

Leg. Finance - Finance Comte Files (1971-72) 8879

HB 522 cont.

109

STATEMENT OF THE CLAIMANT

FOR AND IN CONSIDERATION OF THE PAYMENT TO IT OF THE

SUM OF FIFTY THOUSAND THREE HUNDRED FORTY SEVEN DOLLARS

(\$53,347.00) and other good and valuable consideration, I, IAN

DOE, d/b/a Doe's of Alaska, her released and discharged, and

by these presents does hereby release, defend, acquit and warrant

release, acquit and forever discharge the State of Alaska and

any and all other persons, firms and corporations of and from

any and all actions, causes of action, claims or demands for

damages, costs, loss of use, loss of service, expenses, emp-

loyment, consequential damages, interest, attorney's fees,

property damage and loss, or any other thing here known or

unknown whatsoever on account of, or in any way growing out

of, resulting from, or to result from an incident that happened

on or about June 24, 1968, wherein the said State of Alaska,

its agents, contractors or employees and collectively the

Department of Fish and Game and its employees, and hunters,

allegedly caused the crash of one Piper aircraft No. 36974,

Model PA-12 in the vicinity of the Kona National Moose Range,

Alaska. Said incident is the subject matter of a lawsuit

captioned IAN DOE, d/b/a Doe's of Alaska vs. STATE OF ALASKA,

now pending in the Superior Court of the State of Alaska, titled

Judicial District, No. 19-26150. Counsel for IAN DOE is the

FIRM OF HODGKINSON & GRONLUND, Attorneys at Law, Anchorage, Alaska.

IAN DOE, d/b/a Doe's of Alaska, hereby acknowledges

and assumes all risk, chance or hazard that all damages and

losses arising from said incident may be more extensive than

is now known, anticipated or expected. He presumes or infers-

ment which is not herein expressed has been made to him, and

in executing this release, he does not rely upon any statement

or representation made by any person, firm or corporation

hereby released, or any agent or other person representing

him, concerning the nature and extent of said damages or

losses or the legal liability therefor.

Jack Lee, d/b/a Lee's of Alaska understands that this settlement is the compromise of a disputed claim, and that the payment is not to be construed as an admission of liability on the part of the State of Alaska.

The undersigned acknowledges that it is familiar with the decision of the Alaska Supreme Court in the case of Frank P. Young v. State of Alaska and Peter Kievit Sons Co., Opinion No. 559, dated June 13, 1971, and it is still its true intent and desire herein to fully release all individuals, firms or corporations who could at any future date be possible defendants in any action arising out of this matter as fully as though they were specifically listed and named herein.

This release contains the entire agreement between the parties hereto, and the terms of this release are contractual and not a mere recital.

Jack Lee, d/b/a Lee's of Alaska further states that he has carefully read the foregoing release and knows the contents thereof, and it signs the same as its own free act.

WITNESS its hand and seal this _____ day of May, 1971.

WITNESSES:

READ BEFORE SIGNING:

Jack Lee, d/b/a Lee's of Alaska

BY _____
of McCutcheon & Gruening
Attorneys at Law

Introduced: 3/23/71
Referred: Finance

1 IN THE SENATE

BY THE FINANCE COMMITTEE

2 SENATE BILL NO. 182

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SEVENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act appropriating \$3,503.75 to Harmon R.
7 Helmericks for loss of a boat being used by the
8 Alaska Department of Fish and Game; and providing
9 for an effective date."

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

To SCS Cost 522
11 * Section 1. The sum of \$3,503.75 is appropriated from the general fund
12 to reimburse Harmon R. Helmericks for loss of his Grumman G-19 boat, "The
13 Explorer", while being used by the Alaska Department of Fish and Game ~~1969~~
14 August, 1969.

15 * Sec. 2. This Act takes effect on the day after its passage and approval
16 or on the day it becomes law without approval.
17
18
19
20
21
22
23
24
25
26
27
28
29

Memo of 3/16/72

H + SS

Back-up
only

.00 *

4 8.00

2 8.00

8.00

2 6.20

3 5.20

3 0.00

3 2.50

7 1 0.00

1 6.50

2.30

1 1 2.50

1 4.50

7 3 7.25

9 4.50

6 0.00

8 0.00

4 3.56

8 7.50

1, 3 6 6.51 *



STATEMENT
THE ALASKA CLINIC
 "A Professional Corporation"
 825 L STREET PHONE 272-4551
 ANCHORAGE, ALASKA

February 11, 1972

account no 00-016-7

Division of Correction
 Rm 222 MacKay Bldg
 338 Denali
 Anchorage, Alaska 99501
 Attn: Mrs Berrens 92-0036732

DATE	TREATMENT	CHARGES	CREDIT	BALANCE
Re: Douglas Koski				
originally billed Veteran's Administration 2-11-70 no payment received- not a service connected injury				
8-25-69	9023 Hospital call	8.00	Dr David Dietz	
"	" " "	8.00	" " "	"
8-26-69	9023 Hospital call	8.00	" " "	"
"	" " "	8.00	" " "	"
8-27-69	9023 Hospital call	8.00	: " "	"
"	" " "	8.00	" " "	"
Total due				48.00
This portion of the hospital charges for doctor's services is being forwarded to Div of Correction per phone call with Mrs Berren 2-7-72.				
If any questions remain on these charges, please direct them to department of Special Accounts, 272-4551, ext 221.				
S				
Thank you.				

STATEMENT

DRS. BLANKINSHIP, RHYNEER AND BALDAUF
A PROFESSIONAL CORPORATION
3300 PROVIDENCE DRIVE, SUITE 314
ANCHORAGE, ALASKA 99504

December 30, 1971

State of Alaska
Division of Welfare
~~919~~ MacKay Bldg.
338 Denali Street
Anchorage, AK 99501

Re: Thomas E. McIntire
DOB: 10/16/05

FOR PROFESSIONAL SERVICES:

1/21/66 - Initial Exam	\$15.00
2/7/66 - Electrocardiogram	20.00
2/18/66 - Two-hr pp blood sugar	6.00
2/23/66 - Office Visit	8.00
6/14/66 - Office Visit	8.00
Total Charges	<u>\$57.00</u>

Payments Received:

6/13/66 \$29.00

Balance Due:

\$28.00

Attending Physician: Gilbert P. Blankinship, M.D.

**EXPLANATION OF EXPENSES CREDITED TO
CALENDAR YEAR DEDUCTIBLE ON WHICH
NO MEDICAL INSURANCE BENEFITS CAN BE PAID.
FOR GENERAL INFORMATION SEE REVERSE SIDE.**

MEDICARE

Carrier: Ethna Life & Casualty
Medicare Claim Administration
 Yeon Building
 522 S. W. 5th Avenue
 Portland, Oregon 97204
 Telephone No. 222-6831

Date: _____

HEALTH INSURANCE CLAIM NUMBER:
574-05-5341A

BENEFICIARY'S NAME & ADDRESS:
Kingdon

IMPORTANT:
 These expenses have been credited toward the beneficiary's calendar year deductible. No benefits can be paid on these charges.

DATE	LOCATION OF*	NUMBER OF	RENDERED BY	DESCRIPTION OF*	CHARGES		
					TOTAL	NOT ALLOWED	ALLOWED
9/9/69	Kingdon	1	G. P. Blankenship, MD		10.00	200	800

DEDUCTIBLE STATUS CALENDAR YEAR: 19 69

Deductible to be met for this year according to Social Security records → 46.00

Total allowed expense on this claim: 800

Deductible balance to be met for this year: 32

If zero your deductible has been met for this year

EXPLANATION OF CHARGES NOT ALLOWED
 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.

G. P. Blankenship, MD.

***SEE REVERSE SIDE**
~~9/9/69~~ 9/9/69 06-37-31-03-385
 PHYSICIAN'S OR SUPPLIERS COPY CAT. 150 PRINTED

Name and address of physician or supplier (Number and street, city, state, ZIP code)	Telephone No.	9 Total charges	\$ 46.00
	Physician or supplier code	10 Amount paid	\$
		11 Any unpaid balance due	\$ 46.00
Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)		13 Show name and address of facility where services were performed (if other than home or office visits)	
Signature: <u>J. Blankenship, MD.</u>			
Accept assignment <input type="checkbox"/> I do not accept assignment		Date signed: <u>8/5/70</u>	
Other degree: _____		ECF—Extended Care Facility OH—Outpatient Hospital OL—Other Locations NH—Nursing Home	



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

HEALTH INSURANCE CLAIM NUMBER

IMPORTANT

SEE REVERSE SIDE FOR
GENERAL INFORMATION.

BENEFICIARY'S
NAME
AND ADDRESS

G McSorley

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
	MO	DAY	MO	DAY				
1	2	2	2	6				
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 at left.

- 1. Medical Care
- 2. Surgery
- 3. Consultation
- 4. Diagnostic X-rays
- 5. Diagnostic Lab
- 6. Radiation Therapy
- 7. Anesthesia
- 8. Assistant Surgeon
- 9. Other Service
- 0. Whole Blood or Packed Red Blood Cells

2/12/70 - 6/12/70

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. 91-27143

06-37-31-03-385 relaw

Your \$50.00 deductible has been met for 19 70

	TOTAL	NOT ALLOWED	ALLOWED
1	40.00		40.00
2	48.00		48.00
3	24.00	1.00	23.00
4	20.00		20.00
5			
6			
7			
8			
9			
10			

TOTAL ALLOWED CHARGES 131.00
 LESS DEDUCTIBLE 0.00
 BALANCE OF ALLOWED CHARGES 131.00
 LESS 20% COINSURANCE (26.20)
 MEDICARE PAYS 104.80

BENEFITS PAID TO

G P Blankinship, MD
207 E No. Lights Blvd.
Anchorage, Alaska 99503
3300 Providence Dr 99504
Suite 314

Needs legislative approval

SEE *Kim D.P.A.M.*
 DR.

FAIRBANKS MEDICAL & SURGICAL CLINIC
 P.O. BOX 1330 - FAIRBANKS, ALASKA 99701
 PHONE: 452-2127

DATE:

INVOICE NO. *69-1-2*

6-2-69

Bill to: DEPARTMENT OF PUBLIC HEALTH Acct. No. *2009370*

LABORATORY STAT

Case No. _____ Medicine No. _____

PATIENT: *Albridge White*
 Parent: *(Mrs. & Mr. White) (Parents)*
 Diagnosis: *Mycoplasma, early*

TEST	FEE	TEST	FEE
UCr.		GRAM STAIN	
UA		WET PREP	
CBC		FUNG	
SED RATE		SPUTUM	
COB & HCT		STOOL	
WBC & DIFF		LE PREP	
PRO TIME		GASTRIC	
F&S		RAP	
P.B.I.		BSP	
LRC ACD		THYROID	
CHOL.		HETEROPHILE	
BUN.		RH TITER	
GLUC. TOL.		PTT	
BILIRUBIN		ASO TITER	
CERUPLOCC		PKU	
LATEX		OB LAB	
TYPE & RH		SPECIFY OTHER	
TISSUE			
CREATININE			
ET-3		PHYSICAL THERAPY	
ICTERUS INDEX		EXERCISE	
SGPT		HEAT	
P.S.P.		WHIRLPOOL	
L.D.H.		ULTRASOUND	
SGOT		TRACTION	
VDRL		AMBULATION	
CULTURE		SPECIFY OTHER	
SENS			

PHYSICIAN	FEE	X-RAY DEPT.	FEE
OFFICE VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC. <input type="checkbox"/> REG.		CHEST	
INJECTION:		SPINE: CERVICAL:	
		DORSAL: LUMBAR:	
		LUMBO-SACRAL:	
DRESSING:		ARM	
OB VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC. <input type="checkbox"/> REG.		LEG	
OFFICE SURGERY		G.I.	
CASE:		E.E.	
<input type="checkbox"/> USE OF MINDT SURGERY <input type="checkbox"/> USE OF RECOVERY ROOM		GB	
PHYSICAL EXAMS: <input type="checkbox"/> TEACHER <input type="checkbox"/> STUDENT <input type="checkbox"/> P.A.		HP	
<input type="checkbox"/> REG. ELEC. <input type="checkbox"/> PRE-EMP. <input type="checkbox"/> LIFE INS. <input type="checkbox"/> TEAMSTER		SKULL	
<input type="checkbox"/> ANNUAL <input type="checkbox"/> IF OTHER SPECIFY.		FACIAL	
CONSULTATION:		SINUS	
OPHTHALMOLOGICAL EXAM:	<i>30-</i>	MASTOID	
OTHER TREATMENT:		FELV'S	
SUPPLIES USED:		F&S	
		MAMMOGRAM	
		SPECIFY OTHER:	
		MISCELLANEOUS	FEE
		ELECTROCARDIOGRAM	
		AUDIOGRAM	
		BENNETT MACHINE	

SUNDRY & ADJUSTMENTS	AMOUNT
TOTAL INVOICE AMOUNT:	
OTHER CHARGES:	
CREDITS:	
NET INVOICE AMOUNT	<i>30.00</i>

Need legislative approval

TO SEE DR.

Duffy

FAIRBANKS MEDICAL & SURGICAL CLINIC

P.O. BOX 1330 - FAIRBANKS, ALASKA 99701
PHONE: 452-2127

DATE:

REFER TO DR.

INVOICE NO.

10-16-69

Bill to: DEPARTMENT OF PUBLIC WELFARE Acct. No. *220780*

LABORATORY

STAT

Case No.

Medicare No.

PATIENT

English, Steve

Parent:

Scott, Robert

Diagnosis:

*Very close to normal
Physical exam: growth & development good.*

TEST	FEE	TEST	FEE
UCG		GRAM STAIN	
UA		WET PREP	
CBC		FUNG.	
SED RATE		SPUTUM	
HGB & HCT		STOOL	
WBC & DIFF		URIC ACID	
PRO TIME		GASTRIC	
FBS	<i>MAR 08 1972</i>	PHOSPHORUS	
P.R.T.		BSP	
URIC ACID		THYROID	
CHOL.		PETROPHILE	
BUN.		RH ITER	
GLUC. TOL.		PTT	
BILIRUBIN		ASO ITER	
CEPHFLOCC		OB LAB	
LATEX		SPECIFY OTHER	
ISSUE			
CREATININE			
ET-3		PHYSICAL THERAPY	
ICTERUS INDEX		EXERCISE	
SGPT		HEAT	
P.S.P.		WHIRLPOOL	
LDH.		ULTRASOUND	
SCO-T		TRACTION	
VDRL		AMBULATION	
CULTURE		SPECIFY OTHER	
SENS			

PHYSICIAN	FEE	X-RAY DEPT.	FEE
OFFICE VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC <input type="checkbox"/> REG.		CHEST	
INJECTION: <i>Hydrocortisone</i>	<i>3.00</i>	SPINE: CERVICAL:	
		DORSAL: LUMBAR:	
		LUMBO - SACRAL:	
DRESSING:		ARM	
OB VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC <input type="checkbox"/> REG.		LEG	
OFFICE SURGERY		G.I.	
		S.E.	
		GE	
CAST:		IVP	
<input type="checkbox"/> USE OF MINOR SURGERY		SKULL	
<input type="checkbox"/> USE OF RECOVERY ROOM		FACIAL	
PHYSICAL EXAM: <input type="checkbox"/> TEACHER <input type="checkbox"/> STUDENT <input type="checkbox"/> FAA	<i>10.00</i>	SINUS	
<input type="checkbox"/> PRO ELEC <input type="checkbox"/> PAL-EMP <input type="checkbox"/> LIFE <input type="checkbox"/> TENSION		MASTOID	
<input type="checkbox"/> ANNUAL <input type="checkbox"/> OTHER		PELVIS	
<input type="checkbox"/> ECITY.		RIBS	
CONSULTATION:		MAMMOGRAM	
		SPECIFY OTHER:	
OPHTHALMOLOGICAL EXAM:		MISCELLANEOUS	FEE
OTHER TREATMENT:		ELECTROCARDIOGRAM	
SUPPLIES USED:		AUDIOGRAM	
		BENNETT MACHINE	

SUNDRY & ADJUSTMENTS	AMOUNT
TOTAL INVOICE AMOUNT:	<i>32.50</i>
OTHER CHARGES:	
CREDITS:	
NET INVOICE AMOUNT:	<i>32.50</i>

still pay but must receive suppl. approp. from Legislature to do so
Needs legislative approval

DIVISION OF PUBLIC WELFARE

FAIRBANKS MEDICAL & SURGICAL CLINIC
 P.O. BOX 1330 - FAIRBANKS, ALASKA 99701
 PHONE 452-2127

MAR 02 1972

DATE:

DR.

