATION OF SYMBOLS

1. E. P. ...
 2. EMERGENCY ...
 3. ...
 4. ...
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 94. ...
 95. ...
 96. ...
 97. ...
 98. ...
 99. ...
 100. ...



EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM

Prepared By:

Etna Life & Casualty
Medicare Claim Administration
Yoon Building
522 S. W. 5th Avenue
Portland, Oregon 97204
Telephone No. 222-6831

DATE

2-23-72

HEALTH INSURANCE CLAIM NUMBER

574-12-379M

IMPORTANT

FOR GENERAL INFORMATION, SEE THE REVERSE SIDE.

The enclosed Request for Medicare Payment form (SSA-1490) is for your use in submitting future claims.

RECIPIENT'S NAME AND ADDRESS
MR

R. Kirsch
Carriage House
Anchorage, AK

LOCATION OF SERVICE CODES

The following will explain the codes shown in the "Location of" column to the right.

- O Doctor's Office
- IH Inpatient Hospital
- IL Independent Lab
- ECF Extended Care Facility
- H Patient's Home
- OH Outpatient Hospital
- OL Other Location
- NH Nursing Home

SERVICES

NO.	FIRST DATE		LAST DATE		LOCATION OF	NUMBER OF	RENDERED BY	DESCRIPTION
	MO	DAY	MO	DAY				
1	03	23	03	24	0	01	L. D. Ferrucci, MD	1
2								
3								
4								
5								
6								
7								
8								
9								
10								

DESCRIPTION OF SERVICE CODES

The following will explain the number shown in the "Description of" column of left.

- 1. Medical Care
- 2. Surgery
- 3. Consultation
- 4. Diagnostic X-ray
- 5. Diagnostic Lab
- 6. Radiation Therapy
- 7. Anesthetic
- 8. Assistant Surgeon
- 9. Other Service
- 0. Whole Blood or Packed Red Blood Cells

THIS

If an amount is shown in the "Not Allowed" column at right, the paragraph checked below will explain.

- The Allowed Charge is less than the actual charge for psychiatric service, because only 62 1/2% of such expenses are allowed under the law.
- The Allowed Charge is less than the actual charge for psychiatric service, because the \$250.00 maximum payable in one calendar year has been reached.
- The charges have been reduced to the amount indicated, because they have been determined to be higher than we can consider as covered expense under the Medicare Program.

06-33-6-350-380

Your \$50.00 deductible has been met for 19 71

DEBITS PAID TO

L. D. Ferrucci, MD
Prot. Prof. Bldg #34
Anchorage, AK 99504

CHARGES	TOTAL	NOT ALLOWED	ALLOWED
	1	30.00	
2			
3			
4			
5			
6			
7			
8			
9			
10			

TOTAL ALLOWED CHARGES

LESS DEDUCTIBLE 5.00

BALANCE OF ALLOWED CHARGES 24.11

LESS 20% COINSURANCE 4.82

MEDICARE PAYS 19.29

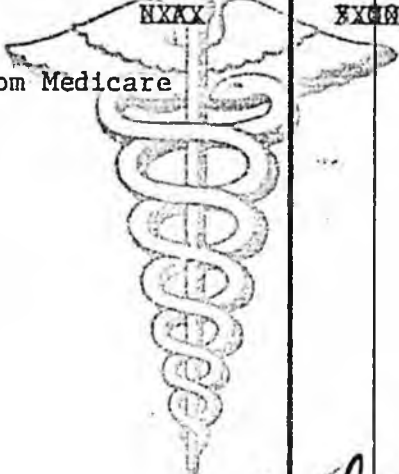
STATEMENT
LEONARD D. FERUCCI, M.D.,

OBSTETRICS & GYNECOLOGY
Providence Professional Bldg. Suite 304 -3300 Providence Rd.
Phone 279-0588 (24 Hours) Anchorage, Alaska

RECEIVED
MAR 9 1973

Division of Family &
Children Services

DATE	FAMILY MEMBER	DESCRIPTION	CHARGE	CREDITS		CURRENT BALANCE
				PAYMENTS	ADJ.	
RE: ROSE M. KIRSCH			BALANCE FORWARD →			
2/23/73	Rose	Initial GYN exam. Lab. Fee: Pap NXKX	\$30.00 6.00 EXOR			\$36.00 \$XX.00
2/28/72	Received	from Medicare		\$20.00		\$16.00 10.00



State Gate

PLEASE PAY LAST AMOUNT THIS COLUMN →

- | | | |
|---------------------|---------------------|------------------|
| IG—Initial GYN | CZ—Cauterize | CC—Circumcision |
| IOB—Initial OB | IUD—I.U.D. | BI—Biopsy |
| ROB—Return OB | IJ—Injection | C—Consultation |
| FUV—Follow-Up Visit | LAB—Laboratory | HC—Hospital Care |
| OC—Office Call | IP—Insurance Papers | S—Surgery |

G. O. GOULD, D.D.S.
1080 FIREWEED LANE
SPENARD, ALASKA 99503

9-17-73

Re: Danny Davidson
Mother Anita Amick
Welfare
Dentist Robert Biggs

Billing for Danny Davidson

12-8-69	#30 FO	Amalgam Filling	\$20.00
" "	#31 FO	" "	20.00
" "	#19 FO	" "	20.00
" "	#18 FO	" "	20.00
1-13-70	#3 OL	" "	20.00
" "	#14 O	" "	15.00

Total

\$115.00

This was never billed at the time work was done because mother did not tell us she was on welfare. We hve recently been contacted by our collection agency to whom we had turned the account over for collection, to send the billing in to welfare. to the attention of case worker Mary Kilgore.

Dr. Robert ~~Biggs~~ D.D.S.

Uapl as of 1/24/74

06-336-400-380

NAME Dawson, Ethel 543-12-2609 A med
 ADDRESS Ridgeway Manor, A AD 42443 W28 ACCT. NO. Welfare
 CITY 2604 Eagle St. Spencr. 272-4976 (MRS) DAWSON

DATE	DESCRIPTION	CHARGES	CREDITS	BALANCE	PREVIOUS BALANCE
	BALANCE FORWARD				
3-13-70	B11882 Consult at Ridge ^{deklided} Ridge, etc	50 00		50 00	
3-23-70	B11943 Ridgeway visit 3-18	20 00		70 00	50 00
4-20-70	B12465 Ridgeway visit 4-15	10 00		80 00	70 00
5-11-70	B12840 at Ridgeway 5-8	10 00		90 00	80 00
8-20-70	Medicare		52 00	38 00	90 00
11-10-70	Costa Biop Tongue Exam ^{12/17}	15 00		18 00	38 00
11-23-70	1713 at Ridgeway	15 00		203 00	18 00
11-16-71	2678 at Providence, 4/1 to 4/17/71	60 00		263 00	203 00
5-24-71	3220 at Providence 5-14, 5-15, 5-16 & 5-17	40 00		203 00	263 00
4-17-72	Medicare				
4-19-72	Rec'd from Medicare		52 48	250 52	303 00
4-19-72	Rec'd from Medicare		129 60	120 92	250 00
JUN 15 1972	Bill of Welfare				
10-2-72	Sent ledger copy to welfare - asked why not paid				

Some Reason this one isn't being paid? Have sent bill twice w/ Medicare Paper Copies

06-33-6-350-380

DR GEO E HALL
 509 L ST

ANCHORAGE

NAME BURTON, GEORGE MEDICARE CT. NO. _____
 ADDRESS 308 NORTH LANE WELFAREHEET NO. _____
 CITY ANCHORAGE, ALASKA CREDIT LIMIT _____

DATE	DESCRIPTION	CHARGES	CREDITS	BALANCE	PREVIOUS BALANCE
	BALANCE FORWARD				
5/23/72	Actna 323		11449	157371	25986
JUN 15 1972	Sent ledger copies to Perret P. 2-72 again wrote Lorraine				
	Still wondering why this isn't getting paid after several billings.				
	06-33-6-350-380				
	DR. GEORGE E. HALE 501 L STREET ANCHORAGE AK				

MEDICARE FORM 8550 PRINTED IN U.S.A.
 1972

PHONE NO.

DR. PAUL J. EGER
602 COWLES STREET
Fairbanks, Alaska
Phone 456-4268

DEPARTMENT OF
HEALTH & SOCIAL SERVICES
DIVISION OF
MEDICAL ASSISTANCE

MAY 22 1 23 PM '73

RECEIVED

Barth Woolley

EMPLOYED

Medical Dept. Health

PERSON RESPONSIBLE FOR THIS ACCOUNT:

ADDRESS

Barth Woolley

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

Miriam Merrill 5-14-73

Signature

Date

~~06-22-3-340-383-71-0080~~

8-Digit Account Code

3-Digit Object Code

3 copies H&W, 527-5410. 279-8514

ADD 39874-01

Case or Med. Card No.