DR.

INVOICE NO. 23728

FAIRBANKS

INSURANCE WORK COMP MEDICARE NO.

LABORATORY STAT

YOUR ACCOUNT NO. 220580 SUB NO.

TEST	FEE	TEST	FEE
UCG		GRAM STAIN	
UA		WET PREP	
CBC		FLUNG	
SED RATE		SPUTUM	
HGB & HCT		STOOL	
WBC & DIFF		LE PREP	
PPO TIME		GASTRIC	
FBS		PAP	
P.B.I.		BSP	
URIC ACID		THYMOL	
CHOL.		METROPHILE	
BUN.		RH TITER	
GLUC. TOL.		FTI	
BILIRUBIN		ASO TITER	
CEPHFLOCC		PKU	
LATEX		OB LAB	
TYPE & RH		SPECIFY OTHER	
ISSUE			
CREATININE			

PATIENT
 BILL TO
 MAILING ADDRESS
 CITY & STATE

Brunson, Laurel A.
11 P III
 Diagnosis: *Pregnancy*

PHYSICIAN	FEE	X-RAY DEPT.	FEE
OFFICE VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC. <input type="checkbox"/> REG.		CHEST	
DIAGNOSIS:		SPINE: CERVICAL:	
		DORSAL: LUMBAR	
		LUMBO-SACRAL:	
		ARM	
		LEG	
DRESSING:			
OB VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC. <input checked="" type="checkbox"/> REG.	110.00		
OFFICE SURGERY			
CASE:			
<input type="checkbox"/> USE OF MINOR SURGERY <input type="checkbox"/> RECOVERY ROOM			
PHYSICAL EXAMS: <input type="checkbox"/> TEACHER <input type="checkbox"/> STUDENT <input type="checkbox"/> RES.			
<input type="checkbox"/> PED BAC <input type="checkbox"/> PRE EMP <input type="checkbox"/> LIFE INS <input type="checkbox"/> TEAMSTER			
<input type="checkbox"/> ANNUAL <input type="checkbox"/> IF OTHER SPECIFY			
CONSULTATION:			
OPHTHALMOLOGICAL EXAM:			
OTHER TREATMENT:			
SUPPLIES USED:			

3/13/69 - 4/1/69 - 4/15/69 - 4/29/69 - 5/6/69
5/13/69 - 5/20/69 - 5/27/69 - 6/10/69 - 6/23/69 - 7/25/69

PHYSICAL THERAPY	
EXERCISE	
HEAT	
WATERPOOL	
ULTRASOUND	
TRACTION	
AMBULATION	
SPECIFY OTHER	

SUNDRY & ADJUSTMENTS	AMOUNT
TOTAL INVOICE AMOUNT:	310.00
OTHER CHARGES:	
CREDITS:	
NET INVOICE AMOUNT	310.00

MISCELLANEOUS FEE
 ELECTROCARDIOGRAM
 ALDIOGRAM
 BENNETT MACHINE

310.00

Needs legislative approval

FAIRBANKS MEDICAL & SURGICAL CLINIC

P.O. BOX 1330 - FAIRBANKS, ALASKA 99701
PHONE: 452-2127

DATE:

1-10-69

TO: SEE DR. *Condy*

REFER TO DR.

INVOICE NO. *250880*

INSURANCE WORK/COMP MEDICARE NO.

LABORATORY STAT

D. P. W. NO. _____
YOUR ACCOUNT NO. *220880* SUB NO. _____

TEST	FEE	TEST	FEE
ICC		GRAM STAIN	
<i>42</i>		WEI PREP	
CBC		FUNG	
SED RATE		SPUTUM	
HGB & HCT		STOOL	
WBC & DIFF		LE PREP	
PRC TIME		GASTRIC	
FES		PAP	
PBI		PSYCHIC TESTS	

PATIENT
BILL TO
MAILING ADDRESS
CITY & STATE

*Compton, Catherine ✓
O-PW*

PHYSICIAN	FEE	X-RAY DEPT.	FEE
OFFICE VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC <input type="checkbox"/> REG. <i>1/0</i>		CHEST:	
INJECTION:		SPINE: CERVICAL:	
		DORSAL: LUMBAR:	
		LUMBO - SACRAL:	
DRESSING:		ARM	
OB VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC <input type="checkbox"/> REG.		LEG	
OFFICE SURGERY		G.I.	
		B.E.	
CAST:		GB	
<input type="checkbox"/> USE OF MINOR SURGERY <input type="checkbox"/> USE OF RECOVERY ROOM		IVP	
PHYSICAL EXAMS: <input type="checkbox"/> TEACHER <input type="checkbox"/> STUDENT <input type="checkbox"/> FAA		SKULL	
<input type="checkbox"/> BED ELEC <input type="checkbox"/> PRE EMP <input type="checkbox"/> LIFE INS <input type="checkbox"/> TEAMSTER		FACIAL	
<input type="checkbox"/> ANNUAL <input type="checkbox"/> IF OTHER SPECIFY <i>12.50</i>		SINUS	
CONSULTATION:		MASIOD	
OPHTHALMOLO. EXAM:		PELVIS	
OTHER TREATMENT:		RIBS	
SUPPLIES USED:		MAMMOGRAM	
		SPECIFY OTHER:	
		MISCELLANEOUS	FEE
		ELECTROCARDIOGRAM	
		AUDIOGRAM	
		BENNETT MACHINE	

U.P.C. ACID	THYMOL
CHOL.	PETTEROMUE
BUN.	PH. TEST
GLUC. TOL.	PTT
BIL. RUBIN	FAIRBANKS
CEPHFLOCC	PKU <i>FICF</i>
LATEX	OB LAB
TYPE & RH	SPECIFY OTHER
TISSUE	
CREATININE	
ET: 3	PHYSICAL THERAPY
ICTERUS INDEX	EXERCISE
SGP-T	HEAT
P.S.P.	WHIRLPOOL
L.D.H.	ULTRASOUND
SGO-T	TRACTION
VDR	AMBULATION
CULTURE	SPECIFY OTHER
SENS	
SUNDRY & ADJUSTMENTS	
TOTAL INVOICE AMOUNT:	
OTHER CHARGES:	
CREDITS:	
NET INVOICE AMOUNT	<i>16.50</i>

81-95

PARKE-DAVIS

INVOICE SEATTLE

ALASKA DEPARTMENT OF HLTH
JUNEAU
ALASKA 99801

SOUTHEAST REGIONAL LAB
POUCH J
JUNEAU ALASKA 99801

PAGE	CUSTOMER NO.			DATE
	LOC.	TERR.	ACCOUNT	
1	44	6	1440	1118

40
JAN 10 1958

PICKED BY	BAGS	ZONE
CHECKED BY	PACKED CARTONS	POSTAGE
PACKED BY	DISPLAY	SPEC. DEL.
	UNIT PACKERS	C.O.D.
NO. OF BOTTLES	TOTAL	WEIGHT

FORMER ORDER NO. 73	NARCOTIC REG. NO.	NARCOTIC ORDER NO.	DATING CODE	INVOICE NO. 1271
------------------------	-------------------	--------------------	-------------	---------------------

STOCK NO.	DESCRIPTION	SIZE	T.C.	C.C.	PBC	QTY.	LIST PRICE	NET PRICE	EXTENDED AMOUNT
443	1810 TUBERC FPD FIRST DIL	B10TEST				970	2 ⁵ 245 ⁵	115 ⁵	230

06-11-10-12-470

ALL ITEMS BECAME YOUR PROPERTY
SHORTAGES OR BREAKAGES SHOULD BE
NOTATION BILL BY CARRIER'S AGENT.
SHOULD BE REPORTED TO CARRIER

* TRANSACTION CODES
0 - SALE REVERSAL OF SALE 2 B 7 - RETURN
3 B 9 - REVERSAL OF RETURN 4 - ALLOWANCE
5 - REV. POLY 6 - SHORT WILL

C. O. R. C.
DRUG ABUSE
CONTROL PRODUCTS

2

TOTAL \$ 230

SHIPPING ORDER (4)

JOHN A. PENNINGTON, M.D.

Anesthesiologist 099-24-0866

5003 Cambridge Way
ANCHORAGE, ALASKA 99503
Phone: 279-2612

American Board of Anesthesiology
American College of Anesthesiologists

January 24, 1972

Sarah J. Bedding
Box 194
Palmer, Alaska

WELFARE ADC 40542

DATE	DESCRIPTION	AMOUNT..
2/11/69	Anesthesia services PROCEDURE--58720--6 basic units DURATION--2 hours 3 minutes-- 9 time units. TOTAL--15 units at \$7.50 each	112. 80

Doris Sturdevant, Nurse

12

7/12

09-22-69

9:30 PM

KATHY STUDEVANT
STUDEVANT

Welfare

PROVIDENCE HOSPITAL
Anchorage, Alaska

DIVISION OF MENTAL HEALTH
(Hope Cottage)

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

DO NOT BILL

19 Signed

[Signature]

DATE	DESCRIPTION	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
69 JUN 22	ERRM	10.00								
69 JUN 22	MAT	4.50							14.50	
SUB TOTALS								TOTAL CHARGES		
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
AL - ALLOWANCE
ANES - ANESTHESIA
ANT - ANTIBIOTICS
BID - BLOOD
BMR - BASAL METABOLISM
CBC - COMPLETE BLOOD COUNT
CI - CIRCUMCISION
CV - CLINIC VISIT
CY - CYSTOSCOPY
DAN - DELIVERY ANESTHETIC

DEL - DELIVERY ROOM
DIA - DIATHENY
EC - ERROR CORRECTION
EEG - ELECTROENCEPHALOGRAM
EKG - ELECTROCARDIOGRAM
ES - EMERGENCY SURGERY (OR SERVICES)
EST - ELECTRIC SHOCK TR.
HC - HEART CENTER
IC - INTENSIVE CARE
ID - IDENTIFICATION

IS - ISOTOPES
IV - INTRAVENOUS
N - NARCOTICS, ENTIRE STAY
NO2 - NEWBORN OXYGEN
◇ - DEPARTMENTAL CREDIT
OR - OPERATING ROOM
O2 - OXYGEN
OX TR - OXYGEN THERAPY
PAR - RECOVERY ROOM
PE - PERISTALTIC ENEMA

PEN - PENICILLIN
PHY - PHYSIOTHERAPY
PHO - PHOTOGRAPHS
PL - PLASMA
REF - REFUND
TEL - TELEPHONE
TI - TISSUE
TR - TRANSFUSION
UR - URINALYSIS
XT - X-RAY THERAPY

BURBANK SYMBOLS ONLY
C/S - CENTRAL SUPPLY
CHG - CHARGE UNDER SUNDRY
ER - EMERGENCY ROOM
IPPB - INTERMITTENT POSITIVE
PRES - PRESSURE BENNETT MACHINE
R/C FEE - RED CROSS BLOOD
PRO - PROCESSING FEE
RX - DRUG CHARGE UNDER SUNDRY

WILLIAM SUMMERVILLE
 8 895 KARLUK BLDG. 11 APT. 1325
 C CITY 99504

BETTY SWEAT & BABY

3Y)

OB

68-30-30

08-30-68

4:45 PM

PROVIDENCE HOSPITAL
 Anchorage, Alaska

OF INSURANCE BENEFITS: I hereby authorize payment directly to the above
 of the Hospital Benefits otherwise payable to me but not to exceed the hospi-
 tal charges for this period of hospitalization. I understand I am financially responsi-
 ble for charges not paid under this agreement.

19 Signed _____

INSURED

7-3 (68) 12:30 PM

DATE	DESCRIPTION	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
							50.0 0		50.0 0	
08AUG 30							50.0 0		100.0 0	50.0 0
08AUG 31										
08SEP	1 DEL RM	75.0 0					55.0 0			
08SEP	1 ANES	10.0 0					25.0 0		265.0 0	100.0 0
08SEP	2 TEL	.5 0								
08SEP	2 PHONE DEPOSIT SUMMERVILLE 07521							5.0 0		
08SEP	2						55.0 0			
08SEP	2						25.0 0		340.5 0	265.0 0
08SEP	3 DEL MAT TR	28.0 0	16.75	10.0 0						
08SEP	3			2.5 0		45.0 0			440.0 0	
08SEP	3 TRANSFERRED FROM OTHER LEDGER							00.0 0		
08SEP	3 SUMMERVILLE PHONE REFUND 67550							4.5 0	347.2 5	442.7 5
08SEP	6 TR			10.0 0					357.2 5	347.2 5
08OCT 29	357.2 5									
09JAN 3	SUMMERVILLE US MERC 72024							20.0 0	337.2 5	357.2 5
SUB TOTALS								TOTAL CHARGES		

ACKNOWLEDGMENT
 We have received your accounts and they will be worked promptly.
 U. S. MERCANTILE SYSTEMS
 2000 Spruce St. Road
 Anchorage, Alaska 99503
 Phone 277-0500

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 - ISOTOPIES | PHN - PENICILLIN |
| AL - ALLERGANCE | DR - DIATHERMY | IV - INTRAVENOUS | PHY - PHYSIOTHERAPY |
| ANES - ANESTHESIA | DIA - DIAPHRAGM | N - NARCOTICS, ENTIRE STAY | PT - PHYSIOGRAPHY |
| ANES - ANESTHETICS | EC - ECG CONNECTION | HO2 - NEWBORN OXYGEN | PHO - PHOTOGRAPHS |
| BLO - BLOOD | EGG - ELECTROENCEPHALOGRAPH | OR - OPERATING ROOM | PL - PLASMA |
| BMR - BASAL METABOLISM | EGC - ELECTROCARDIOGRAM | OX - OXYGEN | REF - REFUND |
| CBC - COMPLETE BLOOD COUNT | ES - EMERGENCY SURGERY (OR SERVICES) | OX II - OXYGEN THERAPY | TEL - TELEPHONE |
| CI - CIRCUMCISION | ES - ELECTRIC SHOCK TR. | PAR - RECOVERY ROOM | TI - TISSUE |
| CV - CLINIC VISIT | HC - HEART CENTER | PE - PERISTALTIC LINTA | TR - TRANSFUSION |
| CY - CYSTOSCOPY | IC - INTENSIVE CARE | | UR - URINALYSIS |
| DAN - DELIVERY ANESTHETIC | ID - IDENTIFICATION | | XX - X-RAY THERAPY |

- SYMBOLS ONLY
- C/S - CENTRAL SUPPLY
 - CH - CHARGES UNDER SUNDRY
 - ER - EMERGENCY ROOM
 - IPPD - INTERMITTENT POSITIVE PRESSURE BENNETT MACHINE
 - R/C FEE - RED CROSS BLOOD
 - PRO - PROCESSING FEE
 - DR - DRUG CHARGES UNDER SUNDRY

STATE OF ALASKA

KEITH H. MILLER, Governor

DEPARTMENT OF HEALTH AND WELFARE

DIVISION OF PUBLIC HEALTH

SOUTHCENTRAL REGIONAL OFFICE
ROOM 222, MACKAY BUILDING
338 DENALI STREET - ANCHORAGE 99501

Itinerant Nursing Service

July 2, 1969

RECEIVED
JUL 3 1969
Wein Consolidated
Airlines

Wein Consolidated Airlines
4100 International Airport Rd.
Anchorage, Alaska

Dear Sir:

Please find enclosed TR # 209423 and # 209424 for Richard
Evan and Mrs. Antone Evan for a round trip ticket from
Iliamna to Anchorage.

Thank you.

Sincerely,

Edith Moerschell
(Miss) Edith Moerschell
Public Health Nurse
Iliamna Itinerant

EM/ds
Enclosures - 2

TR 209423 31.50
TR 209424 63.00

94.50

SA-19
2M 8-68

STATE OF ALASKA

Nº 209423

Request For Transportation
Department of Health & Welfare
Pouch H
Juneau, Alaska 99801

The DEPARTMENT OF HEALTH & WELFARE requests the
(Department or Office requesting transportation and address)
Wien Consolidated Company to furnish Transportation
for Richard Evan + return from Umanna
(Name of Traveler)
To Anchorage Anchorage June 1, 1969
(Place and Date of Issue)
Form No. _____ Ticket No. _____
(Signature of Traveler)
Value \$ 31.50 (No tax payable). _____
Tourist class fare (See instruction #1 on reverse side) (To be inserted by carrier). (Title)
Carrier will forward this request to the Department or Office Requesting Transportation
(SEE INSTRUCTIONS ON REVERSE SIDE)

SA-19
2M 8-68

STATE OF ALASKA

Nº 209424

Request For Transportation
Department of Health & Welfare
Pouch H
Juneau, Alaska 99801

The DEPARTMENT OF HEALTH & WELFARE requests the
(Department or Office requesting transportation and address)
Wien Consolidated Company to furnish Transportation
for Mrs. Antone Evan + return from Umanna
(Name of Traveler)
To Anchorage Anchorage June 1, 1969
(Place and Date of Issue)
Form No. _____ Ticket No. _____
(Signature of Traveler)
Value \$ 63.00 (No tax payable). _____
Tourist class fare (See instruction #1 on reverse side) (To be inserted by carrier). (Title)
Carrier will forward this request to the Department or Office Requesting Transportation
(SEE INSTRUCTIONS ON REVERSE SIDE)

SA-19
2M 8-68

STATE OF ALASKA 5
Request For Transportation

No 209371
29

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

Wain Consolidated Company to furnish Transportation

for Zachar Anelson from Iliamna
(Name of Traveler)

To Anchorage + return Anchorage May 13, 1969
(Place and Date of Issue)

Form No. Ticket No.

Value \$ 60.00 (No tax payable) Edith Moerschell
Tourist class fare (See instruction #1 on reverse side) (To be inserted by carrier). (Title)

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

traveled 5/20 - 5/25/69

Third and E
Westward Ticket Office
Anchorage, Alaska

Dear Sir:

Enclosed please find Request for Transportation # 209371
for Zachar Anelson of Iliamna for a round trip ticket.

Thank you.

Sincerely,

Edith Moerschell
(Miss) Edith Moerschell
Public Health Nurse
Iliamna Itinerant

EM/ds
Enclosure

60.00

STATEMENT

Wien Consolidated Airlines, Inc.



4100 INTERNATIONAL AIRPORT RD.
ANCHORAGE, ALASKA 99502

TO StateK Department of Health & Welfare
Pouch H
Juneau, Alaska 99801

33-005

1-19-71

PLEASE DETACH AND
RETURN THIS PORTION
WITH YOUR REMITTANCE

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

DATE			CODE	ITEMS	DEBITS	CREDITS	BALANCE
DAY	YEAR						
BALANCE FORWARD IS							
8	8	69		21849-014130	80.00	207739	

This Exchange Order was voided but, there was a ticket written and used against it.
So, I am sending copy's of both with this billing.
Thanks

*2 yrs old
big amount needed
Layal*

13-12-18

Alaska Business License No. 70 65277
Type of Business - Certified Air Carrier
License issued - February 9, 1969

I hereby certify the above bill is correct and just,
and payment of same has not been received.
Signed *Betty Miles*
WIEN CONSOLIDATED AIRLINES, INC.

PASSENGER'S COPY

- 1 - FREIGHT
- 2 - TICKETS (PASS)
- 3 - CASH RECEIPTS
- 4 - TRAVEL MEMOS
- 5 - CREDIT MEMOS
- 6 - JOURNAL VOUCHERS
- 7 - INVOICE BILLINGS
- 8 - EXCHANGE ORDERS

Our books close on the 31st 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

*Include Bills for
Approved*

SA-19
2M 9-67

STATE OF ALASKA
Request For Transportation

216644

The Dept of Health & Welfare - Division of Public Health (cos) requests the
(Department or Office requesting transportation and address)
Wien Consolidated Airlines Company to furnish Transportation
 for Isabell Douglas (b. 9/5/55) from Koyuk
(Name of Traveler)
 To Nome & return to Koyuk June 27, 1970
(Place and Date of Issue)
 Form No. 213 200 Ticket No. 014 097 Margaret Sivakova
(Signature of Traveler)
 Value \$ 40.00 (No tax payable) Sr. PHN - Nome, Alaska
(Title)
 Tourist class fare (See instruction #1 on reverse side) (To be inserted by carrier).

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

STATEMENT

Wain Consolidated Airlines, Inc.



4100 INTERNATIONAL AIRPORT RD.
ANCHORAGE, ALASKA 99503

To State Department of Health & Welfare
Pouch #
Juneau, Alaska 99801

33-005

8-6-70

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

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

MO	DATE	YEAR	COOL	ITEMS	DEBITS	CREDITS	BALANCE
					BALANCE FORWARD \$0		
5	19	69		2126-029159	10.15	2061.17	486.2
5	15	69		2126-029079	2.00	2061.17	281.95
5	1	69		2126-024796	13.75	2061.12	NAT ON FILE
5	22	69		2126-012607	3.00	2061.10	781.73
5	21	69		2126-018572	9.66	1805.6	NAT ON FILE

THESE ARE ALL EXCESS BAGGAGE TITLES THAT SHOULD HAVE BEEN BILLED WITH YOUR LAST STATEMENT THAT SHOWS BUT, SOMEHOW THEY GOT DELETED FROM THEM SO, YOU HAVE THEM BILLED ON THEM BEFORE. SORRY!
I HOPE TO GET ALL OF THESE EXCESS BAGGAGE TITLES CLEARED SOON.

PLEASE RETURN A COPY OF THIS STATEMENT WITH YOUR PAYMENT.
THANKYOU

2 yrs old neg. approved
Ray D

Alaska Business License No. 70-05277
Type of Business - Certified Air Carrier
License Issued - February 24, 1970

certify that the above bill is correct and just;
but payment therefor has not been received.
Signed by *Betty Miles*
WAIN CONSOLIDATED AIRLINES, INC.

- 1. FREIGHT
- 2. TICKETS (PASS)
- 3. CASH RECEIPTS
- 4. DEBIT MEMOS
- 5. CREDIT MEMOS
- 6. TRANSFERS
- 7. JOURNAL VOUCHERS
- 8. INVOICE BILLINGS
- 9. EXCHANGE ORDERS

Our books close on the 31st 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
Wain Consolidated Airlines, Inc., 4100 International Airport Rd., Anchorage, Alaska 99503

PAY LAST AMOUNT IN THIS COLUMN

In old Bills for approval

TICKET				COUPON	
From Fairbanks				212.600 029.159	
DATE OF ISSUE				MAY 19 59	
DECLARED VALUE				212.100	
AMOUNT OF EXCESS 350.00				SERIAL NO. 074505	
VALUATION CHARGE				FORM OF PAYMENT	
NOT GOOD FOR PASSAGE				STR 209215	
FROM	CARRIER	REASON FOR CHARGE		FOR CONDITIONS OF CONTRACT SEE PASSENGER TICKET & BAGGAGE CHECK	
Fairbanks	WC	EXTRA	OVER SIDE WEIGHT SPECIAL CHARGES	MAY 19 59	
Barrow			X 10.15	FAIRBANKS 34	
NO. 10.0		TEL EXCESS BAG CHARGED 10.15		34 5130	
TOTAL 10.15		33-005			

EXCESS BAGGAGE TICKET				AGENT'S COUPON	
ISSUED BY Western Consolidated Airlines, Inc.				212.600 029.079	
DATE OF ISSUE				MAY 19 59	
DECLARED VALUE				212.100	
AMOUNT OF EXCESS 20.00				SERIAL NO. 067578	
VALUATION CHARGE				FORM OF PAYMENT	
NOT GOOD FOR PASSAGE				STR 2064057	
FROM	CARRIER	REASON FOR CHARGE		FOR CONDITIONS OF CONTRACT SEE PASSENGER TICKET & BAGGAGE CHECK	
NO. 10.0		EXTRA	OVER SIDE WEIGHT SPECIAL CHARGES	MAY 19 59	
Fairbanks			20.00	FAIRBANKS 34	
Minto		TEL EXCESS BAG CHARGED 20.00		34 5130	
TOTAL 20.00		33-005			

ISSUED BY
WIEN CONSOLIDATED AIRLINES

EXCESS BAGGAGE TICKET

AGENT'S COUPON
212:600 :024:796

DATE OF ISSUE
21 APR 69

DECLARED VALUE
115

AMOUNT OF EXCESS
75

VALUATION CHARGE
75

FROM	CARRIER	REASON FOR CHARGE				CHARGED
		EXTRA CB #70	OVER SIZE	EXCESS WEIGHT	SPECIAL	
VOID	Y					
FAZ	W	X	X	X	X	
OTZ	C				1875	

TTL EXCESS BAG CHARGED

FORM 212-200

SERIAL NO. 053-788

FORM OF PAYMENT
STR-2090

34 4 38

33-005

ISSUED BY
WIEN ALASKA AIRLINES, INC.

EXCESS BAGGAGE TICKET

AGENT'S COUPON
212:600 :012:607

DATE OF ISSUE
20 APR 69

DECLARED VALUE
300

VALUATION CHARGE
300

FROM	CARRIER	EXCESS BAGGAGE				CHARGE
		TOTAL WEIGHT	EXCESS WEIGHT	EXCESS WEIGHT	EXCESS WEIGHT	
Crc	Wca	60	40	20	15	300
FAZ	Wca	60	40	20	15	300

TOTAL CHARGES
600

FORM 212-200

SERIAL NO. 017627

FORM OF PAYMENT
43-005

33-005

40 5 4

ISSUED BY
WIEN CONSOLIDATED AIRLINES

EXCESS BAGGAGE TICKET

AGENT'S COUPON
212:600 :016:572

DATE OF ISSUE
21 MAR 69

DECLARED VALUE
445

VALUATION CHARGE
445

FROM	CARRIER	REASON FOR CHARGE				CHARGED
		EXTRA CB #70	OVER SIZE	EXCESS WEIGHT	SPECIAL	
me	Wc					9.66
me						7.66

TTL EXCESS BAG CHARGED

FORM 212-200

SERIAL NO. 010751

FORM OF PAYMENT
STR 188556

3 30

SA-19
2M 8-68

STATE OF ALASKA
Request For Transportation

Nº 100477

A

The DEPARTMENT OF HEALTH & WELFARE ALASKA DEPARTMENT OF HEALTH & WELFARE requests the
(Department or Office requesting transportation and address)
Wien Consolidated Airlines Company to furnish Transportation
for Mr. + Mrs. Moses Crickshank + Janet from Anchorage
(Name of Traveler)
To Fairbanks July 27, 1969
(Place and Date of Issue)
Form No. 2129 Ticket No. 5434 Jack D. McCool
(Signature of Traveler)
Value \$ 97.50 (No tax payable) Regional Supervisor
(Title)
Tourist class fare (See instruction #1 on reverse side) (To be inserted by carrier).

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

X O - 2129-5434

H+SS

memo of 1/20/72

*
*
*

4	8	0.00	C	+
	7	4.00		+
	2	5.00		+
	2	5.00		+
	1	5.75		+
	8	6.40		+
		5.00		+
	1	4.00		+
1	0	2.00		+
	6	0.00		+
	5	0.00		+
	1	3.80		+
	1	0.00		+
	2	5.00		+
1	2	5.00		+
3	1	0.00		+
	1	6.50		+
	1	0.00		+
	1	4.00		+
	2	0.00		+
4	4	2.10		+
	1	0.00		+
	1	5.00		+
	1	4.10		+
	1	1.25		+
5	5	5.00		+
	5	5.00		+
		7.00		+
	8	2.00		+
3	2	1.25		+
4	1	1.00		+
1	0	0.00		+
	1	5.00		+
	5	1.65		+
	6	7.50		+
5	5	5.13		-
		0.25		+
		6.00		+
	4	3.00		+
	4	0.00		+
	4	0.00		+
10	0	1.60		+
6	5	2.50		+
5	5	4.97		+
	5	6.50		+
	4	3.00		+
		4.50		+
		7.00		+
		6.80		+
	5	4.80		+
	0	1.20		+
1	5	1.00		+
	8	1.00		+
	4	3.56		+
	1	2.00		+
1	8	0.00		+
	3	0.00		+
	5	0.00		+
1	1	0.00		+
8	0	1.50		+
8	4	5.73		+

Total 9544.55

Copper Valley 113.82

STATEMENT
THE ALASKA CLINIC
"A Professional Corporation"

825 L STREET PHONE 272-4551
ANCHORAGE, ALASKA

6-11-71

Department of Health and Welfare

Re: Sara Redding

IRS 92-0036732

DATE	TREATMENT	CHARGES	CREDIT	BALANCE
2-10-69	Admitted Abdominal hysterectomy	480.00		
2-17-69	Discharged			
3-3-69	Office call	n/c		
William Ivy, MD Diagnosis; Large uterine Fibroids Fibroids				480.00

RECEIVED

Div. of
Public Welfare

STATEMENT
THE ALASKA CLINIC
"A Professional Corporation"

825 L STREET PHONE 272-4551
ANCHORAGE, ALASKA
6-23-71

Department of Health and Welfare

Re: Elinore Tondu

IRS 92-0036732

DATE	TREATMENT	CHARGES	CREDIT	BALANCE
6-23-69	Office call	10.00		
	T3	5.00		
	T4	5.00		
	ENG	20.00		
6-27-69	SMA-12	18.00		
7-1-69	Office call	10.00		
Robert Prouty, MD				
				225.00 74.00

RECEIVED
JUN 29 1971

Div. of
Public Welfare

STATEMENT
AMBULANCE SERVICE
CITY OF FAIRBANKS

No. _____

Date August 30, 1968

Charge To: V. A. N. S.