Band

NO.	SERVICES RENDERED	FEE	DATE DONE	AMOUNT PAID	DATE PAID	BALANCE
	Clinical Examination ✓	10.00	2-6-71			0-
	F/M X-Rays	25.00		10	2-7	1-
	Clearing & Scaling	20.00				0-
	<i>Periodontal - 1st</i>					0-
	<i>for welfare -</i>					0-
	<i>#340.00</i>					0-
	<i>Tissue - 1st</i>					0-
	<i>7th charge for 5th</i>					0-
	<i>to 5th - 1st</i>	10	1-18-71			0-
12-12	<i>X-ray</i>	10	2-7-71			0-
3-03						0-
2-0						0-
4-0	<i>Fixed Prosthodontics</i>					0-
	<i>1st visit - 5/6/73</i>					0-
9-0						0-

45.00

06-33-6 400 380

14-0

ALL ACCOUNTS PAYABLE IN 30 DAYS OR A CHARGE OF 1% PER MONTH IS ADDED
UNLESS OTHER ARRANGEMENTS ARE MADE.

452-07-1
Jensen's Clinic - Fairbanks, Alaska

THIRD BILLING

279-0536
Gloria

STATEMENT

STANLEY N. JONES, M.D.
P. O. BOX 249 HAINES, ALASKA 99827
TELEPHONE 766-2821

Alaska Department of Welfare
210 Admiral Way
Juneau, Alaska 99801

6/1/73

FOR PROFESSIONAL SERVICES: Katherine Dayer
Petersburg

7/11/70	Phenebarb	\$4.60
7/13/70	Darvon cpd.	7.00
	Robaxin	
8/5/70	Dilantin #200	6.00
9/25/70	Diazide #100	22.00
	Roniacal #100	
10/23/70	Dilantin 100 mg #100	3.00
11/17/70	House Call	15.00
	Drugs	2.00
	Phenebarb	

unpaid
as of
7/19/73
42.60

DRUGS:

~~06-22-3-350-477-21~~ *This was paid under*
medicare 8/14/72
VO # 337607.
0784

06-33-6-390-470 PLEASE PAY \$ 59.60

When you have private insurance coverage: This statement includes our total charges. Payments we receive from your insurance will be credited to your account. Overpayments are refunded. If no such credits appear in 30 days, you should contact the Insurance Company or Agent directly.
PLEASE NOTE: THE RESPONSIBILITY FOR BRINGING OR SENDING INSURANCE FORMS IS YOURS-- DON'T DELAY OR FORGET.

STATEMENT

B. D. Gayman DDS
1815 S. Brogan
Anch. Ak. 99504

Dept. of Health & Welfare
338 Denali - Mac Kay Bldg.
Anch. Ak. 99501

DETACH AND MAIL WITH YOUR CHECK. YOUR CANCELLED CHECK IS YOUR RECEIPT.

The following was done for Michael
Malone, Mother Patsy.

1971		
11-24-71	- Examination	45.
11-24-71	Bite wing trap	10.
		15.

This work was authorized but was
unable to get him to make appt.

06-33-6-400-380

second billing

PAID BY CHECK NO.

STATEMENT

B. D. Layman DDS
1815 S. Bragaw
Anch. Ak. 99504

Dept of Health & welfare
338 Denali - Mac Kay Bldg
Anch. Ak. 99504

DETACH AND MAIL WITH YOUR CHECK. YOUR CANCELLED CHECK IS YOUR RECEIPT.

All following was done for Keith
Malone, mother Patsy.

11-24-71 Examination \$5.

11-24-71 Site using map \$10.

1971

His work was authorized but unable
to get him back in.

33-6-400-380

second billing

PAID BY CHECK NO.

STATEMENT

B. D. Layman, DDS
1815 S. Bragan
Anch. Ak. 99504

Dept of Health & Welfare
338 Denali - Mackay
Anchorage, Alaska, 99504

DETACH AND MAIL WITH YOUR CHECK. YOUR CANCELLED CHECK IS YOUR RECEIPT.

The following work was done for Rich
Malone, mother Patsy Malone.

11-24-71 Examination \$ 5.00
11-24-71 Bitewing Xray \$ 10.00

1971

15.00

This work was authorized but never
came in to have it done.

STATE OF ALASKA
DEPARTMENT OF HEALTH & WELFARE

Second Billing

PAID BY CHECK NO.

STATEMENT

B. D. Hayman DDS
1815 S. Bragaw
Anch. Ak. 99504

Dept. of Health & Welfare
338 Denali - Mae Kay Build
Anch. Ak. 99501

DETACH AND MAIL WITH YOUR CHECK. YOUR CANCELLED CHECK IS YOUR RECEIPT.

The following work was done
for Patsy Malone

1971

11-24-71 - Examination

11-24-71 full mouth xray

\$5.

\$30.

\$35.

The work was authorized but she
would come in to get it done.

PAID BY CHECK NO.

Second billing

PAID BY CHECK NO.

STATEMENT


DAVID LEISTIKOW, M.D.
 2110 E. NO. LIGHTS BLVD.
 ANCHORAGE, ALASKA 99504
 277.4535

- DEPT. OF HEALTH & WELFARE
- DIV. OF PUBLIC WELFARE
- 338 Denali 222 MacKay Bldg.
- Anchorage, Alaska 99501

PLEASE RETURN THIS STUB WITH YOUR CHECK

Pat Backus (Eugene)

9-20-72

DATE	REFERENCE	CHARGES	CREDITS	BALANCE
BALANCE FORWARD 				
9-14-70	Exam	10.00		10.00
06-33-6-350-380				

PLEASE REFER TO PATIENT VISIT SLIP FOR DETAIL

PAY
 LAST AMOUNT
 IN THIS
 COLUMN



06

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital-Practitioner-Home Health Agency Invoice No. 106813

A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number 21		NAME	Name of Provider D.J. McIntyre, Inc.	
Name of Patient Pintano, Deo.			Provider ID No. DIM-899	Category
Date of Birth ___/___/___	Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Elig. Code	Payee ID No. (if different from above)	
Case No.		Resource		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First Cataract, OU.		Primary 374.9
		Secondary
Have all other payment sources been exhausted? <input type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable)
Comments:		Referring or Consulting Physician

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
10 Oct 70	O	Complete ophthalm exam		30-	
		06-33-6-350-380			
		06-22-2-330-305-31-0742			
*Place of Service		12 Coordination of Other Benefits		Total Charge	
DO Doctor's Office		M/Care Pd.	Other Paid	Total	
IL Independent Lab					
H Patient's Home					
IH Inpatient Hospital					
OL Other Location					
NH Nursing Home		M/Care CoIr	M/Care Ded.	Total	
ECF Extended Care Fac.					
OH Outpatient Hosp.					
				Unpaid Balance	30-

PROVIDER CERTIFICATION

<p>"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."</p> <p>To the best of my knowledge no other resource exists.</p>		<p>Remarks: thru ref. Dr. 10/10/70, to pt. 2/8/71 & 5/3/71 thru welfare 8/25/71 and 3 Jul 72 — still no response!</p>	
Signature	Date	Resubmittal Indicator	Medical Review
<i>[Signature]</i>	6 Jul 73		Admin

06

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital-Practitioner-Home Health Agency Invoice

No. 106810 **A**

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number 23		Race W	Name of Provider D.J. McKinley, Inc	
Name of Patient Colman, John			Provider ID No. DJM-899	Category
Date of Birth / /	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Elig. Code 20 A	Payee ID No. (if different from above)	
Case No. 36315-01		Resource		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First Cataract, All. entropion, LLL		Primary 374.9
		Secondary
Have all other payment sources been exhausted? <input type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable)
Comments:		Referring or Consulting Physician

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
11 Jan 71	IH	cataract, OS.		600-	
3 May 71	IH	entropion, OS.		340-	
16 Aug 71	IH	cataract, OD.		600-	
				Total Charge	980.00
				Less	1354
				Unpaid Balance	196.00

20% COINSURANCE ON THIS SURGERY PAID 6/18/71 NO 190027 PROVIDER CERTIFICATION

<p>"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."</p> <p>To the best of my knowledge no other resource exists.</p> <p>Signature <i>[Signature]</i> Date 6/24/73</p>		<p>Remarks Medicare payments thru 27 Dec 72 for all but \$226.00 balance</p>
Resubmittal Indicator	Medical Review	



EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM

1032

Prepared By:

DATE

Aetna Life & Casualty
Medicare Claim Administration
Yeon Building
522 S. W. 5th Avenue
Portland, Oregon 97204
Telephone No. 222-6831

9-24-71

IMPORTANT

HEALTH INSURANCE CLAIM NUMBER

544 10 245A

SEE REVERSE SIDE FOR
GENERAL INFORMATION.