Requested by Pappas Nursing Home

Address Calhoun Road

Phone No. _____

Patient's Name Annex Jolley

Home Address Pappas Nursing Home

From Fairbanks Community Hospital

To Pappas Nursing Home

Mileage _____

Nature of Service: Injury Illness Transportation

Time Rec. 1222

Charges Basic 25.00

First Aid Performed None

Mileage 5

Driver W. J. JENSEN

Out 1235

Oxygen _____

First Aider PHILIPPI

DIVISION OF 1250

Waiting Time _____

BILLING ADDRESS

PUBLIC WELFARE

Tax _____

TOTAL 30.00

Department of Public Welfare

NOV 09 1970

604 Tomlinson Street

Fairbanks, Alaska 99701

FAIRBANKS

Statement Given Patient Hospital for _____

Received Payment DELINQUENT

Cash Receipt by _____

Statement Must Be Returned With Remittance

DISPOSAL: Payment and Receipts to Driver or City Cashier - 410 Cushman Street

FW

STATEMENT
AMBULANCE SERVICE
CITY OF FAIRBANKS

No. 5

Date August 29, 1963

Charge for V. A. N. S.

Requested by Pappas Nursing Home Address Clifney Road Phone No.

Patient's Name Amy Johnson Home Address Pappas Nursing Home

From Pappas Nursing Home To Fairbanks Community Hospital Mileage

Nature of Service: Injury Illness Transportation Time Rec. 2051 Charges Basic \$ 25.00

First Aid Performed None Mileage

Driver Slaughter Out 2052 Oxygen \$

First Aider Price DIVISION OF PUBLIC WELFARE 5127 Tax \$

BILLING ADDRESS

TOTAL \$ 25.00

Department of Public Welfare 1970

604 Burnetts Street

Fairbanks, Alaska 99701

Statement Given Patient Hospital for Patient

Received Payment DELINQUENT

Cash Receipt by

Statement Must Be Returned With Remittance

DISTRICT OFFICE

NOTE: Payment may be made to Driver or City Cashier - 41C Cushman Street

EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM

By:

Aetna Life & Casualty
 Medicare Claim Administration
 Yeon Building
 522 S. W. 5th Avenue
 Portland, Oregon 97204
 Telephone No. 222-6831

DATE

4-2-70

HEALTH INSURANCE CLAIM NUMBER

553-03-1091D

IMPORTANT

SEE REVERSE SIDE FOR
 GENERAL INFORMATION.

BENEFICIARY'S
 NAME
 AND ADDRESS

7 Wickiukham State

LOCATION OF SERVICE CODES

The following will explain the codes shown in the "Location of" column to the right.

- DO Doctor's Office
- IH Inpatient Hospital
- IL Independent Lab
- ECF Extended Care Facility
- H Patient's Home
- OH Outpatient Hospital
- OL Other Location
- NM Nursing Home

SERVICES

	FIRST DATE		LAST DATE		LOCATION OF	NUMBER OF	RENDERED BY	DESCRIPTION OF
	MO	DAY	MO	DAY				
1	2	26	4		11			
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 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

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.

OH 38051-01

06-37-31-03-545

Your \$50.00 deductible has been met for 19-69

	TOTAL	NOT ALLOWED	ALLOWED
1	4000		4000
2	54000	10800	43200
3			
4			
5			
6			
7			
8			
9			
10			

TOTAL ALLOWED CHARGES

LESS DEDUCTIBLE

BALANCE OF ALLOWED CHARGES

LESS 20% COINSURANCE

MEDICARE PAYS

47200

4000

43200

8640

34560

BENEFITS PAID TO

[Handwritten signature]



EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM

896

Prepared 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

IMPORTANT

SEE REVERSE SIDE FOR
GENERAL INFORMATION.

BENEFICIARY'S
NAME
AND ADDRESS

J. Whitney
3711 ...
ANCHORAGE, ALASKA 99503

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>	03	18	03	18				<p>The following will explain the number shown in the "Description of" column to the 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 10. Whole Blood or Packed Red Blood Cells</p>
	2							
	3							
	4							
	5							
	6							
	7							
	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 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.

71-23029-01
06-37-31-03-385

Your \$50.00 deductible has been met for 1972

BENEFITS PAID TO

A.C. CHALKER, MD
707 E. NORTHMAN LIGHTS RD
ANCHORAGE ALASKA 99503

CHARGES	TOTAL	NOT ALLOWED	ALLOWED
	1	25.00	
2			
3			
4			
5			
6			
7			
8			
9			
10			
TOTAL ALLOWED CHARGES			25.00
LESS DEDUCTIBLE			50.00
BALANCE OF ALLOWED CHARGES			25.00
LESS 20% COINSURANCE			5.00
MEDICARE PAYS			20.00



EXPLANATION OF MEDICARE BENEFITS

207 E. NORTHERN
ANCHORAGE

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM

Prepared By: *W. J. Whitney*

DATE: *1-15-76*

Aetna Life & Casualty
Medicare Claim Administration
Yeon Building
522 S. W. 5th Avenue
Portland, Oregon 97204
Telephone No. 222-6831

HEALTH INSURANCE CLAIM NUMBER: *06-37-31-03-385*

IMPORTANT

SEE REVERSE SIDE FOR
GENERAL INFORMATION.

BENEFICIARY'S
NAME
AND ADDRESS

W. J. Whitney
377 Bridge Street
Anchororage, Alaska

LOCATION OF SERVICE
CODES

The following will explain
the codes shown in the "Lo-
cation 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
<i>0507</i>	<i>1204</i>	<i>OH</i>	<i>1</i>	<i>C. C. Walters, M.D.</i>	<i>2</i>
	<i>69</i>	<i>OH</i>	<i>1</i>		<i>1</i>
		<i>OH</i>	<i>1</i>		<i>1</i>

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. Anesthesia
- 8. Assistant Surgeon
- 9. Other Service
- 0. Whole Blood or Packed Red Blood Cells

If an amount is shown in the "Not Allowed" column at right, the paragraph checked below will explain.

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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. *71-23029-01*

	TOTAL	NOT ALLOWED	ALLOWED
1	<i>20.00</i>	<i>2.00</i>	<i>18.00</i>
2	<i>3.50</i>		<i>3.50</i>
3	<i>70.00</i>	<i>18.00</i>	<i>52.00</i>
4			
5			
6			
7			
8			
9			
10			

Your \$50.00 deductible has been met for 1967.

O. C. Walters, M.D.
209 E. 7th Street, Supt. Bldg.
Anchorage, Alaska 99503

BENEFITS
PAID TO

TOTAL ALLOWED CHARGES *75.50*
 LESS DEDUCTIBLE *12.50*
 BALANCE OF ALLOWED CHARGES *63.00*
 LESS 20% COINSURANCE *12.60*
 MEDICARE PAYS *50.40*

THE CHILDREN'S CLINIC
3300 PROVIDENCE DRIVE
ANCHORAGE, ALASKA 99504
TELEPHONE: (907) 279-8571

Dept. of Health & Welfare
338 Denali, Rm. 222
Anchorage, Alaska

Steckel, Susan
Mother - Charlotte

12/10/69	Newborn care	\$30.00
12/29/69	Office visit	12.00
	PKU	3.00
2/4/70	Office visit	12.00
3/6/70	Hospital	25.00
	Care in Hospital	20.00
		<u>102.00</u>

OCT 10 1971

Richard A. Peterson, M.D.

J. Metzler

Joseph R. Cumming, D.D.S.
406 G Street
Anchorage, Alaska 99501
Phone 272-9575

April 14, 1971

Department of Health & Welfare
Division of Public Welfare
338 Denali St. Room 222
Anchorage, Alaska 99501

RE: DEBRA WILLIAMS

Billing for emergency treatment services rendered.

11/6/68	Full Mouth X-Rays	\$25.00
	#30 B Amalgam Filling	10.00
	#30 MOD Amalgam Filling	25.00

\$60.00

To date our records show no payment on the account
which was originally submitted for payment 11/15/68.

Please advise or send payment as quickly as possible.

Thank You.

Sincerely,
Sharon C. Miller
(Mrs.) Sharon C. Miller
Office of Dr. Joseph R. Cumming

STATEMENT

PAUL L. ENEBOR, M.D.

Physician and Surgeon

BOX 194

HOMER, ALASKA 99608

Telephone 285-8805

HUDSPETH, ROBERT
BOX 251
HOMER, ALASKA

HEM

DATE	PROFESSIONAL SERVICE	CHARGE	PAID	BALAN
10-29-69	L.A. DRUGS			50.
	(Dr. Pl. Vray & Lab done 5-8-69)			
Dear Mr. Hudspeth:				
We have received no response to date either from insurance or other sources as to payment of this account. Rather than retain it on our books indefinitely, we would very much like to close it as soon as possible. Please advise us at your earliest convenience when we may expect payment.				
Your understanding and cooperation will be deeply appreciated.				
Sincerely, This examination was applied for by the Dept H.W. of Social Security and conducted with the intent that Millie Morantz, Office Manager, they would pay for it. I would not have had the exam if it was intended that I should pay for it.				

7808

PAY LAST AMOUNT IN THE COLUMN

OC—Office Call
MCD—House Call Day
MCHN—House Call Night
HOSP—Hospital Care
L—Laboratory

I—Injection
INS—Insurance
OB—Obstetrical Care
OS—Office Surgery
HS—Hospital Stay

PE—Physical Examination
EKG—Electrocardiogram
XR—X-Ray
M—Medication
NC—No Charge



EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM

Atna Life & Casualty
Medicare Claim Administration
Yeon Building
527 S. W. 5th Avenue
Portland, Oregon 97204
Telephone No. 222-6831

DATE 8-20-69
HEALTH INSURANCE CLAIM NUMBER
434-82-14470

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.

S. YATES
712 16th AVE APT 2
FAIRBANKS ALASKA

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

TH

SERVICES

NO.	FIRST DATE		LAST DATE		LOCATION OF	NUMBER OF	RENDERED BY	DESCRIPTION OF
	MO	DAY	MO	DAY				
1	12	20	02	20	IH of		JOSEPH V. JOHNSON M.D.	3
2	12	15	02	22	IH of		RAYMOND D. EVANS M.D.	1
3								
4								
5								
6								
7								
8								
9								
10								

DESCRIPTION OF SERVICE CODES

The following will explain the number shown in the "Description of" column on 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

If an amount is shown in the "Not Allowed" column at right, the paragraph checked below will explain.

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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.

	TOTAL	NOT ALLOWED	ALLOWED
1	30.00		30.00
2	20.00	56.00	64.00
3			
4			
5			
6			
7			
8			
9			
10			

Your \$50.00 deductible has been met for 69

FAIRBANKS MEDICAL & SURGICAL CLINIC
P.O. BOX 1330
FAIRBANKS ALASKA

TOTAL ALLOWED CHARGES 9466
LESS DEDUCTIBLE 2500
BALANCE OF ALLOWED CHARGES 6966
LESS 20% COINSURANCE 1380
MEDICARE PAYS 5586

BENEFIT PAID TO

MB 4067 3-01

BENEFICIARY'S COPY

06-37-41-03-385

CAT. 196895 PRINTED IN U.S.A.

TO SEE DR. *Kinn D.P.M.*
 REFER TO DR.

FAIRBANKS MEDICAL & SURGICAL CLINIC

P.O. BOX 1330 -- FAIRBANKS, ALASKA 99701
 PHONE: 452-2177

DATE:

INVOICE NO. *69-6-2*

6-2-69

Bill to: DEPARTMENT OF PUBLIC WELFARE Acct. No. _____

Case No. _____ Medicare No. _____

LABORATORY STAT

TEST	FEE	TEST	FEE
UCG		GRAM STAIN	
UA		WET PREP	
CBC		FLUNG	
SED RATE		SPUTUM	
HGB & HCT		STOOL	
WBC & DIFF		LE PREP	
PRO TIME		GASTRIC	
FBS		PAP	
P.B.I.		BSP	
URIC ACID		THYMOL	
CHOL.		HETEROPHILE	
BUN.		RH TITER	
GLUC. TOL.		PTT	
BILIRUBIN		ASO TITER	
CEPH-FLOCC		PKU	
LATEX		OB LAB	
TYPE & RH		SPECIFY OTHER	
TISSUE			
CREATININE			
ET-3			
ICHTERUS INDEX			
SGP-T			
P.S.P.			
L.D.H.			
SGO-T			
VDRL			
CULTURE			
SENS			

PATIENT *Albridge, Mike*
 Parent: *Wm. & M. (Parents)*
 Diagnosis: *Myopia, early*

PHYSICIAN	FEE	X-RAY DEPT.	FEE
OFFICE VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC. <input type="checkbox"/> REG.		CHEST	
INJECTION:		SPINE: CERVICAL:	
		DORSAL: LUMBAR:	
		LUMBO-SACRAL:	
DRESSING:		ARM	
OB VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC. <input type="checkbox"/> REG.		LEG	
OFFICE SURGERY		G.I.	
CAS:		E.E.	
<input type="checkbox"/> USE OF MINOR SURGERY <input type="checkbox"/> USE OF RECOVERY ROOM		GB	
PHYSICAL EXAMS: <input type="checkbox"/> TEACHER <input type="checkbox"/> STUDENT <input type="checkbox"/> FAA		HP	
<input type="checkbox"/> FED ELEC <input type="checkbox"/> PRE-EMP <input type="checkbox"/> LIFE INS. <input type="checkbox"/> TEAMSTER		SKULL	
<input type="checkbox"/> ANNUAL <input type="checkbox"/> IF OTHER SPECIFY:		FACIAL	
CONSULTATION:		SINUS	
OPHTHALMOLOGICAL EXAM:	<i>30-</i>	MASO.D	
OTHER TREATMENT:		PELVIS	
SUPPLIES USED:		RBS	
		MAMMOGRAM	
		SPECIFY OTHER:	
		MISCELLANEOUS	FEE
		ELECTROCARDIOGRAM	
		AUDIOGRAM	
		BENNETT MACHINE	

SUNDRY & ADJUSTMENTS	AMOUNT
TOTAL INVOICE AMOUNT:	
OTHER CHARGES:	
CREDITS:	
NET INVOICE AMOUNT	<i>30.00</i>

[Handwritten Signature]

OFFICE NO. 574 59 553 R
 YOUR ACCOUNT NO. 205505-1 SUB NO.