BENEFICIARY'S
NAME
AND ADDRESS

A. Perry
A. L. Perki
Ketchikan, Alaska 99901

LOCATION OF SERVICE CODES	SERVICES					DESCRIPTION OF SERVICE CODES	
	FIRST DATE	LAST DATE	LOCATION OF	NUMBER OF	RENDERED BY		
	MO	DAY	MO	DAY			
<p>The following will explain the codes shown in the "Location of" column to the right.</p> <p>O Doctor's Office IH Inpatient Hospital IL Independent Lab ECF Extended Care Facility H Patient's Home OH Outpatient Hospital OL Other Location NH Nursing Home</p>	1	8	24	9	01	1	<p>The following will explain the number shown in the "Description of" column at left.</p> <p>1. Medical Care 2. Surgery 3. Consultation 4. Diagnostic X-ray 5. Diagnostic Lab 6. Radiation Therapy 7. Anesthesia 8. Assistant Surgeon 9. Other Service 0. Whole Blood or Packed Red Blood Cells</p>
	2					1	
	3					1	
	4					4	
	5					5	
	6					5	
	7					5	
	8					5	
	9					5	
	10						

If an amount is shown in the "Not Allowed" column at right, the paragraph checked below will explain.

- The Allowed Charge is less than the actual charge for psychiatric service, because only 62½% of such expenses are allowed under the law.
- The Allowed Charge is less than the actual charge for psychiatric service, because the \$250.00 maximum payable in one calendar year has been reached.
- The charges have been reduced to the amount indicated, because they have been determined to be higher than we can consider as covered expense under the Medicare Program.

06-33-6-350-380

Your \$50.00 deductible has been met for 19 70

BENEFITS PAID TO

J.W. A. Tenness, M.D.
3612 Tenness Ave.
Ketchikan, Alaska 99901

	TOTAL	NOT ALLOWED	ALLOWED
1	200		200
2	800	100	700
3	1500		1500
4	1600	400	1200
5	350	50	300
6	350		350
7	500		500
8	600		600
9	800	35	765
10			

TOTAL ALLOWED CHARGES 7715

LESS DEDUCTIBLE 5000

BALANCE OF ALLOWED CHARGES 2915

LESS 20% COINSURANCE 583

MEDICARE PAYS 2332

HAUGLAND, WILLIAM A.

517

MEDICARE - DO NOT BILL WELFARE

MEDICARE

PROVIDENCE HOSPITAL
Anchorage, Alaska

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to the above named hospital of the Hospital Benefits otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the hospital for charges not paid under this agreement.

Date _____ 19 _____ Signed _____

INSURED

DATE & TIME OF DISCHARGE

admitted 05-21-71

DATE	DESCRIPTION	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
	1371 HAUGLAND MED 22351							709.36	117.00	1,026.45
	200.09									117.00
	1071 TRAN FROM OTHER LEDGER							4.86	112.15	
SUB TOTALS								TOTAL CHARGES		

06-33-6-310-380

TERMS: BILLS ARE PAYABLE WEEKLY IN ADVANCE AND MUST BE SETTLED IN FULL BEFORE PATIENT LEAVES THE HOSPITAL

This statement is as complete as possible to render at this time. However, if there are any omissions an additional statement will be mailed to you. The Hospital Day ends at 11:30 A.M. This allows the patient to leave the Hospital without an extra day's charge being made.

LESS: COVERAGE

DUE FROM PATIENT

EXPLANATION OF SYMBOLS

Ⓛ

- | | | | | |
|---------------------------|--------------------------------------|----------------------------|---------------------|----------------------|
| ADM - ADMINISTRATION | DEL - DELIVERY ROOM | IS - ISOTOPES | PEN - PENICILLIN | SURBANK SYMBOLS ONLY |
| AL - ALLOWANCE | DIA - DIATHERMY | IV - INTRAVENOUS | PHT - PHYSIOTHERAPY | |
| ANES - ANESTHESIA | EC - ERROR CORRECTION | N - NARCOTICS, ENTIRE STAY | PHO - PHOTOGRAPHS | |
| ANT - ANTIBIOTICS | EEG - ELECTROENCEPHALOSGRAM | NO2 - NEWBORN OXYGEN | PL - PLASMA | |
| BLD - BLOOD | EKG - ELECTROCARDIOGRAM | OP - OPERATIONAL CREDIT | REF - REFUND | |
| BMR - BASAL METABOLISM | EM - EMERGENCY SURGERY (OR SERVICES) | OR - OPERATING ROOM | TEL - TELEPHONE | |
| CC - COMPLETE BLOOD COUNT | ES - ELECTRIC SHOCK TR. | OT - OXYGEN | TI - TISSUE | |
| C - CIRCUMCISION | HC - HEART CENTER | OTM - OXYGEN THERAPY | TR - TRANSFUSION | |
| CV - CLINIC VISIT | IC - INTENSIVE CARE | PAR - RECOVERY ROOM | UR - URINALYSIS | |
| CVS - CYSTOSCOPY | ID - IDENTIFICATION | PE - PERISTALTIC ENEMA | X - X-RAY THERAPY | |
| DEL - DELIVER ANESTHETIC | | | | |

HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

72-8074

1. Name (Last, first, middle initial) **Rolland** k

2. Sex M F

3. Health insurance claim number **72-99932**

4. Address (Street number, City, State, ZIP Code) **Salvation Army, Anchorage, Alaska 99501**

5. Date of birth **01-03-72**

6. Medical record number **387-16-5123-A**
72-0032

7. Admission date **03-72**

8. Provider name and address (City and State) **Providence Hos Anchorage**

9. Provider number **02-0001**

10. Attending physician **Hein**

11. Qualifying and other prior stay information

12. Qualifying and other prior stay information

MEDICAL REVIEW: *[Signature]*

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you wish information about this claim released to them upon their request, complete items 13 and 14.

13. Insuring organization or State agency name and address **Dept of Public Assistance 10-4-72**

14. Policy or medical assistance no

15. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.

Contained in provider's record

Signature (Patient or authorized representative) (Signature by mark must be witnessed) *Rolland K. Forrester*

Date **03-72**

16. Admitting diagnoses (If employment related, also give name and address of employer)

Circulation Problem L. Foot

Do not use this space

17. Discharge or current diagnoses

(a) Primary **Arteriosclerosis obliterans with complete occlusions of the L. iliac artery & distally down to the L. profunda femoris which is patent but the superficial femoral artery on the left is occluded. There is patency of the popliteal artery.**

Do not use this space

18. Surgical procedures (Show date of each) **01/10/72**

Transfemoral aortogram 1-4-72, Cross femoral R common femoral to L. profunda femoral cross bypass.

19. STATEMENT OF SERVICES RENDERED

Blood pints furnished	Pints replaced	Not replaced	Charge per pint	Total Charges	Non covered Chgs.
Accommodation					
B. 1 Bed					
C. 2-3-4 Bed 19 0000 138502					
D. 5 or more Beds					
FOR HOSPITAL					
E. Intensive care 120 00					
F. Self care					
G. PIP total					
H. Operating room 435 25					
I. Anesthesia 45 60					
ONLY J. Outpatient services					
K. Blood administration					
L. Pharmacy 199 01					
M. Radiology 648 00					
N. Laboratory 647 00					
O. Medical, surgical and central supplies 439 10					
P. Physical therapy 12 00					
Q. Occupational therapy					
R. Speech therapy					
S. Inhalation therapy 289 75					
T. Other (Describe) EKG 90 00					
U. TOTALS 4450 11					
V. Outpatient deductible 68 -					
W. Blood deductible pts. @					
X. Coinsurance days () ()					
Y. TOTAL DEDUCTIONS 68 -					

20. Statement covers period FROM **01 03 72** THRU **03 22 72**

21. Date guarantee of payment began

22. Date UR notice received

23. Date active care ended

24. Date benefits exhausted

25. Patient status

A. Date discharged **01 22 72**

B. Date of death

C. Still patient

26. Lifetime reserve days used

27. Non-covered days

28. Covered days **19**

30. Remarks: **80 2/6**

PIP per diem amount \$

197 - This is extra preventive given to the patient for 7 of the 19 day hospitalized.

346 92 09

31. Reimbursement amount \$ **68 -**

FOR INTERMEDIARY USE

32. Verified non-covered stays From Thru

33. Non-pmt. code

34. Days used

29. I certify that the required physician's certification and recertifications are on file.

Signature of provider representative *[Signature]*

Date received **04-28-72**

35. Approved by *[Signature]*

Date approved **05-04-72**

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

Send white & canary copies for payment.