NEW ADDRESS HERE
 PATIENT
 CALL TO
 MAILING ADDRESS
 CITY & STATE

PLEASE SHOW YOUR NEW OR CORRECT MAILING ADDRESS BELOW
Bailey, Florence
Self + Medicare
Steel House

HSE	HOUSE CALL DATE:	208
CSN	CONSULTATION WITH DR.:	209
MISC	MISCELLANEOUS:	210

HOSPITAL SERVICES RENDERED BY PHYSICIAN

HA	HOSPITAL ADMITTANCE DATE:	<u>6-2-69</u>	<u>#90200</u>	200	<u>35.00</u>
OV	HOSPITAL VISITS	<u>6-2-69</u>	<u>#90240 FROM 15:30 per day</u>	201	<u>90.00</u>
PV	OUT PATIENT VISIT	DATE: <u>2nd 4th 6th 7th</u>		202	
BD	OB DELIVERY	<u>8th 10th 12th</u>		203	
NB	NEW BORN PHYSICAL			204	
UR	HOSPITAL SURGERY			205	
SA	SURGICAL ASSISTANT	<u>OK</u>		206	
ANES	ANESTHETIST			207	

(Disch. 6-12-69)

TOTAL INVOICE AMOUNT 115.00

Extensive Hematoma

Less 80% Discount
Walter H. [Signature]

115.00
20%
23.00 Pay

FAIRBANKS MEDICAL & SURGICAL CLINIC

P.O. BOX 1330 - FAIRBANKS, ALASKA 99701
PHONE: 352-2127

(DATE & TIME STAMP HERE)

O SEE DR. *Petajan*

INVOICE NO. **H**

3-25-69

INSURANCE WORK COMP MEDICARE NO.

D.P.W. YOUR ACCOUNT NO. 212475 SUB NO.

PLEASE SHOW YOUR NEW OR CORRECT MAILING ADDRESS BELOW

NEW ADDRESS HERE

PATIENT

BILL TO

MAILING ADDRESS CITY & STATE

Harris, Winifred

HOSPITAL SERVICES RENDERED BY PHYSICIAN

HA	HOSPITAL ADMITTANCE DATE:	FROM	TO	200
<input checked="" type="checkbox"/>	HOSPITAL VISITS	<i>3 X</i>		201 <i>125.00</i>
DPV	OUT PATIENT VISIT DATE:			202
OBD	OB DELIVERY			203
NB PHY	NEW BORN PHYSICAL			204
SUR	HOSPITAL SURGERY			205
SA	SURGICAL ASSISTANT			206
ANES	ANESTHETIST			207

HSE	HOUSE CALL DATE:	208
CSN	CONSULTATION WITH DR.:	209
MISC	MISCELLANEOUS:	210

TOTAL INVOICE AMOUNT *125.00*

old pay.

FAIRBANKS MEDICAL & SURGICAL CLINIC

P.O. BOX 1330 - FAIRBANKS, ALASKA 99701
PHONE: 452-2127

DATE:

TO SEE DR. Thornall

REFER TO DR.

INVOICE NO. 23728

INSURANCE WORK/COMP MEDICARE NO.

LABORATORY STAT

D. P. W. NO. 220880 SUB NO.

TEST	FEE	TEST	FEE
UCG		GRAM STAIN	
UA		WET PREP	
CBC		FUNG	
SED RATE		SPUTUM	
HGB & HCT		STOOL	
WBC & DIFF		LE PREP	
PRO TIME		GASTRIC	
FBS		PAP	
P.B.I.		BSP	
		THYMOL	
		HETEROPHILE	
		RH TITER	
		PTT	
		ASO TITER	
		PKU	
		OB LAB	
		SPECIFY OTHER	
		PHYSICAL THERAPY	
		EXERCISE	
		HEAT	
		WHIRLPOOL	
		ULTRASOUND	
		TRACTION	
		AMBULATION	
		SPECIFY OTHER	

PATIENT
BILL TO
MAILING ADDRESS
CITY & STATE

Baumgartner, Laurel A.
W P W
Diagnosis: Pregnancy

PHYSICIAN	FEE	X-RAY DEPT.	FEE
OFFICE VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC. <input type="checkbox"/> REG.		CHEST	
INJECTION:		SPINE: CERVICAL:	
		DORSAL: LUMBAR:	
		LUMBO - SACRAL:	
DRESSING:		ARM	
OB VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC. <input checked="" type="checkbox"/> REG.	<u>110.00</u>	LEG	
OFFICE SURGERY		GL	
		SE	
CASI:		on following dates:	
<input type="checkbox"/> USE OF MINOR SURGERY		<u>3/13/69 - 4/1/69 - 4/15/69 - 4/29/69 - 5/6/69</u>	
<input type="checkbox"/> USE OF RECOVERY ROOM		<u>5/13/69 - 5/20/69 - 5/27/69 - 6/10/69 - 6/23/69</u>	
PHYSICAL EXAMS:		TEACHER	
<input type="checkbox"/> FED ELEC		STUDENT	
<input type="checkbox"/> PRE EMP		FAA	
<input type="checkbox"/> ANNUAL		LIFE INS.	
<input type="checkbox"/> IF OTHER SPECIFY.		TEAMSTER	
CONSULTATION:		MAMMOGRAM	
OPHTHALMOLOGICAL EXAM:		SPECIFY OTHER:	
OTHER TREATMENT:			
SUPPLIES USED:		MISCELLANEOUS	FEE
		ELECTROCARDIOGRAM	
		AUDIOGRAM	
		BENNETT MACHINE	

SUNDRY & ADJUSTMENTS		AMOUNT
TOTAL INVOICE AMOUNT:		<u>310.00</u>
OTHER CHARGES:		
CREDITS:		
NET INVOICE AMOUNT		<u>310.00</u>

OB delivery 4/15/69 200.00
Submit to key
Old

TO SEE DR. *Lindy*

FAIRBANKS MEDICAL & SURGICAL CLINIC
 P.O. BOX 1330 - FAIRBANKS, ALASKA 99701
 PHONE: 452-2127

DATE:

1-10-69

REFER TO DR.

INVOICE NO. *85086*

INSURANCE WORK/COMP MEDICARE NO.

LABORATORY STAT

D. P. W. NO. _____
 YOUR ACCOUNT NO. *220880* SUB NO. _____

PATIENT
 BILL TO
 MAILING ADDRESS
 CITY & STATE

Completz, Catherine V
OPW

TEST	FEE	TEST	FEE
UCC		GRAM STAIN	
<i>UA</i>	<i>11.40</i>	WET PREP	
CBC		FUNG	
SED RATE		SPUTUM	
HGB & HCT		STOOL	
WBC & DIFF		LE PREP	
PRO TIME		GASTRIC	
FBS		PAP	
P.B.I.		BSP	

PHYSICIAN FEE *11.0*

OFFICE VISIT: FIRST SPEC. REG.

INJECTION: _____

DRESSING: _____

OB VISIT: FIRST SPEC. REG.

OFFICE SURGERY _____

CAST: _____

USE OF MINOR SURGERY USE OF RECOVERY ROOM

PHYSICAL EXAMS: TEACHER STUDENT FAA
 FLS ELEC PRE-EMP LIFE INS TEAMSTER
 ANNUAL IF OTHER SPECIFY *divisibility*

X-RAY DEPT.	FEE
CHEST	
SPINE: CERVICAL:	
DORSAL: LUMBAR:	
LUMBO - SACRAL:	
ARM	
LEG	
G.I.	
B.E.	
GB	
IVP	
SKULL	
FACIAL	
SINUS	
MASTOID	
PELVIS	
RIBS	
MAMMOGRAM	
SPECIFY OTHER:	
MISCELLANEOUS	FEE
ELECTROCARDIOGRAM	
AUDIOGRAM	
BENNETT MACHINE	

URIC ACID	THYMOL
CHOL.	HETEROPHILE
BUN.	RH TITER
GLUC. TOL.	PTT
BILIRUBIN	ASO TITER
CEPHFLOCC	PKU
LATEX	OB LAB SPECIEY OTHER
TYPE & RH	
TISSUE	
CREATININE	
ET-3	PHYSICAL THERAPY
ICTERUS INDEX	EXERCISE
SGP-T	HEAT
P.S.P.	WHIRLPOOL
L.D.H.	ULTRASOUND
SGO-T	TRACTION
VDRL	AMBULATION
CULTURE	SPECIFY OTHER
SENS	

CONSULTATION: *ph*

OPHTHALMOLOGICAL EXAM: _____

OTHER TREATMENT: _____

SUPPLIES USED: _____

SUNDRY & ADJUSTMENTS	AMOUNT
TOTAL INVOICE AMOUNT:	
OTHER CHARGES:	
CREDITS:	
NET INVOICE AMOUNT	<i>16.50</i>

FAIRBANKS MEDICAL & SURGICAL CLINIC

P.O. BOX 1330 - FAIRBANKS, ALASKA 99701
PHONE: 452-2127

DATE:

TO SEE DR. *P. Olson*

REFER TO DR.

INVOICE NO.

11-8-69

Bill to: DEPARTMENT OF PUBLIC WELFARE Acct. No. 220980

Case No. _____ Medicare No. _____

PATIENT

Parent:

*Roni, Ronald Lee
Eileen*

Diagnosis:

Acute N.R.D. -

LABORATORY

STAT

TEST	FEE	TEST	FEE
UCG		GRAM STAIN	
UA		WET PREP	
CBC		FUNG	
SED RATE		SPUTUM	
HGB & HCT		STOOL	
WBC & DIFF		LE PREP	
PRO TIME		GASTRIC	
FBS		PAP	
P.S.I.		BSP	
URIC ACID		THYMOL	
CHOL.		HEIEROPHILE	
BUN.		RH TITER	
GLUC. TOL.		PTT	
BILIRUBIN		ASO TITER	
CEPHFLOCC		PKU	
LATEX		OB LAB	
TYPE & RH		SPECIEY OTHER	
TISSUE			
CREATININE			
ET-3		PHYSICAL THERAPY	
ICIERUS INDEX		EXERXISE	
SGP-T		HEAT	
P.S.P.		WHIRLPOOL	
L.D.H.		ULTRASOUND	
SGO-T		TRACTION	
VDRL		AMBULATION	
CULTURE		SPECIFY OTHER	
SENS			

PHYSICIAN OFFICE VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC <input checked="" type="checkbox"/> REG.	FEE 10.00
INJECTION:	
DRESSING:	
OB VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC <input type="checkbox"/> REG.	
OFFICE SURGERY	
CASI:	
<input type="checkbox"/> USE OF MINDA SURGERY <input type="checkbox"/> USE OF RECOVERY ROOM	
PHYSICAL EXAMS: <input type="checkbox"/> TEACHER <input type="checkbox"/> STUDENT <input type="checkbox"/> FAA <input type="checkbox"/> FED ELEC <input type="checkbox"/> PRE-EMP <input type="checkbox"/> LIFE INS. TEAMSTER <input type="checkbox"/> ANNUAL <input type="checkbox"/> IF OTHER SPECIFY	
CONSULTATION:	
OPHTHALMOLOGICAL EXAM:	
OTHER TREATMENT:	
SUPPLIES USED:	

X-RAY DEPT.	FEE
CHEST	
SP.NE: CERVICAL:	
DORSAL: LUMBAR:	
LUMBO - SACRAL:	
ARM	
LEG	
G.I.	
B.E.	
GB	
IVP	
SKULL	
FACIAL	
SINUS	
MASTOID	
PELVIS	
RIBS	
MAMMOGRAM	
SPECIFY OTHER:	
MISCELLANEOUS	FEE
ELECTROCARDIOGRAM	
AUDIOGRAM	
BENNETT MACHINE	

SUNDRY & ADJUSTMENTS	AMOUNT
TOTAL INVOICE AMOUNT:	10.00
OTHER CHARGES:	
CREDITS:	
NET INVOICE AMOUNT	10.00

TO SEE DR.

Ribar

FAIRBANKS MEDICAL & SURGICAL CLINIC

P.O. BOX 1333 - FAIRBANKS, ALASKA 99701
PHONE: 452-2127

DATE:

9-18-69

PETER TO DR.

INVOICE NO.

Bill to: DEPARTMENT OF PUBLIC HEALTH Acct. No. 220980

LABORATORY STAT

Case No. Medicare No.

PATIENT

Poni Eileen

Parent:

Diagnosis:

Cystitis (pyuria)

TEST	FEE	TEST	FEE
UCG		GRAM STAIN	
UA		WET PREP	
CBC		FUNG	
SED RATE		SPUTUM	
HGB & HCT		STOOL	
WBC & DIFF		LE PREP	
PRO TIME		GASTRIC	
FBS		PAP	
F.B.I.		BSP	
URIC ACID		THYMOL	
CHOL.		METEROPHILE	
BU'N.		RH TITER	
GLUC. TOL.		PTT	
BILIRUBIN		ASO TITER	
CEPHFLOCC		PRU	
LATEX		OB LAB	
TYPE & RH		SPECIFY OTHER	
TISSUE			
CREATININE			
ET-2			
ICTERUS INDEX			
SGPT			
P.S.P.			
LDH.			
SGO-T			
VDRL			
CULTURE			
SENS			

PHYSICIAN	FEE	X-RAY DEPT.	FEE
OFFICE VISIT: <input checked="" type="checkbox"/> FIRST <input type="checkbox"/> SPEC <input checked="" type="checkbox"/> REG	10.00	CHEST	
INJECTION:		SPINE: CERVICAL:	
		DORSAL: LUMBAR:	
		LUMBO - SACRAL:	
DRESSING:		ARM	
OR VISIT: <input type="checkbox"/> FIRST <input type="checkbox"/> SPEC <input type="checkbox"/> REG		LEG	
OFFICE SURGERY		G.I.	
CASE:		B.E.	
<input type="checkbox"/> USE OF MINOR SURGERY <input type="checkbox"/> USE OF RECOVERY ROOM		G&S	
PHYSICAL EXAMS: <input type="checkbox"/> TEACHER <input type="checkbox"/> STUDENT <input type="checkbox"/> FEE		IVP	
<input type="checkbox"/> REG ELEC <input type="checkbox"/> PRE-EMP <input type="checkbox"/> LIFE INS <input type="checkbox"/> TEAMSTOCK		SNUB	
<input type="checkbox"/> ANNUAL <input type="checkbox"/> IF OTHER SPECIFY:		FACIAL	
CONSULTATION:		SINUS	
OPHTHALMOLOGICAL EXAM:		MASTO D	
OTHER TREATMENT:		PELVIS	
SUPPLIES USED:		RIBS	
		MAMMOGRAM	
		SPECIFY OTHER:	
		MISCELLANEOUS	FEE
		ELECTROCARDIOGRAM	
		AUDIOGRAM	
		BENNETT MACHINE	

SUNDRY & ADJUSTMENTS	AMOUNT
TOTAL INVOICE AMOUNT:	14.00
OTHER CHARGES:	
CREDITS:	
NET INVOICE AMOUNT	14.00

TO SEE DR. *Selton*

FAIRBANKS MEDICAL & SURGICAL CLINIC

(DATE & TIME STAMP HERE)

P.O. BOX 1330 - FAIRBANKS, ALASKA 99701
PHONE: 452-2127

REFER TO DR.