15 Provider Ref

06

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital-Practitioner-Home Health Agency Invoice

No 115163

A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number		Name of Provider <i>William S. Stover, M.D.</i>	Provider ID No. <i>1155-275</i>	
Name of Patient <i>PHILLIP WOODS</i>				
Date of Birth <i>1/1/</i>	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Phys. Code	Category	
Case No.	Resource	Payee ID No. (if different from above)		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First <i>HNP L5-S1, right</i>		Primary <i>725</i>
WILLIAM S. STOVER, M.D. A PROFESSIONAL CORPORATION 2211 E. NORTHERN LGTS. BLVD., SUITE 103 ANCHORAGE, ALASKA 99504		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable)
Comments:		Referring or Consulting Physician

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
<i>8-24-71</i>	<i>IH</i>	<i>Assistant Surgery</i>	<i>163405</i>	<i>240.00</i>	
*Place of Service		12 Coordination of Other Benefits		Total Charge	
DO Doctor's Office	M/Care Pd.	Other Paid	Total	<i>240.00</i>	
IL Independent Lab					
H Patient's Home					
IH Inpatient Hospital					
OL Other Location					
NH Nursing Home	M/Care CoIn	M/Care Ded.	Total		
ECF Extended Care Fac.					
OH Outpatient Hosp.					
				Unpaid Balance	<i>240.00</i>

PROVIDER CERTIFICATION

<p>"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."</p> <p>To the best of my knowledge, no other resource exists.</p>	Remarks: <i>33-6-350-380</i>
	Signature <i>William S. Stover, M.D.</i> Date <i>1-15-74</i>

TANANA VALLEY MEDICAL SURGICAL GROUP
1007 NOBLE STREET FAIRBANKS, ALASKA 99701

TELEPHONE: 452-1231

10/23/72

STATEMENT OF ACCOUNT

Department of Health & Welfare
Family & Children's Services
Room 320 Chena Building
Fairbanks, Alaska

FOR PROFESSIONAL SERVICES RENDERED:

Archie Peterson

dent concession-UNI

11/2/70
2/22/71

long distance call
office call

1.00
12.00

Total

\$13.00

Total

James A. Lundquist, M. D.

JAN 11 1973

Second request for payment

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

Cleanse Booth 1-12-73
Signature Date

01-11-2370-380-41-0480
6-Digit Account Code 3-Digit Object Code

33-6-350-380

AD 29719-01
Case or Med. Crd No. Remarks

RECEIVED
JAN 16 4 55 PM '73
DEPARTMENT OF
HEALTH & SOCIAL SVCS
DIVISION OF
MEDICAL ASSISTANCE

1 September 1971

RR

Department of Health & Welfare
Crippled Children's Services
604 Burnett
Fairbanks, Alaska

For professional services rendered: JOHN V. BEZA ^{BEZA}

5/12/71	Office Call, Physical Exam - Dr. James: (decreased motion, spasticity and poor coordination of right arm & leg)	\$ 11.00
6/14/71	Injection of Vistaril for EEG Prep. (EEG not done)	6.00
7/25/71	Injection of Vistaril for EEG Prep. (EEG not done)	6.00

Total: \$ 23.00

"I certify the above to be a true and accurate accounting
for which no payment has been received."

Tanana Valley Medical-Surgical Group

Mrs Shirley Ristow
(Mrs.) Shirley Ristow
Billing Department

Bobbie


Miss Claems

Supplemental

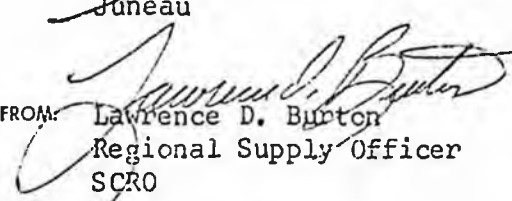
File

STATE
of ALASKA

MEMORANDUM

TO: 
Gary Horton
Supply & Facilities
Juneau

DATE : October 23, 1974

FROM: 
Lawrence D. Burton
Regional Supply Officer
SCRO

SUBJECT: Sea-Land

Reference the attached letter from Sea-Land regarding non-payment of freight bills (copies attached). As you can see these are quite old, so I had to do some digging back into the 1972 files. I found copies of the original invoices in the 1972 files and it does not look to me like they have been paid but, there's no way that I can tell for sure.

Would you please review this with Fiscal and see if there is anyway they can tell if these freight bills have been paid? If not, it looks to me like we will have to process them for payment.

Please advise me of your decision on this matter.

Thanks.

LDB/jeg

*Freight bill # 992908461 dated 10/6/72
Subject to approval of Alaska
State Legislative Approval for payment.
LDB*

2201

ISSUING TERMINAL

SEATTLE, WASHINGTON

FREIGHT BILL

NUMBER 992908461

ISSUING DATE 10 6 72	ISSUING TIME 083	ISSUING OFFICE SU 286 N	ISSUING BY 998	ISSUING TO 27 235	ISSUING FROM 27 235
ISSUING TO 10 6 72	ISSUING TO 083	ISSUING TO SU 286 N	ISSUING TO 998	ISSUING TO 27 235	ISSUING TO 27 235
ISSUING TO 10 6 72	ISSUING TO 083	ISSUING TO SU 286 N	ISSUING TO 998	ISSUING TO 27 235	ISSUING TO 27 235

HEALTH SOCIAL SVC RM 222
MACKAY BLD
338 DENALI ST
ANCHORAGE ALASKA

G.S.A. SPLY DEPOT
AUBURN WASH

EX. B
L L L T O

02-R-PD-192-71

REQUISITIONER 750*80	PRIORITY GROUP 3	ROUTE STOP 420A	DATE 2263	GM/L NUMBER 80 249347	SHEET NO.
ULTIMATE CONSIGNEE HEALTH SOCIAL SVC RM 222 MACKAY BLD 338 DENALI ST ANCHORAGE AK 99501			FROM SHIPPING POINT G.S.A. SUPPLY DEPOT AUBURN, WA, 96002		
TRANSPORTATION COMPANY TENDERED TO			MANIFEST NO. 1 NO OF ITEMS 1 TRANSPORTATION CONTROL NO.		

REQUISITIONER DATE	STOCK OR PART NO	PACKAGES NO	DESCRIPTION OF ARTICLES	WEIGHTS
22210020	71100226229	1CT	CHAIRS REVOLVING NOI METAL	501 G 44
22210022	71107540744	1CT	CHAIRS NOI STL OT FLONG CT STKD SU	502 F 29
22210022	71109508144	1CT	CHAIRS OR STOOLS NOI ST CK WIRE ETC	505 F 29
222560001	71102738793	1CT	CHAIRS REVOLVING NOI	502 G 40

NUMBER OF 1344'S		REPACKS		PACKAGES		PP	RECEIVED BY	DATE	WEIGHTS
BULK	REPACKS	TOTAL	NO	WGT	BULK				
4		4			4	4			142

Form Approved By Comptroller General, U.S., October 2, 1964

CHECKER 641	NO. PCS 4	FROM CE 6	DATE 10-7
584	4	223	27-233
142	1550	2201	
4711	41360		
SU-286-N	Z-A	D-66	
10-6			

RECEIVED

OCT 1 1972

SEA-LAND SUPPLY

SEA-LAND
SERVICE, INC.PLEASE RETURN THIS
COPY WITH YOUR
REMITTANCE:

3
DUPLICATE
FREIGHT BILL
REMITTANCE COPY
SL-241-GA 9170

DUPLICATE
 THE
 BUREAU OF
 PUBLIC
 AFFAIRS
 HAS
 REGISTERED
 THIS
 MARK
 AS
 TRADE
 MARK
 OF
 THE
 BUREAU
 OF
 PUBLIC
 AFFAIRS

O. BOX 1939, CITY DOCK ANCHORAGE, ALASKA 99510 - PHONE: (907) 274-2671



SEA-LAND
SERVICE, INC.

DATE April 29, 1974

Public Health Service
Room 222 MacKay Bldg.
338 Denali St.
Anchorage, Alaska

Gentlemen:

We are in the process of auditing our books. Your account has been brought to my attention because we show the attached bill(s) to be open for your account.

Please check your records. If your records do not agree, or you have a problem with the bill(s), please contact me immediately.

Not hearing from you, I will assume the bill(s) is (are) in order, and I will look for your prompt remittance to P. O. Box 1939, Anchorage, Alaska.

Because of the age of the item(s), we would appreciate your handling this matter at your earliest convenience.

Thank you in advance for your cooperation.

Sincerely,

SEA-LAND SERVICE, INC.

Terry Carlson
274-2671

*Sealand Trust bill 992 907090
dated 10/4/72 in amt. \$4.21
Subject to approval of
Alaska State Legislature for
payment*

84.21

G.M.

25 1973

SEATTLE, WASHINGTON

352 5012-0

DATE OF ISSUE 10 7 72	ISSUED BY GL 68 11	DESTINATION 10 3 72 RSJH
CONTRACT NO 53 515	SHIPPER'S CONTROL AF	INVOICE AMOUNT
SHIPPER'S ORIGIN ANCHORAGE ALASKA	REVERSE CARRIER NAME AF	REV. BILL NO.
TYPE OF SHIPMENT 5 1 1		AMOUNT
CONSIGNEE HAS-DIV OF PUBLIC BLDG SECT OF LAIS 627 E POUND AVE ANCHORAGE ALASKA		SPECIAL INSTRUCTIONS
SHIPPER LONDON COMMERCIAL REFRIGERATOR CO 2200 KENNEDY ST PHILA PA		EX.

10/12

NOV 17 1972

demo fast freight, inc.