INVOICE NO. H 11195

11-24-69

INSURANCE WORK/COMP MEDICARE NO. [] [] [] [] [] [] [] [] [] []

D.P.W. YOUR ACCOUNT NO. 9328810 SUB NO. [] []

PLEASE SHOW YOUR NEW OR CORRECT MAILING ADDRESS BELOW

NEW ADDRESS HERE

10 P.W

PATIENT

Baillie, Aaron, F

BILL TO

Baillie, Aaron

MAILING ADDRESS CITY & STATE

Wadeville

HSE	HOUSE CALL DATE:	208
CSN	CONSULTATION WITH DR.:	209
MISC	MISCELLANEOUS:	210

HOSPITAL SERVICES RENDERED BY PHYSICIAN

HA	HOSPITAL ADMITTANCE DATE:	200
HOV	HOSPITAL VISITS	201
DPV	OUT PATIENT VISIT <i>11-23</i> DATE: <i>11-23-69</i>	202 <i>2000</i>
OBD	OB DELIVERY	203
NB PHY	NEW BORN PHYSICAL	204
SUR	HOSPITAL SURGERY	205
SA	SURGICAL ASSISTANT	206
ANES	ANESTHETIST	207

Diagnosis: Nisticaria

TOTAL INVOICE AMOUNT 2000

3697

NAME & ADDRESS

ROOM

CASE #

DATE & TIME OF ADMISSION

AIGNER, Susan V. (19)

202

001738

12-9-69 7:35 PM

WELFARE

Fairbanks Clinic

FAIRBANKS COMMUNITY HOSPITAL

119 N. CUSHMAN STREET - PHONE: 456-6655

FAIRBANKS, ALASKA 99701

10-27-69

DATE & TIME OF DISCHARGE

12-12-69 5:50 PM

DATE	DESCRIPTION	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
69DEC 9			.25			10.00	55.00		165.25	165.25
69DEC 10	DR	78.75	.75						336.75	
69DEC 10	ANES	37.00					55.00		336.75	336.75
69DEC 11			18.25	7.05		15.00			441.85	441.85
69DEC 11	02			9.80			55.00		442.10	441.85
69DEC 12			.25						442.10	
SUB TOTALS		115.75	19.50	16.85		125.00	165.00	TOTAL CHARGES	442.10	
LESS: COVERAGE										
DUE FROM PATIENT										

EXPLANATION OF SYMBOLS

- ANES - ANESTHESIA
- BBA - BLOOD
- CI - CIRCUMCISION
- DEL } DELIVERY ROOM
- DR }
- EKG - ELECTROCARDIOGRAM
- ES - EMERGENCY SURGERY (OR SERVICES)
- IV - INTRAVENOUS
- NO2 - NEWBORN OXYGEN
- - DEPARTMENTAL CREDIT
- OR - OPERATING ROOM
- O2 } OXYGEN
- OXY }
- PHY } PHYSIOTHERAPY
- PT }
- PL - PLASMA
- REF - REFUND
- TEL - TELEPHONE
- TI - TISSUE
- TR - TRANSFUSION
- XT - X-RAY THERAPY

Tel. 694-2105 or
279-0100

THOMAS F. GREEN, M.D.
PARK PLACE BOX 1125
EAGLE RIVER, ALASKA 99577

Division of Welfare
338 Dunali St., MacKay Bldg.
Anchorage, Ak. 99501

FOR PROFESSIONAL SERVICES

Randy Ferris
Gr-Med 24620

2/8/69

Examination

\$10.00

Total Amount Due ~~_____~~ **\$10.00**

Thomas F. Green, M.D.

PARK PLACE

P. O. BOX 1125

Please make check payable to:

~~THOMAS F. GREEN, M.D.~~

Telephone 894-2105 or
279-0100

THOMAS F. GREEN, M.D.
PARK PLACE BOX 1125
EAGLE RIVER, ALASKA 99577

Division of Welfare
398 Denali St., MacKay Bldg.
Anchorage, Ak. 99501

FOR PROFESSIONAL SERVICES

Randy Ferris

GR MED 24620

2/11/69 Hospital Services \$15.00

Total Amount Due ~~---~~ \$15.00

Please make check payable to: Thomas F. Green, M.D.

**PARK PLACE
P. O. BOX 1125
EAGLE RIVER, ALASKA 99577**

Telephone 694-2105 or
279-0100

THOMAS F. GREEN, M.D.
PARK PLACE BOX 1125
EAGLE RIVER, ALASKA 99577

Division of Welfare
338 Denali St., MacKay Bldg.
Anchorage, Ak. 99501

FOR PROFESSIONAL SERVICES

Mr. William Ferris
Gr-Med 24620

12/30/68 Examination \$14.10

Total Amount Due ———— **\$14.10**

Please make check payable to:

Thomas F. Green, M.D.
PARK PLACE
P.O. BOX 1125
EAGLE RIVER, ALASKA 99577

Telephone 694-2105 or
279-0100

THOMAS F. GREEN, M.D.
PARK PLACE BOX 1125
EAGLE RIVER, ALASKA 99577

Division of Welfare
338 Denali St., Mackay Bldg.
Anchorage, AK 99501

FOR PROFESSIONAL SERVICES

William Ferris Jr.
Exam 24620

4/6/68

Examination

\$11.25

Total Amount Due 11.25

Please make check payable to:

Thomas F. Green, M.D.
PARK PLACE
P.O. BOX 1125
EAGLE RIVER, ALASKA 99577

DEPT. OF HEALTH & WELFARE
POUCH H
JUNEAU, ALASKA 99801


7/19/1971

SECOND BILLING - PER YOUR REQUEST

RE: LESTER MANGLE, DEC.
D.O.D. 4/30/1969

TOTAL FUNERAL EXPENSES-----\$325.00

I CERTIFY, THAT THE ABOVE STATEMENT IS TRUE AND JUST, THAT NO PAYMENTS HAVE BEEN RECEIVED AS OF THE ABOVE DATE MENTIONED.


GORDON E. GREEN, OWNER & DIRECTOR
GREEN FUNERAL CHAPELS
P.O. BOX 1012
ANCHORAGE, ALASKA 99501

GEG/vg

RECEIVED

AUG 2 9 42 AM '71

FISCAL SERVICES
JUNEAU

Div. of
Public Welfare

RECEIVED
JUL 28 1971

1971 AUG 13 PM 3:31

DIVISION OF PUBLIC WELFARE

RECEIVED
AUG 2 9 42 AM '71
FISCAL SERVICES
JUNEAU

Gynob Cyto - Biological Laboratories

BILLING OFFICE

550 WASHINGTON ST.
SAN DIEGO, CALIF. 92103
PHONE 297-4967

REPORTS OR SUPPLIES

525 HAWTHORN P.O. BOX 70
SAN DIEGO, CALIF. 92101
PHONE 239-2029

PLEASE MAKE REMITTANCE PAYABLE TO GYNOB CYTO-BIOLOGICAL LABORATORIES

- ALASKA PSYCHIATRIC INSTITUTE
2900 PROVIDENCE AVE.
- ANCHORAGE, ALASKA 99504

AMOUNT

\$ _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE.

PROFESSIONAL SERVICES	DATE	CHARGES	PAYMENTS	BALANCE
BALANCE FORWARD			DEC 1 68	316.00
CHECK	DEC 3 68		213.00	103.00
CHECK	DEC 9 68		42.50	60.50
136830 KERR FRANCES-2SL	DEC 14 68	5.50		
136820 PIKE MABEL-2SL	DEC 14 68	5.50		
136850 ROBBINS TRUDY-2SL	DEC 14 68	5.50		
136845 SINGYKE ALICE-2SL	DEC 14 68	5.50		
136835 TANNER NANCY-2SL	DEC 14 68	5.50		
136835 TSONIS DOROTHY-2SL	DEC 14 68	5.50		
				93.50

Due (33.00)
JP

PAY LAST AMOUNT
SHOWN IN THIS
COLUMN

STATEMENT

R. E. HARRELL, M.D.

620 EAST 14TH AVENUE
ANCHORAGE, ALASKA 99501

PHONE 272-9711

RECEIVED

To

Kenneth Young
1214 East 10th Avenue
Anchorage, Alaska 99501

NOV 27 1970

Dept. of
Public Welfare

23 Nov 70

Physical Examination

11-27-67	Physical Examination	7.00	
		7.00	

I certify that the above bill is correct and just,
that payment therefor has not been received, and that the rates
charged were in effect at the time services were rendered.

R. E. Harrell

To
Department of Public Welfare
Fairbanks Division
Chena Building Room 320
Fairbanks, Alaska 99701

FROM
C. A. Higgins DDS
529 5th Ave. Suite 6
Fairbanks, Alaska 99701

Subject Rodney Selid, Dependent of Pearl Selid

Date Aug. / 12 / 1971

MESSAGE: We have been carrying a delinquent balance of \$82.00 for the above patient.

His balance as of May 9, 1968 was \$122.00. On January 30, 1969, we received

a check from Department of Welfare in the amount of \$40.00 -- leaving the

delinquent balance of \$82.00. We would be most appreciative if you or your

Juneau office would be kind enough to check your records and help us to verify

whether or not this amount has ever been paid.

DEPARTMENT OF
PUBLIC WELFARE

AUG 13 1971

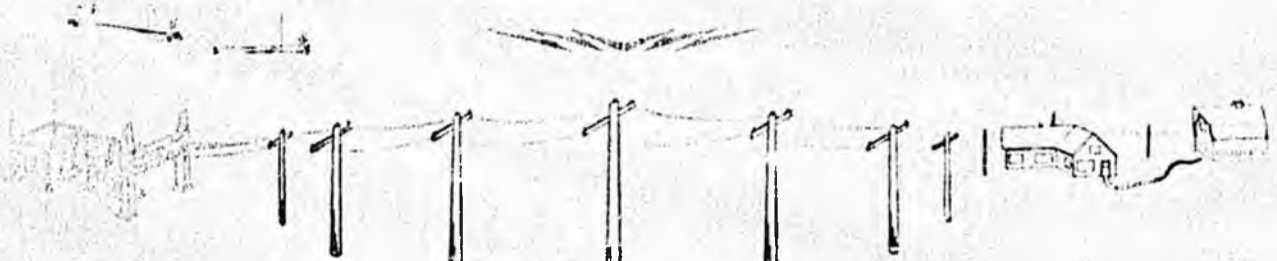
RECEIVED
DEPARTMENT OF PUBLIC WELFARE

Signed *Maria Simpson*
Receptionist

Rediform 45 468

NO REPLY NECESSARY

REPLY REQUESTED — USE REVERSE SIDE



Matanuska Electric Association Inc.

745-3231

PALMER, ALASKA 99645

BOX G

November 2 , 1971

Mrs. Hazel Mauger
Fiscal Officer
Fiscal Services
Pouch H
Juneau, Alaska 99801

Re: Account 90113

Dear Mrs. Mauger:

We have been corresponding with the Bureau of Indian Affairs in Juneau about a balance due of \$407.45 on the Health Center Account in Unalakleet.

Mrs. Vera Horsley of the BIA Finance Office, has advised us that \$76.20 of the above account is due from BIA and that the period from October 1969 through June 1970 should have been paid by the State of Alaska.

The total amount of the invoices for period 10/13/69 through 6/15/70 was \$637.00. A \$98.00 payment was made by BIA on 3/23/70. You reimbursed them the \$98.00 which was for the 1/16/70 billing. On 8/24/70 you paid the \$257.75 leaving a balance now due of \$331.25.

This payment from you in the amount of \$257.75 is the figure you obtained after receiving our letter of July 13, 1970, copy enclosed. You deducted the balance forward of \$255.45 and paid the difference. Now in researching this account and checking with Mrs. Horsley the payment of \$237.00 made by BIA was not intended for this account and has been transferred.

Copies of all invoices for the period the State was to pay are enclosed, with the exception of the invoice for 1/16/70 as that one has been paid. The total of the enclosed invoices is \$589.00.

Please deduct the amount of \$257.75 paid 8/24/70 and you have a balance due of \$331.25.

If you have any questions, please call us as we are most anxious to clear up this account.

Very truly yours,

WILLARD H. JOHNSON, P.E.
General Manager

(Mrs.) Alice Snodgrass
Manager of Office Services

GD/dh

Enclosure 3: 9

CC: Mrs. Vera Horsley
CC: Public Health Service

If you have any questions, please ask for Gloria Deland who has done the research on your account.

005480

DATE	DESCRIPTION	AMOUNT	REMARKS
02118			
	Payment Made 8/24/70	257.75 CR	
<p>Please deduct this credit from attached invoices. Thank you.</p>			
<p>FROM:</p> <p>ANTANKA ELECTRIC ASSOCIATES, INC. BOX 6 PALM BEACH, ALASKA 99501 P.O. BOX 1000 PALM BEACH, ALASKA 99501 DANIELS ROAD, PALM BEACH, ALASKA</p>		<p>10</p> <p>State of Alaska Dept. of Health & Welfare Ak Native Health Center Unalakleet, Alaska</p>	
		257.75CR	257.75 CR

MLA 75G 1/77

085657

METER NUMBER	ISSUE YEAR	TRIP MILES	CONSUMPTION	AMOUNT
02118	0920	0060	860	95.00 23



FROM: MALANUSHA ELECTRIC ASSOCIATION, INC. BOX 6 PALMER, ALASKA 99645
 IF THIS BILL IS PAID AFTER THE DUE DATE, PLEASE ADD A \$2.00 LATE CHARGE.

12/15/69 90118 05643 95.00

State of Alaska
 Dept. of Health & Welfare
 Ak Native Health Center
 Unalakleet, Alaska

085658

METER NUMBER	ISSUE YEAR	TRIP MILES	CONSUMPTION	AMOUNT
02118	0060	9380	680	78.00 23



FROM: MALANUSHA ELECTRIC ASSOCIATION, INC. BOX 6 PALMER, ALASKA 99645
 IF THIS BILL IS PAID AFTER THE DUE DATE, PLEASE ADD A \$2.00 LATE CHARGE.

11/15/69 90118 05643 78.00

State of Alaska
 Dept. of Health & Welfare
 Ak Native Health Center
 Unalakleet, Alaska

085659

METER NUMBER	ISSUE YEAR	TRIP MILES	CONSUMPTION	AMOUNT
02118	9380	8760	620	72.00 23



FROM: MALANUSHA ELECTRIC ASSOCIATION, INC. BOX 6 PALMER, ALASKA 99645
 IF THIS BILL IS PAID AFTER THE DUE DATE, PLEASE ADD A \$2.00 LATE CHARGE.

10/18/69 90118 05643 72.00

State of Alaska
 Dept. of Health & Welfare
 Ak Native Health Center
 Unalakleet, Alaska

085652

METER NUMBER	ISSUE YEAR	TRIP MILES	CONSUMPTION	AMOUNT
02118	4730	4390	340	46.00 23



FROM: MALANUSHA ELECTRIC ASSOCIATION, INC. BOX 6 PALMER, ALASKA 99645
 IF THIS BILL IS PAID AFTER THE DUE DATE, PLEASE ADD A \$2.00 LATE CHARGE.

6/15/70 90118 05643 46.00

State of Alaska
 Dept. of Health & Welfare
 Ak Native Health Center
 Unalakleet, Alaska

METER NUMBER	PRESENT READ	PREVIOUS READ	CONSUMPTION	DEMAND	AMOUNT
02118	4390	3940	450		56.00 23



FROM:
 MATANUSKA ELECTRIC ASSOCIATION, INC.
 BOX G PALMER, ALASKA 99645
 IF THIS BILL IS PAID AFTER THE BILLING DATE, PLEASE ADD A \$2.00 LATE CHARGE.