CONSIGNEE'S MEMO 6

SHIPPER LONDON COMMERCIAL REFRIGERATOR CO 2200 KENNEDY ST PHILA PA 19137	CONSIGNEE SEALAND SERVICE INC SEATTLE WASH	DATE 9 5 72	KIND OF SHIPMENT 1	DESTINATION CODE SEAT 350
DESCRIPTION OF ARTICLES RECEIVED 1 REFRIGERATOR HOLDING 17 1/2 TON A/C AND ORANGE ALASKA		DATE 9 5 72	ACR 12375	TOTAL CHARGES 12375
FREIGHT BILL		PAID TO SEATTLE ONLY		

SEA-LAND SERVICE, INC.

CONTAINERS LOADED 2A D-66-etc	CHECKER 620	NO. PCS 1	FROM AF	TO 53515	DATE 10/12
EXCESS HANDLING	RATE	COMMODITY NO.	CLASS	TOTAL RATE	TOTAL CHARGES
		47111	6-1225	507	8421
EXCESS FROM THIS ZONE	EXCESS RATES	11 COD FREIGHT			
<input type="checkbox"/>	<input type="checkbox"/>	12 COD FEE			
ORL	IN BOND	13 CONTINUATION			
<input type="checkbox"/>	<input type="checkbox"/>	14 SPECIAL DELIVERY			
C.C.D.	<input type="checkbox"/>	15 SPECIAL DELIVERY			
<input type="checkbox"/>	<input type="checkbox"/>	16 SPECIAL DELIVERY			
SPOY	CEL	17 OTHER			
<input type="checkbox"/>	<input type="checkbox"/>	18 ADVANCE TRANSIT			
		19 BEYOND TRANSIT			
				TOTAL CHARGES	8421

5/5

Adm - 3 weeks ago stopped taking any more claims until next year.

MEMORANDUM

State of Alaska

TO:

37.25.010 Public finance - Misc. provisions

DATE:

FROM:

SUBJECT:

SB-78

- 1) Dating back 1971 & 1972 - Deceased Employee final payments
- 2) Div. of Adm. Services } 1973-1974 "state dated" legislation
Dept. of Adm. - capital office supply.
- 3) Misc. claims submitted but not approved
Glenn L. Miles Transportation - Western Alaska
- 4) Misc. claims to DOE - various vendors, state etc.
- 5) Div. of Adm. Dept. of Fish & Game - misc. claims
- 6) Dept. of H. & SS - billings not submitted - statute of limitation expired (misc. - after 1973)
- 7) Request from Dept. of Law - Alaska state attorney fees - Court order
- 8) Div. of Bldgs - Dept. of public works - various claims
Winnipeg 40 Machinery, Yukon office equipment
Books, light & power
- 9) Dept. of Revenue - HB-482 - state debt - 1973 legislation, but died in the Ways, rule Income Committee + Resubmitted including 1974 Misc. Claims
- 10) Div. of Adm. Wilson
Dept. of Fish & Game Pattenille

Chapter 25. Miscellaneous Provisions.

Section	Section
10. Unexpended balances of one-year appropriations	20. Unexpended balances of appropriations for capital projects

Sec. 37.25.010. Unexpended balances of one-year appropriations.

(a) The unexpended balance of a one-year appropriation authorized in an appropriation bill lapses on June 30 of the fiscal year for which appropriated. However, a valid obligation (encumbrance) existing on June 30 is automatically reappropriated for the fiscal year beginning on the succeeding July 1 if it is recorded with the Department of Administration by August 31 of the succeeding fiscal year.

(b) An indebtedness arising from a prior year for which the appropriation has lapsed shall be paid from the current year's appropriations, if (1) this expenditure does not exceed the balance lapsed; and (2) the original obligation date is not more than two years from the requested date of disbursement. (§ 1 ch 113 SLA 1962)

Sec. 37.25.020. Unexpended balances of appropriation for capital projects. An appropriation made for a capital project is valid for the life of the project and the unexpended balance shall be carried forward to subsequent fiscal years. Between July 1 and August 31 of each fiscal year, a statement supporting the amount of the unexpended balance required to complete the projects for which the initial appropriation was made and the amount that may be lapsed shall be recorded with the Department of Administration. (§ 2 ch 113 SLA 1962)

Chapter 30. Local Government Bonding.

Article

1. Anticipatory Borrowing (§§ 37.30.010—37.30.090)

Article I. Anticipatory Borrowing.

Section	Section
10. Borrowing in anticipation of the sale of bonds permitted	60 Security for repayment of revenue bonds
20 Issuance of notes	70 Limitation on issuance of notes
30 Issuance of new notes	80 Use of proceeds from sale of notes
40 Repayment of notes	90 Sale of notes
50. Security for repayment of general obligation bonds	

Sec. 37.30.010. Borrowing in anticipation of the sale of bonds permitted. A political subdivision of the state which is authorized by law to incur bonded indebtedness may borrow money in anticipation of the sale of general obligation and revenue bonds, if

(1) the general obligation bonds to be sold have been authorized by the governing body of the political subdivision and ratified by

Supplemental?

MEMORANDUM

State of Alaska

DEPARTMENT OF COMMERCE

#3

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

DATE: October 29, 1974

FILE NO:

TELEPHONE NO: 465-2505

SUBJECT: Miscellaneous Claims

RECEIVED
OCT 30 1974
BUDGET & MANAGEMENT

FROM: Lois J. Cook *LJ Cook*
Administrative Officer

Attached is a miscellaneous claims supplemental request which was submitted last year but not approved because the bill did not pass.

Please resubmit.

Attachment

WESTERN ALASKA AIRLINES, INC.

TO										VENDOR IF MORE THAN ONE CITY CIRCLED										ORIGIN									
DILLINGHAM										7-19-70										WA 1-38270									
KING SALMON										AGENT																			
QUEEN										FLIGHT DATE TIME																			
ALEKNAGIK										7-19-70																			
CLARKS POINT										FARE																			
EGEGIK										TAX																			
EKUK										TOTAL										1.60									
EKWAK										GOING																			
IGIUGIG										FARE BASIS																			
IGUSHIK										E 1/2																			
KOLIGANEK										FORM OF PAYMENT										CASH IP									
LEVELOCK										NEW STRAYHOCK										CHK GR									
MANDAKOTAK										PILOT POINT										CHG									
MARNER										SOUTH NAKNEK																			
NEW STRAYHOCK										TOGIAK																			
PILOT POINT										UGASNIK																			
SOUTH NAKNEK																													
TOGIAK																													
UGASNIK																													
										NAME										GLENN L MILES									
										COMPANY																			
										EOLD SUBJECT TO CARRIER REGULATIONS																			
										PASSENGER'S COUPON — NOT GOOD FOR PASSAGE																			

SA-19
2M 8-68

STATE OF ALASKA
Request For Transportation

No 210417

The Dept of Commerce w/m Box 57 North Pole AK requests the
(Department or Office requesting transportation and address)
Western Alaska Airlines Company to furnish Transportation
for Glenn L Miles from DLG.
(Name of Traveler)
To AKN DLG 7-19-70, 19__
(Place and Date of Issue)
Form No. WA 1 Ticket No. 58270
Glenn L Miles
(Signature of Traveler)
Value \$ 21.60 (No tax payable)
w/m Champ II
(Title)

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

#4

MEMORANDUM

State of Alaska

TO:

Myrton R. Charney, Director
Division of Budget and Management
Dept. of Administration

DATE : November 13, 1974

FROM:

William D. Thomson, Director
Management and Finance
Dept. of Education *WDT*

SUBJECT:

1975 Miscellaneous Claims

Attached is a listing of prior year indebtedness for which the Department of Education requests submission of a miscellaneous claims supplemental. The list contains the names of vendors, date of invoice, number of invoice, reasons for non-payment, and the amounts claimed. The attached envelope contains a copy of all invoices listed.

W. D. T.

<u>NAME OF VENDOR</u>	<u>DATE/INVOICE</u>	<u>INVOICE NUMBER</u>	<u>REASON FOR NON-PAYMENT</u>	<u>AMOUNT</u>
Alaska Airlines	2/2/71	027-6106435	Forwarded to us late by Univ. of Alaska	3.15
DHEW-PHS-AK Health Svc.	8-24-71	Area 72-1	Received late from SOS	4,914.42
Alaska Railroad	8-30-70	700261	Forwarded from other Depts; late arriving	6.68
Betty City Cleaners	8-11-71 8-4-71 4-20-71	07532 06386 01714	Unable to obtain invoices from company	364.10
Blake, Moffitt & Towne	11-17-69	167260	Duplicate shipment rec'd; one paid for	398.23
Central Scientific Co.	10-18-66 4-18-71	CJ92549 CJ92549A	Invoice rec'd 5-15-74	281.26
Copper Valley Fuel	11-17-70	11503	Invoice rec'd 2-20-73	15.00
Grossett-Dunlap	5-28-69 7-16-69 7-17-69	100775 OP45747 120308	Invoices outdated when received	7.41
Houghton-Mifflin	12-16-70 12-30-70 12-16-70	53700 55001 53702	Rec'd late from SOS	1,024.93
Island Flying Service	9-12-69	TR218213	Rec'd late from company	287.50
Fred G. Kohli	1-27-69 2-17-69 2-10-69 1-7-69	C6965 C7100 C7085 P17683	Rec'd late from company after they checked files	93.93
MacMillan Teachers Center	2-12-70 6-1-71	7537 206876	Invoices requested; none rec'd; have a statement	41.36
National Organization on Legal Problems of Education	3-9-71	PA14596	Rec'd invoice late	15.00

<u>NAME OF VENDOR</u>	<u>DATE/INVOICE</u>	<u>INVOICE NUMBER</u>	<u>REASON FOR NON-PAYMENT</u>	<u>AMOUNT</u>
SeaLand	4-29-70	992101051	Due to book audit, invoice rec'd late	22.56
Tok Distributing Soc.	4-30-70 10- -70 12-2-70 5-19-70	16695 17186 17291 16807	Sent to two other Depts. first; rec'd late	45.50
University Microfilm	1-14-71 6-26-70	670563 551864	Did not receive invoices until we requested them	76.75
H. W. Wilson Co	12-31-69	C21187	Invoice was not forwarded from Librarian	120.00
Yukon Office Supply	4-28-71 5-21-71 10-30-70	A 49828 A 52943 K 48079	Rec'd in DOE after two year limitation expired	93.05
Janice M Clark	2-17-74	Memorandum of Agreement for travel	Itinerary rec'd after close of fiscal year	140.00

TOTAL: \$7950.83

MEMORANDUM

State of Alaska #5

TO: Ron Lind, Deputy Director
Division of Budget and Management
Department of Administration

DATE: November 26, 1974

FILE NO:

TELEPHONE NO:

FROM: Vern Roberts, Director *V.R.*
Division of Administration
Department of Fish and Game

SUBJECT: 1975 Miscellaneous
Claims Supplemental

We are requesting a supplemental appropriation for the following miscellaneous claims (see attached).

Sterling Marine Products	FP0212163 Inv 006007	5/9/72	8.32
VWR Scientific	FP0229671 Inv05-027-0242	6/12/72	78.56
VWR Scientific	FP0229670 Inv05-055-7612		115.30
Unv. of Alaska	FP0229914	12/1970	216.30
Unv. of Alaska	FP0229915	1/1971	21.25
Univ. of Alaska	FP0229916	7/1971	6.30
Unv. of Alaska	FP0229917	8/1971	68.46
Unv. of Alaska	FP0229918	12/1971	36.50
Stanford Research Inst.	FP0221912 Inv902523	6/7/71	12.50
Baranof Book Store	Inv9965	4/15 & 4/27/71	333.36

We can offer no explanation of why the payments are late other than the fact that the original billings were probably misplaced.

To our knowledge, sufficient funds were lapsed in the year involved and the claims have not been paid.

Sterling Marine Products

a Division of Sterling Net & Twine Co., Inc.
7 OAK PLACE • MONTCLAIR, NEW JERSEY 07042 • phone: (201) 783-9800
Maine Plant . . . JONESPORT, MAINE 04649 • phone: (207) 497-5635

Date 11/12/74

Attn: Accounts Payable Department

D.E. Jones
ADF G
Box 667
Petersburg, Alaska 99833

Re: Your P.O.# 212163

Dated 9/72

Our Inv.# 0289

Amt. of Inv. \$8.32

Dear Sir:

Our records show your above purchase order has been shipped and we invoiced you.

The invoice is now past due and we would like to inquire about its status. Could you please advise whether you received the merchandise and if so when you would expect to make payment?

In the space below may we have your reply? Thank you.

Very truly yours,

Deborah Pascale

Sterling Net and Twine Co., Inc.

Date _____

Reply: _____

PAST DUE
PLEASE REMIT

Federal Truth-in-Lending Act

We will bill your account a 1 1/2% Finance Charge per Month or Annual Rate of 18% on all unpaid balances beyond the Normal Terms of Sale.

Signed _____

**IF PAID
PLEASE SEND COPY OF
CANCELLED CHECK**

"Manufacturers of Sporting and Fishing Nets for Every Purpose"

INVOICE



STERLING NET & TWINE CO., INC.

7 OAK PLACE
 MONTCLAIR, NEW JERSEY 07042
 RECREATION, EDUCATIONAL AND MARINE PRODUCTS
 TELEPHONE: (201) 783-9800

INVOICE
 NUMBER
 2
 MS
 X

SOLD TO
 P. E. Jones
 ADI FC
 Box 667
 Potosi, Alaska 99833

SHIP TO
 Same
 P
 T
 O
 SAME AS SOLD TO UNLESS OTHERWISE INDICATED

INVOICE DATE 2/9/72	OUR ORDER NO. 000007	YOUR ORDER NO. 212159	TERMS net 30	SALESMAN B-21
DATE SHIPPED 4/27/72	VIA AIR X	COMMON CARRIER	F O B DESTINATION	ORIGIN N
	U.S.	HLA		PPD OR COLL 3

QUANTITY	DESCRIPTION	PRICE	
212	1" Sq. Bulk Knotted Nylon Seine Netting 6' deep	2.7910	5.53
	FREIGHT		2.74
	SHIP Air Parcel Post		8.32
	TOTAL		8.32

P. E. Jones
Statement 10/8/73
11-41-4-001-490
MS
Acc
A/P card

"Seller represents that with respect to the goods and the services covered by the invoice, it has fully complied with the provisions of the Fair Labor Standards Act of 1938, as amended."

No claims allowed after 10 days

ACCOUNTING COPY

Interest of 18% per annum on overdue accounts.

INVOICE

208 WASHINGTON ST
SUITE 500
SEATTLE, WA 98101

06/17/72 05 037 0162 060

STATE OF ALASKA DEPT
FISH & GAME
1300 COLLEGE RD
FAIRBANKS, AK 99701

QUANTITY	UNIT PRICE	TOTAL
2	14.74	29.48
2	15.44	30.88
1	18.20	18.20
TOTAL		78.56

THIS CHECK IS PAYABLE TO THE ORDER OF THE STATE OF ALASKA DEPARTMENT OF FISH AND GAME
IT IS NOT VALID UNLESS IT IS COUNTERSIGNED BY THE STATE COMPTROLLER OF PUBLIC ACCOUNTS

STATE OF ALASKA
FIELD PURCHASE ORDER AND INVOICE

PRINT NAME OF SELLER Van Waters and Rogers - Scientific	ORDER NUMBER 229671
ADDRESS OF SELLER Box 3551, Terminal Annex	DATE OF ORDER 5-25-72

Seattle, Washington 98124

DEPARTMENT: Fish and Game DIVISION: Game

DELIVER TO:
1300 College Rd., Fbks, Alaska 99701

QUAN TITY	ITEM (DESCRIPTION)	UNIT PRICE	TOTALS
2 ct	66012-022		
	Vial No 1 Pk-24	14.74	29.48
2 ct	66012-044		
	Vial No. 2 Pk-24	15.44	30.88
1 ct	66012-088		
	Vial No. 4 Pk-24	18.20	18.20
RESTRICTIONS: FIELD PURCHASE ORDERS WILL NOT EXCEED \$1000 IN TOTAL AMOUNT SELLER'S CERTIFICATION: I, THE UNDERSIGNED, HEREBY CERTIFY THAT THE MATERIAL FURNISHED, SERVICE RENDERED OR EXPENDITURES INCURRED AS SHOWN ABOVE OR ATTACHED, IS A TRUE AND CORRECT CHARGE, AND THAT NO PART OF THE SAME HAS BEEN PAID.			TOTAL 78.56
			DISCOUNT TERMS % DAYS

BY N/A CA # _____

TITLE _____ INV. # 027-0242-000

ORDERED BY Edward Koptuk

RECEIVED BY Carlson Kholer

CODE 11-41-2-137-470-j303 G.M.

DATE PAID _____ VOUCHER NUMBER _____

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX



UNIVERSITY OF ALASKA
COLLEGE, ALASKA 99701

May 30, 1974

JUL 16 74 00000

Mrs. Wilma Wallace
State of Alaska Dept. of Fish & Game
1300 College Road
Fairbanks, Alaska 99701

Dear Mrs. Wallace;

Enclosed are copies of the invoices for computer center charges that we have outstanding on your account.

December 1970	\$216.21
December 1970	.10
January 1971	20.16
January 1971	1.09
July 1971	1.80
August 1971	68.46
August 1971	4.50
December 1971	36.50
February 1973	390.26
	<u>\$739.08</u>

paid

We should be receiving the breakdown on services at Arctic Biology from Joe Nava, and as soon as we receive them a corrected billing will be sent.

The other problem as you know is payment for the Library card for Stephen Tack. We have no record of having received your check.

If you have any questions on the computer center invoices please call.

Sincerely yours,

Anne M. Powers
Anne M. Powers
Accounts Receivable

Encl.