State of Alaska
 Dept. of Health & Welfare
 Ak Native Health Center
 Unalakleet, Alaska

DATE	DAY	ACCOUNT NO	MEMBER NO	AMOUNT	POSTAL NO	ZIP CODE	TOTAL
5/15/70		90118	05643	56.00	90118	05643	56.00

085654

METER NUMBER	PRESENT READ	PREVIOUS READ	CONSUMPTION	DEMAND	AMOUNT
02118	3940	3330	610		71.00 23



FROM:
 MATANUSKA ELECTRIC ASSOCIATION, INC.
 BOX G PALMER, ALASKA 99645
 IF THIS BILL IS PAID AFTER THE BILLING DATE, PLEASE ADD A \$2.00 LATE CHARGE.

State of Alaska
 Dept. of Health & Welfare
 Ak Native Health Center
 Unalakleet, Alaska

DATE	DAY	ACCOUNT NO	MEMBER NO	AMOUNT	POSTAL NO	ZIP CODE	TOTAL
4/15/70		90118	05643	71.00	90118	05643	74.00

085655

METER NUMBER	PRESENT READ	PREVIOUS READ	CONSUMPTION	DEMAND	AMOUNT
02118	3330	02690	640		74.00 23



FROM:
 MATANUSKA ELECTRIC ASSOCIATION, INC.
 BOX G PALMER, ALASKA 99645
 IF THIS BILL IS PAID AFTER THE BILLING DATE, PLEASE ADD A \$2.00 LATE CHARGE.

State of Alaska
 Dept. of Health & Welfare
 Ak Native Health Center
 Unalakleet, Alaska

DATE	DAY	ACCOUNT NO	MEMBER NO	AMOUNT	POSTAL NO	ZIP CODE	TOTAL
3/16/70		90118	05643	74.00	90118	05643	74.00

085656

METER NUMBER	PRESENT READ	PREVIOUS READ	CONSUMPTION	DEMAND	AMOUNT
02118	2690	1310	880		97.00 23



FROM:
 MATANUSKA ELECTRIC ASSOCIATION, INC.
 BOX G PALMER, ALASKA 99645
 IF THIS BILL IS PAID AFTER THE BILLING DATE, PLEASE ADD A \$2.00 LATE CHARGE.

State of Alaska
 Dept. of Health & Welfare
 Ak Native Health Center
 Unalakleet, Alaska

DATE	DAY	ACCOUNT NO	MEMBER NO	AMOUNT	POSTAL NO	ZIP CODE	TOTAL
2/17/70		90118	05643	97.00	90118	05643	97.00

POOR COPY

WILLIAM J. MILLS, JR., M.D.

ORTHOPAEDIC SURGEON

7-2 K STREET

ANCHORAGE, ALASKA

McLaughlin Youth Center
2600 Providence Avenue
Anchorage, Alaska

Re: Mahaffey, Tim
Inj: 2/2/69

PHYSICIAN'S ACCOUNT

DATE	DEBITS				CREDITS			BALANCE
	C	D	MISC	ON ACCT.	CASH	ADJ.		
							157.00	
							157.00	
							114.00	
							277.00	
							111.00	
							277.00	
							157.00	
							157.00	
							659.00	
							659.00	
							722.10	
							799.00	
							605.00	
							385.00	
							385.00	
							411.00	

1—INITIAL OFFICE VISIT
 A—XRAY
 2—XRAY APPLICATION
 3—FOLLOW-UP OFFICE VISIT
 4—INJECTION

5—SURGERY
 6—MINOR SURGERY
 7—CONSULTATION
 8—EVALUATION

9—HOSPITAL CALL
 10—EMERGENCY CALL
 11—TRACTION
 12—LABORATORY

WILLIAM J. MILLS, JR., M.D.
ORTHOPAEDIC SURGEON

WILLIAM J. MILLS, JR., M.D.

ORTHOPAEDIC SURGEON

742 K STREET

ANCHORAGE, ALASKA

McLaughlin Youth Center
2600 Providence Ave.
Anchorage, Alaska

RE: MAHAFFEY, Ti
Inj: 2-2-69

THIS IS A THEMATIC CARBON COPY OF YOUR ACCOUNT

DATE	CHARGES					CREDITS			BALANCE
	C	E	G	F	MISC.	CASH	ADD.		
2/2/69					3.25 ⁰⁰				3.25 ⁰⁰
2/6/69					4.70 ⁰⁰				8.95 ⁰⁰
2/12/69					1.15 ⁰⁰				10.10 ⁰⁰
2/19/69					1.15 ⁰⁰				11.25 ⁰⁰
2/26/69					1.50 ⁰⁰				12.75 ⁰⁰
3/5/69					1.15 ⁰⁰				13.90 ⁰⁰
3/12/69					1.15 ⁰⁰				15.05 ⁰⁰
3/19/69					1.15 ⁰⁰				16.20 ⁰⁰
3/26/69					1.15 ⁰⁰				17.35 ⁰⁰
4/2/69					1.15 ⁰⁰				18.50 ⁰⁰
4/9/69					1.15 ⁰⁰				19.65 ⁰⁰
4/16/69					1.15 ⁰⁰				20.80 ⁰⁰
4/23/69					1.15 ⁰⁰				21.95 ⁰⁰
4/30/69					1.15 ⁰⁰				23.10 ⁰⁰
5/7/69					1.15 ⁰⁰				24.25 ⁰⁰
5/14/69					1.15 ⁰⁰				25.40 ⁰⁰
5/21/69					1.15 ⁰⁰				26.55 ⁰⁰
5/28/69					1.15 ⁰⁰				27.70 ⁰⁰
6/4/69					1.15 ⁰⁰				28.85 ⁰⁰
6/11/69					1.15 ⁰⁰				30.00 ⁰⁰
6/18/69					1.15 ⁰⁰				31.15 ⁰⁰
6/25/69					1.15 ⁰⁰				32.30 ⁰⁰
7/2/69					1.15 ⁰⁰				33.45 ⁰⁰
7/9/69					1.15 ⁰⁰				34.60 ⁰⁰
7/16/69					1.15 ⁰⁰				35.75 ⁰⁰
7/23/69					1.15 ⁰⁰				36.90 ⁰⁰
7/30/69					1.15 ⁰⁰				38.05 ⁰⁰
8/6/69					1.15 ⁰⁰				39.20 ⁰⁰
8/13/69					1.15 ⁰⁰				40.35 ⁰⁰
8/20/69					1.15 ⁰⁰				41.50 ⁰⁰
8/27/69					1.15 ⁰⁰				42.65 ⁰⁰
9/3/69					1.15 ⁰⁰				43.80 ⁰⁰
9/10/69					1.15 ⁰⁰				44.95 ⁰⁰
9/17/69					1.15 ⁰⁰				46.10 ⁰⁰
9/24/69					1.15 ⁰⁰				47.25 ⁰⁰
10/1/69					1.15 ⁰⁰				48.40 ⁰⁰
10/8/69					1.15 ⁰⁰				49.55 ⁰⁰
10/15/69					1.15 ⁰⁰				50.70 ⁰⁰
10/22/69					1.15 ⁰⁰				51.85 ⁰⁰
10/29/69					1.15 ⁰⁰				53.00 ⁰⁰
11/5/69					1.15 ⁰⁰				54.15 ⁰⁰
11/12/69					1.15 ⁰⁰				55.30 ⁰⁰
11/19/69					1.15 ⁰⁰				56.45 ⁰⁰
11/26/69					1.15 ⁰⁰				57.60 ⁰⁰
12/3/69					1.15 ⁰⁰				58.75 ⁰⁰
12/10/69					1.15 ⁰⁰				59.90 ⁰⁰
12/17/69					1.15 ⁰⁰				61.05 ⁰⁰
12/24/69					1.15 ⁰⁰				62.20 ⁰⁰
1/7/70					1.15 ⁰⁰				63.35 ⁰⁰
1/14/70					1.15 ⁰⁰				64.50 ⁰⁰
1/21/70					1.15 ⁰⁰				65.65 ⁰⁰
1/28/70					1.15 ⁰⁰				66.80 ⁰⁰
2/4/70					1.15 ⁰⁰				67.95 ⁰⁰
2/11/70					1.15 ⁰⁰				69.10 ⁰⁰
2/18/70					1.15 ⁰⁰				70.25 ⁰⁰
2/25/70					1.15 ⁰⁰				71.40 ⁰⁰
3/4/70					1.15 ⁰⁰				72.55 ⁰⁰
3/11/70					1.15 ⁰⁰				73.70 ⁰⁰
3/18/70					1.15 ⁰⁰				74.85 ⁰⁰
3/25/70					1.15 ⁰⁰				76.00 ⁰⁰
4/1/70					1.15 ⁰⁰				77.15 ⁰⁰
4/8/70					1.15 ⁰⁰				78.30 ⁰⁰
4/15/70					1.15 ⁰⁰				79.45 ⁰⁰
4/22/70					1.15 ⁰⁰				80.60 ⁰⁰
4/29/70					1.15 ⁰⁰				81.75 ⁰⁰
5/6/70					1.15 ⁰⁰				82.90 ⁰⁰
5/13/70					1.15 ⁰⁰				84.05 ⁰⁰
5/20/70					1.15 ⁰⁰				85.20 ⁰⁰
5/27/70					1.15 ⁰⁰				86.35 ⁰⁰
6/3/70					1.15 ⁰⁰				87.50 ⁰⁰
6/10/70					1.15 ⁰⁰				88.65 ⁰⁰
6/17/70					1.15 ⁰⁰				89.80 ⁰⁰
6/24/70					1.15 ⁰⁰				90.95 ⁰⁰
7/1/70					1.15 ⁰⁰				92.10 ⁰⁰
7/8/70					1.15 ⁰⁰				93.25 ⁰⁰
7/15/70					1.15 ⁰⁰				94.40 ⁰⁰
7/22/70					1.15 ⁰⁰				95.55 ⁰⁰
7/29/70					1.15 ⁰⁰				96.70 ⁰⁰
8/5/70					1.15 ⁰⁰				97.85 ⁰⁰
8/12/70					1.15 ⁰⁰				99.00 ⁰⁰
8/19/70					1.15 ⁰⁰				100.15 ⁰⁰
8/26/70					1.15 ⁰⁰				101.30 ⁰⁰
9/2/70					1.15 ⁰⁰				102.45 ⁰⁰
9/9/70					1.15 ⁰⁰				103.60 ⁰⁰
9/16/70					1.15 ⁰⁰				104.75 ⁰⁰
9/23/70					1.15 ⁰⁰				105.90 ⁰⁰
9/30/70					1.15 ⁰⁰				107.05 ⁰⁰
10/7/70					1.15 ⁰⁰				108.20 ⁰⁰
10/14/70					1.15 ⁰⁰				109.35 ⁰⁰
10/21/70					1.15 ⁰⁰				110.50 ⁰⁰
10/28/70					1.15 ⁰⁰				111.65 ⁰⁰
11/4/70					1.15 ⁰⁰				112.80 ⁰⁰
11/11/70					1.15 ⁰⁰				113.95 ⁰⁰
11/18/70					1.15 ⁰⁰				115.10 ⁰⁰
11/25/70					1.15 ⁰⁰				116.25 ⁰⁰
12/2/70					1.15 ⁰⁰				117.40 ⁰⁰
12/9/70					1.15 ⁰⁰				118.55 ⁰⁰
12/16/70					1.15 ⁰⁰				119.70 ⁰⁰
12/23/70					1.15 ⁰⁰				120.85 ⁰⁰
12/30/70					1.15 ⁰⁰				122.00 ⁰⁰
1/6/71					1.15 ⁰⁰				123.15 ⁰⁰
1/13/71					1.15 ⁰⁰				124.30 ⁰⁰
1/20/71					1.15 ⁰⁰				125.45 ⁰⁰
1/27/71					1.15 ⁰⁰				126.60 ⁰⁰
2/3/71					1.15 ⁰⁰				127.75 ⁰⁰
2/10/71					1.15 ⁰⁰				128.90 ⁰⁰
2/17/71					1.15 ⁰⁰				130.05 ⁰⁰
2/24/71					1.15 ⁰⁰				131.20 ⁰⁰
3/2/71					1.15 ⁰⁰				132.35 ⁰⁰
3/9/71					1.15 ⁰⁰				133.50 ⁰⁰
3/16/71					1.15 ⁰⁰				134.65 ⁰⁰
3/23/71					1.15 ⁰⁰				135.80 ⁰⁰
3/30/71					1.15 ⁰⁰				136.95 ⁰⁰
4/6/71					1.15 ⁰⁰				138.10 ⁰⁰
4/13/71					1.15 ⁰⁰				139.25 ⁰⁰
4/20/71					1.15 ⁰⁰				140.40 ⁰⁰
4/27/71					1.15 ⁰⁰				141.55 ⁰⁰
5/4/71					1.15 ⁰⁰				142.70 ⁰⁰
5/11/71					1.15 ⁰⁰				143.85 ⁰⁰
5/18/71					1.15 ⁰⁰				145.00 ⁰⁰
5/25/71					1.15 ⁰⁰				146.15 ⁰⁰
6/1/71					1.15 ⁰⁰				147.30 ⁰⁰
6/8/71					1.15 ⁰⁰				148.45 ⁰⁰
6/15/71					1.15 ⁰⁰				149.60 ⁰⁰
6/22/71					1.15 ⁰⁰				150.75 ⁰⁰
6/29/71					1.15 ⁰⁰				151.90 ⁰⁰
7/6/71					1.15 ⁰⁰				153.05 ⁰⁰
7/13/71					1.15 ⁰⁰				154.20 ⁰⁰
7/20/71					1.15 ⁰⁰				155.35 ⁰⁰
7/27/71					1.15 ⁰⁰				156.50 ⁰⁰
8/3/71					1.15 ⁰⁰				157.65 ⁰⁰
8/10/71					1.15 ⁰⁰				1

INVOICE
MUNICIPAL UTILITIES SYSTEM
645 FIFTH AVENUE
FAIRBANKS, ALASKA

STATE OF ALASKA
ALASKA STATE JAIL
BOX 510
FAIRBANKS, ALASKA

..... SEPTEMBER 1988 10....

CONTRACT No. or
INVOICE No.

JOB ORDER No. or
TELEPHONE No. .. 452-4312-3
402-3125 SUPERINTENDENT

ACCOUNT No. ~~224018~~

TELEPHONE SERVICE FOR THE MONTH OF ~~AUGUST~~ ^{Sent} 1988

to Sep 15

\$ 168.00

unpaid

REPLY MEMO

Department of Health & Social Services
Fiscal Operations
Pouch H
Juneau, Alaska 99801

OCT 21
State of Alaska

ACH AND
118 STUB
PAYMENT.

MESSAGE

TO North State Telephone Co. DATE 10/23/71

Box 1258, Anchorage, Alaska 99501

Regarding #6-3981, Dillingham Health Center,
we have researched all payments as far back
10/1/69 billing and we have found from that
date there has been an unaccountable 13.00
portion of the balance forward.

Could you possibly send us a copy of the
billing this relates to? If it is over
2 years old, and it apparently is, we will
be unable to process it without Legislative
Approval, which is required for stale dated
bills.

Thank you.

SIGNED

W. J. Jackinsky

REPLY

TO Alice Jackinsky DATE 11-2-71

Department of Health & Social Services

This \$13.00 balance occurred in 1968
as a result of the following:

May 1, 1968 billing for \$18.50
Payment received in June,
1968 from your office (24.50)

Balance (6.00)

August 1, 1968 billing for 44.50
Payment received in September,
1968 from your office (25.50)

Outstanding balance \$ 13.00

Need to pay this amount.