Invoice to replace old bills of
4-15-71 and 4-27-71

10000487000

00001121/TJR

Sold To

Dept. of Fish & Game
Support Building
Juneau, AK 99801

INVOICE

Shipped To

Address

OUR NUMBER 9965
DATE 6-18-74
CUSTOMER'S ORDER JGS SALESMAN
TERMS
F. O. B.

Books from invoice 4859 (signed by Richard Gordon)			332	41
Environmental Handbook (from invoice 9801, signed by Jay McAllister				95
		\$	332	36

Rediform
7H 723

MEMORANDUM

State of Alaska

#7

TO: Ron Lind, Deputy Director
 Division of Budget and Management
 Department of Administration

DATE: Nov. 19, 1974

FILE NO:

TELEPHONE NO:

FROM: *Robert F. Schroeder*
 Robert F. Schroeder
 Legal Administrator
 Department of Law

SUBJECT: 1975 Miscellaneous Claims

RECEIVED
 NOV 22 1974
 BUDGET & MANAGEMENT

In reply to your memo of October we would like two claims to be included in the miscellaneous supplemental request.

One is for \$3,683.88 as Alaska's share of the attorney fees in Wilderness Society v. Morton and payment was ordered in April, 1974 by the U.S. Court of Appeals.

The other is attorney fees ordered by the Superior Court, Juneau in APEA v. State of Alaska in September. We have paid \$346.50 and there is a balance of \$1,850.00.

The balance in our Judgment account is \$1,477.07 which is in-sufficient to pay these costs.

RFS:J

Enc.

Handwritten calculations:
 3683.88
 11051.62
 1850.00
 1515
 7048.89

Handwritten: 7010.75

Schweder

COVINGTON & BURLING
888 SIXTEENTH STREET, N. W.
WASHINGTON, D. C. 20006

TELEPHONE
(202) 442-6000

TWX: 710-822-0005
TELEX: 89-500
CABLE: COVLING

WRITER'S DIRECT DIAL NUMBER

452-6192

November 12, 1974

RECEIVED
Department of Law

NOV 15 1974

AM 1 2 3 4 5 6 PM

The Honorable Norman C. Gorsuch
Attorney General
State of Alaska
State Capitol -- Pouch K
Juneau, Alaska 99811

Dear Norm:

A

On April 4, 1974, the Court of Appeals entered its order taxing costs (apart from attorneys' fees) in Wilderness Society v. Morton against the United States, Alaska and Alyeska. A copy of the order was sent to you and Guy Martin under a memo dated April 5, 1974. I am enclosing another copy.

You will recall that at the same time as this order was entered the Court of Appeals handed down its opinion holding that Alyeska should pay 50 percent of the attorneys' fees requested by the plaintiffs. The attorneys' fees judgment is now pending on review on the merits in the Supreme Court.

The costs other than the attorneys' fees were never questioned by us or the United States, and the April 4 order reflects rejection by the Court of Appeals of certain objections that Alyeska made. Recently there has been correspondence between Dennis Flannery for the plaintiffs and Bob Jordan for Alyeska relating to satisfaction of the order taxing costs. Copies of the letters that have been exchanged are enclosed also.

The sum of all this is that Alaska's share of the costs is \$3,683.88 and we have no reason not to pay. A check should be made out in that amount to "Dennis M. Flannery, Attorney," and sent to him at 1666 K Street, N.W., Washington, D.C. 20006.

Sincerely,

Bill Allen
William H. Allen

ljk
Enclosures
cc: Guy R. Martin, Esq.

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 72-1796, 72-1797 & 72-1798

September Term, 19 73

THE WILDERNESS SOCIETY, ENVIRONMENTAL DEFENSE
FUND, INC., FRIENDS OF THE EARTH and DAVID
ANDERSON, CANADIAN WILD LIFE FEDERATION and
THE CORDOVA DISTRICT FISHERIES UNION, Appellants

Civil Action No. 928-70

United States Court of Appeals
for the District of Columbia Circuit

v.

FILED APR 4 1974

HUGH E. KLINE
CLERK

ROGERS C. B. MORTON, Secretary of the Interior,
EARL L. BUTZ, Secretary of Agriculture, and
ALYESKA PIPELINE SERVICE COMPANY and
STATE OF ALASKA

Before: BAZELON, Chief Judge, and WRIGHT, LEVENTHAL, ROBINSON, MacKINNON, ROBB
and WILKEY, Circuit Judges, sitting en banc.

ORDER

On consideration of the bills of costs and memoranda filed with respect thereto,
it is

ORDERED by the court en banc that all expenses requested by appellants Wilderness
Society, Environmental Defense Fund, Inc., and Friends of the Earth are approved. Costs
therefore are hereby taxed in favor of the aforesaid appellants in the amount of \$11,-
051.65 against Alyeska Pipeline Service Company, the State of Alaska, and the United
States of America. It is

FURTHER ORDERED by the court en banc that the bill of costs is hereby remanded to
the District Court for the setting of attorneys' fees in accordance with the opinion
filed herein this date.

Per Curiam

For the Court

Hugh E. Kline
Hugh E. Kline
Clerk

Date: April 4, 1974

Opinion for the court filed by Circuit Judge Wright.
Dissenting opinion filed by Circuit Judge MacKinnon.
Dissenting opinion, in which Circuit Judges MacKinnon and Robb join, filed by Circuit
Judge Wilkey.

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
 FIRST JUDICIAL DISTRICT
 at Juneau

SEP 16 1974

ALASKA PUBLIC EMPLOYEES
 ASSOCIATION, et al.,
 Plaintiff
 VS
 STATE OF ALASKA and COMMISSIONER
 OF ADMINISTRATION, JOSEPH R. HENRI,
 Defendant

RECEIVED
 Department of Law
 SEP 20 1974
 7:18 AM
 12:12 PM
 12:31 PM
 1:45 PM

Judith R. Jones, Clerk
 By: *[Signature]* Deputy

BILL OF COSTS
 No. 72-298

Judgment having been entered in the above-entitled action on the
10th day of September, 1974, against the defendants,
 the Clerk is requested to tax the following as costs:

BILL OF COSTS

Fees of the clerk	\$ 30.00
Fees for service of process.....	\$ 12.00
Fees for part for all or any part of the transcript necessarily obtained for use in case.....	\$ _____
Fees and disbursements for printing.....	\$ _____
Fees for witnesses (itemize on reverse side).....	\$ _____
Fees for certified copies of papers necessarily obtained for use in the case.....	\$ _____
Docket fees (if any).....	\$ _____
Costs incident to the taking of depositions.....	\$ _____
Costs as shown on Mandate of the Supreme Court.....	\$ 346.50
Attorney Fees	1850.00 ✓

NOTE: The State has already paid the \$346.50 shown on the Mandate of the STATE OF ALASKA) Supreme Court. Total \$2238.50
 First Judicial District)

I, William B. Rozell do hereby swear that the foregoing costs are correct and were necessarily incurred in this action and that the services for which fees have been charged were actually and necessarily performed. A copy was this day mailed to the Attorney General with postage fully-prepaid thereon.

[Signature]
 Attorney for Plaintiffs

Subscribed and sworn to before me this 16th day of September, 1974, at Juneau, Alaska.

[Signature]
 Notary Public for Alaska
 My commission expires 6/3/77

Costs are hereby taxed in the amount of \$ 2238.50 this 20th day of September, 1974 less what has previously been paid.
 SERVICE AND RECEIPT OF COPY acknowledged this 17th day of September, 1974.
 By *[Signature]* Clerk

Roberta

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
WASHINGTON, D. C. 20543

March 27, 1974

Norman C. Gorsuch, Esquire
Atty General of Alaska
Pouch K, Capitol Bldg.
Juneau, Alaska 99801

RECEIVED
Department of Law
APR 1 1974
OFFICE OF THE FEDERAL ATTORNEY
GENERAL
WASHINGTON, D.C.

Attention: Mr. Charles M. Merriner

RE: Davis v. Alaska, No. 72-5794

Dear Mr. Gorsuch:

The mandate of this Court in the above-entitled case has been mailed today to the Clerk of the Supreme Court of Alaska.

As this case was reversed with costs, the following item is due and payable to the Clerk of the Supreme Court of the United States:

Printing of record \$1,515.00

OK to pay
mc

Kindly forward your check for the above amount to the Office of the Clerk, Attention of Mr. Edward Faircloth, at an early date.

Very truly yours,

MICHAEL RODAK, JR., Clerk

By *Evelyn R. Limstrong*

(Mrs.) Evelyn R. Limstrong
Assistant

STATE
of ALASKA

MEMORANDUM

#9

TO: Mr. Ron Lind, Deputy Director
Budget and Management
Department of Administration

DATE : January 16, 1975

FROM: *JMD*
Mr. John M. Daugherty, Director
Treasury Division
Department of RevenueSUBJECT: Request by payees for payment
of "Stale Dated" Warrants for
Calendar years 1973 and 1974,
Totaling \$3,914.84.

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 their 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.

This listing covers a period of approximately two years from February 1973 through November 1974.

House Bill 482 covering the 1973 warrants (copy attached) was presented to the 1973 Legislature requesting an appropriation to allow payment for the 1973 items, but died in the Ways and Means Committee. Since these items continue to remain legitimate claims, I am including the 1973 requests for payment with those received during the calendar year 1974 in the following listing:

Fairbanks Clinic Building	\$	321.42
Charles F. Wayer, Jr.		167.50
Lynn E. Kriley		21.91
Doyle M. Jowers		100.00
Joe Chin		2.94
Dr. L. A. Johnson		80.00
Henry F. Svetina		15.00
Maxine R. Graham		500.53
Internal Revenue Service		182.58
R. C. and L. C. Sears		3.00
Verona Bowles		11.35
Susan Bullock Stone		18.32
H. L. Kirby		35.58
Mary E. Bahr, Administrator of Estate of Peter O. Bahr		310.26
United Vill Volunteer Fire Department		<u>2,144.45</u>
	\$	3,914.84

1209.30

JMD:il
Attachment

Original sponsor: Rules Committee by
request of the Governor

Offered: 4/25/74
Referred: Rules

1 IN THE HOUSE

BY THE FINANCE COMMITTEE

2

SENATE CS FOR HOUSE BILL NO. 482

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

EIGHTH LEGISLATURE - SECOND SESSION

5

A.BILL

6

For an Act entitled: "An Act making supplemental appropriations for miscel-
7 laneous claims; and providing for an effective date."

8

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

9

* Section 1. The sum of \$17,043.27 is appropriated from the general fund
10 for miscellaneous claims as follows:

11

(1) Department of Revenue for stale date warrants \$1,209.30

12

(2) Department of Public Works for vendor claims

13

against the division of buildings \$2,744.70

14

(3) Department of Administration for vendor

15

claims \$ 178.65

16

(4) Department of Administration for final

17

payment to beneficiaries and estates of deceased persons \$2,712.37

18

(5) Department of Health and Social Services

19

for vendor claims \$8,661.65

20

(6) Department of Commerce for vendor claims \$ 21.60

21

(7) Department of Law for assigned court costs \$1,515.00

22

* Sec. 2. This Act takes effect on the day after its passage and approval
23 or on the day it becomes law without approval.

24

25

26

27

28

29

STATE OF ALASKA

WILLIAM A. EGAN, GOVERNOR

DEPARTMENT OF ADMINISTRATION

DIVISION OF BUDGET & MANAGEMENT

POUCH C — JUNEAU 99801

March 27, 1974

The Honorable Clifford J. Groh
Alaska State Legislature
State Capitol
Juneau, Alaska 99801

Dear Senator Groh:

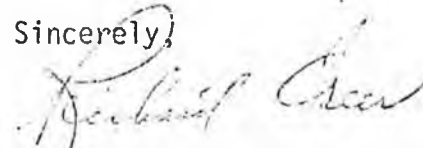
I am requesting that HB 482 "An Act making supplemental appropriations for miscellaneous claims; and providing for an effective date" be amended to provide funds for one additional state dated warrant received by the Department of Revenue. This bill should be amended as follows:

change line 11 to read

(1) Department of Revenue for state date warrants \$1209.30

The Department of Revenue should be contacted if there are any questions concerning this revision or the attached documents.

Sincerely,



Richard Freer, Deputy Commissioner
Department of Administration

Attachment

cc: Jay Hogan

MEMORANDUM

State of Alaska

TO: Mr. Ron Lind
Deputy Director, Budget Management

DATE : March 22, 1974

FROM:

C
John W. Fourharty
Dir. Treasury Division

SUBJECT: Request for additional appropriation
for payment of State Dated
warrant.

On this date Maxine R. Graham delivered the following described
Payroll warrant, requesting if possible that it be included in the appropriation
request for payment of State Dated Warrants.

Warrant No. 150550 dated Jan 31, 1972 in the amount of \$ 500.53
Original warrant in custody of warrant redemption section.

MEMORANDUM

TO: Mr. Ron Lind
Budgets and Management

DATE: 12/3/73

FILE NO:

FROM: John M. Daugherty
Director of the Treasury

SUBJECT: Stale dated warrants for
which appropriations are
requested

Fairbanks Clinic Bldg. Corp. -----	\$321.42
Charles F. Wayer -----	167.50
Mr. Lynn E. Kriley -----	21.91
Doyle Jowers -----	100.00
Joe Chinn -----	2.94
Dr. L.A. Johnson -----	80.00
Mr. Henry F. Svetina -----	15.00

Total
\$703.77

Mazzino S. Graham

500.53

late request (see letter in
file) as attached.

Total \$1,204.30

TO: John Daugherty

DATE: March 21, 1974

FROM: Marion R. Graham

SUBJECT: State-Dated Warrant

Enclosed please note my state-dated
Warrant # 154550.

I would be very grateful if this
could be sanctioned for issuance
by the Legislature now in session.

06-52-40-02

THIS WARRANT WILL BE DEEMED PAID UNLESS REDEEMED WITHIN TWO YEARS AFTER DATE OF ISSUE PER AS 27.05.180

STATE OF ALASKA
TREASURY WARRANT

89-52
1252 No 154550

DATE OF ISSUE

01-31-72 PAY

PAYROLL

***500.53

TO THE
ORDER OF

MAXINE R GRAHAM

PR012772

500.53


⑆ 1 25 2 00 5 2 ⑆

Joseph R. Nease
BY THE ORDER OF THE COMMISSIONER

⑆0000050053⑆

MEMORANDUM**State of Alaska**

TO: Mr. Ron Lind
Deputy Director, Budget Management

FROM: 
John H. Daugherty
Dir. Treasury Division

DATE : March 22, 1974

SUBJECT: Request for additional appropriation
for payment of State Dated
warrant.

On this date Maxine R. Graham delivered the following described
Payroll warrant, requesting if possible that it be included in the appropriation
request for payment of State Dated warrants.

Warrant No. 154550 dated Jan 31, 1972 in the amount of \$ 500.53

Original warrant in custody of warrant redemption section.



MEMORANDUM

TO: Mr. Ron Lind
Budgets and Management

DATE: 12/3/73

FILE NO:

FROM: John M. Daugherty
Director of the Treasury

SUBJECT: State dated warrants for
which appropriations are
requested

Fairbanks Clinic Bldg. Corp. -----	\$321.42
Charles F. Wayer -----	167.50
Mr. Lynn E. Kriley -----	21.91
Doyle Jowers -----	100.00
Joe Chinn -----	2.94
Dr. L.A. Johnson -----	80.00
Mr. Henry F. Svetina -----	15.00

Total \$708.77

Maxine R. Graham

500.53

late request (see letter in
file) as attached.

Total \$1,209.30

STATE
OF ALASKA

MEMORANDUM

TO: John Daugherty

DATE: March 21, 1974

FROM: Maxine R Graham

SUBJECT: Stale-Dated Warrant

Enclosed please note my stale-dated
Warrant # 154550.

I would be very grateful if this
could be sanctioned for reissue
by the legislature now in session.

06-52-40-02

THIS WARRANT WILL BE DEEMED PAID UNLESS REDEEMED WITHIN TWO YEARS AFTER DATE OF ISSUE PER AS 37.05.180

STATE OF ALASKA
TREASURY WARRANT

89-52
1252 No 154550

PAYROLL

DOLLARS CENTS
***500.53

NOT VALID FOR
OVER \$10,000.00

DATE OF ISSUE

01-31-72 **PAY**

TO THE
ORDER OF

MAXINE R GRAHAM

PR012772

500.53

James R. Harris
COMMISSIONER OF ADMINISTRATION

⑈0000050053⑈

⑈1252⑈0052⑈

fm
BY THE RULES COMMITTEE BY
REQUEST OF THE GOVERNOR

1 IN THE SENATE

2 SENATE BILL NO. 78

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 NINTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act making a special appropriation for the payment
7 of miscellaneous claims; and providing for an effective
8 date."
9

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

11 * Section 1. The sum of \$45,910.68 is appropriated from the general
12 fund for the fiscal year ending June 30, 1975 to be allocated as follows:

13 Department of Administration, final payment
14 to beneficiaries and estates of deceased
15 persons

\$2,712.37 ✓ 1

16 Department of Administration, vendor claims

172.65

18 Department of Commerce, vendor claims

21.60 ✓ 2

19 Department of Education, vendor claims

7,950.83 ✓ 3

20 Department of Fish and Game, vendor claims

896.85 ✓ 4

21 Department of Health and Social Services,
22 vendor claims

9,302.51 ✓ 5

23 Department of Law, assigned court costs

7,042.88 ✓ 6

24 Department of Public Works, vendor claims

13,884.15 ✓ 7

25 Department of Revenue, stale date warrants

3,914.84 ✓ 8

\$45,910.68

26 * Sec. 2. This Act takes effect immediately in accordance with AS 01.-
27 10.070(c).
28
29