SIGNED

George Meyer

TOTAL

57.00

Health CT
, AK 99576

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.

STATEMENT

NORTH STATE TELEPHONE COMPANY, INC.
 P. O. BOX 1258 • ANCHORAGE, ALASKA 99501
 277-7591

Please DETACH AND
 RETURN THIS STUB
 WITH YOUR PAYMENT.

BILLING DATE	SERVICE	TOLL	TELEGRAMS	SUB TOTAL	TAX	DEPOSIT	OTHER	CODE	PREVIOUS BALANCE	TOTAL	PHONE NUMBER	TOTAL
May 1'68	18.50			18.50					18.50	37.00	6,3981	37.00

Dillingham Health Center
 Dillingham, AK 99576

PLEASE PAY
 THIS AMOUNT

NOTE: IF AMOUNT DUE FROM
 PREVIOUS BILL WAS PAID,
 PLEASE DEDUCT FROM TOTAL
 WHEN REMITTING.

Thank You

THIS BILL IS DUE ON PRESENTATION. PROMPT PAYMENT WILL BE APPRECIATED!
 DELINQUENT 15 DAYS AFTER ABOVE DATE. DISCONNECTION AFTER 10 DAYS DELINQUENT

FOLD AND TEAR ALONG LINE

Dillingham Health
 Center
 Dillingham, AK 99576

STATEMENT

NORTH STATE TELEPHONE COMPANY, INC.
 P. O. BOX 1258 • ANCHORAGE, ALASKA 99501
 277-7591

Please DETACH AND
 RETURN THIS STUB
 WITH YOUR PAYMENT.

BILLING DATE	SERVICE	TOLL	TELEGRAMS	SUB TOTAL	TAX	DEPOSIT	OTHER	CODE	PREVIOUS BALANCE	TOTAL	PHONE NUMBER	TOTAL
Aug 1'68	3.50 22.00			25.50			19.00	8	12.50	57.00	6,3981	57.00

Dillingham Health Center
 Dillingham, AK 99576

PLEASE PAY
 THIS AMOUNT

NOTE: IF AMOUNT DUE FROM
 PREVIOUS BILL WAS PAID,
 PLEASE DEDUCT FROM TOTAL
 WHEN REMITTING.

Thank You

THIS BILL IS DUE ON PRESENTATION. PROMPT PAYMENT WILL BE APPRECIATED!
 DELINQUENT 15 DAYS AFTER ABOVE DATE. DISCONNECTION AFTER 10 DAYS DELINQUENT

FOLD AND TEAR ALONG LINE

Dillingham Health C
 Dillingham, AK 99576

NORTH STATE Telephone Co., Inc.

P. O. BOX 1258 · ANCHORAGE · ALASKA 99501 · TELEPHONE 277-7501



October 11, 1971

Alaska Department of Health & Welfare
Kotzebue Public Health Nurse
P.O. Box 43
Kotzebue, AK 99752

Gentlemen:

The following is a breakdown of items which make up the delinquent balance of \$31.65 for account 442-3461.

January 1, 1969 statement	\$ 38.65
Amount Paid	(21.00)
Amount still due	<u>17.65</u>
November 1, 1969 statement (copy enclosed)	15.85 <i>PA 12/12/69</i>
October 1, 1969 statement	47.40
Amount Paid	(49.25)
Overpaid	(1.85)
Delinquent Total	<u>\$ 31.65</u>

If you have questions about any of these items, please let us know so that we may get your account up to date.

Very truly yours,

NORTH STATE TELEPHONE CO., INC.

Georgia Morgan
Georgia Morgan



ADDRESS
 Kotzebue Public Health Nurse
 P.O. Box 43
 Kotzebue, Alaska

EXCHANGE NUMBER 3461

DEPOSIT AMOUNT

Page 5

6/20/62 1 Pty. Bus. 21.00

DATE	CHARGES	CREDITS	BALANCE
APR 1'70	33 21.00		75.85 •
APR 8'70		32 23.20	52.65 •
APR 24'70		33 21.00	31.65 •
MAY 1'70	34 23.20		54.85 •
MAY 26'70		34 23.20	31.65 •
JUN 1'70	35 26.50		58.15 •
JUN 22'70		35 26.50	31.65 •
JUL 1'70	36 35.60		67.25 •
AUG 1'70	37 46.15		113.40 •
+ AUG 6'70		36 35.60	77.80 •
- SEP 1'70	38 57.95		135.75 •
SEP 15'70		37 46.15	89.60 •
OCT 1'70	39 30.90		120.50 •
NOV 1'70	40 35.30		155.80 •
NOV 10'70		38 57.95	97.85 •
NOV 23'70		40 35.30	62.55 •
NOV 23'70		39 30.90	31.65 •
DEC 1'70	41 36.46		36.05 •
JAN 1'71	42 29.90		117.95 •
JAN 26'71		41 36.46	31.55 •

See Page 6

Alaska Dept. Health & Welfare
 Kotzebue Public Health Nurse
 ADDRESS P.O. Box 43
 Kotzebue, Alaska

EXCHANGE 442
 NUMBER 3461

DEPOSIT AMOUNT

Page 4

6/20/62 1 Pty. Bus. 21.00

DATE	CHARGES	CREDITS	BALANCE
NOV 1 '68	16 29.20T		51.90 *
DEC 1 '68	17 23.60T		75.50 *
DEC 12 '68		15 22.70	52.80 °
DEC 23 '68		16 29.20	23.60 °
JAN 1 '69	18 38.65		62.25 °
JAN 21 '69		17 23.60	38.65 °
FEB 1 '69	19 3.35		42.00 °
FEB 23 '69		18 21.00	21.00 °
MAR 1 '69	20 21.00		42.00 °
MAR 13 '69		19 3.35	38.65 °
APR 1 '69	21 26.25		54.90 °
APR 4 '69		20 21.00	43.90 °
MAY 1 '69	22 43.55		37.45 °
MAY 9 '69		21 26.25	51.20 °
MAY 23 '69		22 27.35	33.85 °
JUN 1 '69	23 4.80		38.65 °
JUL 1 '69	24 37.00		55.65 °

circulated

17.65 due

16.20 due

Parke, Davis & Company

CREDIT MEMO

PAGE	CUSTOMER NO.			DATE	
	LOC.	TERR.	ACCOUNT		
1	44		144011293		

CREDITED

ALASKA DEPARTMENT OF HLTH
JUNEAU 5
ALASKA 99801

RECEIVED

BRANCH OF NURSING
RM 222 MACKAY BLDG
ANCHORAGE ALASKA



CUSTOMER DEBIT NO.	NARCOTIC REG. NO.	NARCOTIC ORDER NO.	RECEIVING LOCATION							DATING CODE	CREDIT NO.
			SEATTLE							52	3572
STOCK NO.	DESCRIPTION			SIZE	T	C	PBC	QTY.	LIST PRICE	NET PRICE	EXTENDED AMOUNT
30 784102	COTTON BALLS LARGE			2000	1		976	2	\$	\$ 509	\$ <1018
	CORRECTION INV NO: 71868										
	READS										
30 781	COTTON BALLS			500	1		977	60		113	<6780
	SHOULD READ										
30 784102	COTTON BALLS LARGE			2000			977	5		509	2545
99 55	EXTRA TRANSPORTATION				1					260	<260
	CORRECTION CR NO: 3695										
06-13-10-10-470-PJ											

Credit

RETURNED MERCHANDISE FOR WHICH WE ARE UNABLE TO ALLOW CREDIT, WILL BE DESTROYED AFTER 30 DAYS UNLESS YOU REQUEST OTHER DISPOSITION.

*TRANSFER CODES:
0-SALE; 1-REVERSAL OF SALE; 2 & 7-RETURN; 3 & 9-REVERSAL OF RETURN; 4-ALLOWANCE; 5-REVERSAL OF ALLOWANCE

67 TOTAL < 5513

ORDER FILE (3)

Marta B Mother

FRANK, RICHARD L
2433 JUNEAU ST
CITY 99504

ER

12-573

12-20-69

7:40 PM

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 & TIME OF DISCHARGE

Date _____ 19____ Signed *[Signature]*

DATE	DESCRIPTION	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
DEC 20 69	MR	3.00								
DEC 20 69	MAT	.25								
									3.25	
SUB TOTALS								TOTAL CHARGES		
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		

Attach to claim form and submit to insurance carrier
All out patient work is payable at the time of service

- ADM - ADMINISTRATION
- AL - ALLOWANCE
- ANES - ANESTHESIA
- BIO - ANTHROPOLOGY
- BIO - BLOOD
- BMR - BASAL METABOLISM
- CBC - COMPLETE BLOOD COUNT
- CI - CIRCUMCISION
- CV - CLINIC VISIT
- CY - CYSTOSCOPY
- DAN - DELIVERY ANESTHETIC

- DEL - DELIVERY ROOM
- DIA - DIARRHEA
- EC - ERROR CORRECTION
- EKG - ELECTROCARDIOGRAM
- EKG - ELECTROCARDIOGRAPH
- ES - EMERGENCY SURGERY (OR SERVICES)
- EST - ELECTRIC SHOCK TR.
- HC - HEAD CENTER
- IC - INTENSIVE CARE
- ID - IDENTIFICATION

- IS - ISOTONES
- IV - INTRAVENOUS
- N - NARCOTICS, ENTIRE STAY
- NO2 - NEWBORN OXYGEN
- OR - OPERATING ROOM
- O2 - OXYGEN
- OXY - OXYGEN THERAPY
- PAR - RECOVERY ROOM
- PE - PERIPARTAL EDEMA

- PH - PENICILLIN
- PHY - PHYSIOTHERAPY
- PHO - PHOTOGRAPHS
- PL - PLASMA
- REF - REFUND
- TEL - TELEPHONE
- TI - TISSUE
- TR - TRANSFUSION
- UR - URINALYSIS
- XT - X-RAY THERAPY

- BURDANK SYMBOLS ONLY
- C/S - CENTRAL SUPPLY
- CH - CHARGES UNDER SUNDRY
- EM - EMERGENCY ROOM
- IPPB - INTERMITTENT POSITIVE PRESSURE SWENETT MACHINE
- R/C FEE - RED CROSS BLOOD PROCESSING FEE
- RX - DRUG CHARGES UNDER SUNDRY

EXPLANATION OF SYMBOLS

Mother Marta B

PRINE, RICHARD L
2433 JUNEAU ST
CITY 99504

ER

12-567

12-20-69

4:30 PM

PROVIDENCE HOSPITAL
Anchorage, Alaska

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to the claimant named hospital or 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 Dec 20 1969 Signed Marta B. Prine

DATE & TIME OF DISCHARGE

DATE	DESCRIPTION	SURGEY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
DEC 20 69	RM	3.00								
DEC 20 69	MAT	3.00							6.00	
SUB TOTALS								TOTAL CHARGES		
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 reader of this list. However, if there are any omissions an additional statement will be mailed to you. The Hospital Day ends at 11:50 A.M. This allows the patient to leave the hospital without an extra day's charge being made.								LESS: COVERAGE		
								DUE FROM PATIENT		

Attach to claim form and submit to insurance carrier
all out patient work is payable at the time of service

- EXPLANATION OF SYMBOLS
- | | | | |
|----------------------------|--------------------------------------|--------------------------|--------------------|
| ADM - ADMINISTRATION | DEL - DELIVERY ROOM | IS - ISOTOPE | PEN - PENICILLIN |
| AL - ALCOHOL | DR - DRESSING | IV - INTRAVENOUS | PH - PHYSICIAN |
| ANES - ANESTHESIA | DA - DIALYSIS | N - NURSING, ENTIRE STAY | PT - PHYSIOTHERAPY |
| ANT - ANTIBIOTICS | EC - EPROM CORRECTION | NO2 - NITROGEN OXYGEN | PPO - PHOTOGRAPHS |
| BIO - BLOOD | EG - ELECTROENCEPHALOGRAPH | OP - OPERATING ROOM | PL - PLASMA |
| BM - BASAL METABOLISM | EM - ELECTROCARDIOGRAM | OS - OXYGEN | REF - REFUND |
| CNC - COMPLETE BLOOD COUNT | ES - EMERGENCY SURGERY (OR SERVICES) | OX - OXYGEN THERAPY | TFL - TELEPHONE |
| CI - CIRCUMCISION | ET - ELECTRIC SHOCK TR. | PAR - RECOVERY ROOM | TI - TISSUE |
| CV - CLINIC VISIT | HE - HEPT GENIUM | PC - PERISTALTIC ILEUS | TR - TRANSFUSION |
| CY - CYSTOLOGY | IC - IDENTIFICATION | | UR - URINALYSIS |
| DAH - DELIVERY ANESTHETIC | | | XI - X-RAY THERAPY |
- BURBANK SYMBOLS ONLY
- C/S - CENTRAL SUPPLY
 - CH - CHARGES UNDER SUNDRY
 - ER - EMERGENCY ROOM
 - IPPO - INTERMITTENT POSITIVE PRESSURE BREATHING MACHINE
 - R/C FEE - RED CROSS BLOOD PROCESSING FEE
 - RR - DRUG CHARGES UNDER SUNDRY

XRAY

2327

04-08-68

8:25AM

JAMES HOLTER
WELFARE
DO NOT BILL

PROVIDENCE HOSPITAL
Anchorage, Alaska

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

On DISCHARGE

Date _____ 19____ Signed *James J. Holter*

INSURED

DATE	DESCRIPTION	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
68APK 8	DR WRIGHT FEE				28.0 0 17.0 0				45.0 0	
SUB TOTALS								TOTAL CHARGES		
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
AL - ALLOWANCE
ANES - ANESTHESIA
ANT - ANTIBIOTICS
BLD - BLOOD
BMR - BASAL METABOLISM
CBC - COMPLETE BLOOD COUNT
CI - CIRCUMCISION
CV - CLINIC VISIT
CY - CYSTOSCOPY
DAN - DELIVERY ANESTHETIC

DEL - DELIVERY ROOM
DIA - DIATHERMY
EC - ERROR CORRECTION
EEG - ELECTROENCEPHALOGRAM
EKG - ELECTROCARDIOGRAM
ES - EMERGENCY SURGERY (OR SERVICES)
EST - ELECTRIC SHOCK TR.
HC - HEART CENTER
IC - INTENSIVE CARE
ID - IDENTIFICATION

IS - ISOTOPIES
IV - INTRAVENOUS
N - NARCOTICS, ENTIRE STAY
NO2 - NEWBORN OXYGEN
◇ - DEPARTMENTAL CREDIT
OR - OPERATING ROOM
O2 - OXYGEN
OXY - OXYGEN THERAPY
PAR - RECOVERY ROOM
PE - PERISTALTIC ENEMA

PEN - PENICILLIN
PHY - PHYSIOTHERAPY
PT - PHYSIOTHERAPY
PHO - PHOTOGRAPHS
PL - PLASMA
REF - REFUND
TEL - TELEPHONE
TI - TISSUE
TR - TRANSFUSION
UR - URINALYSIS
XT - X-RAY THERAPY

BURBANK SYMBOLS ONLY
C/S - CENTRAL SUPPLY
ER - EMERGENCY ROOM
IPPB - INTERMITTENT POSITIVE
R/C FEE - RED CROSS BLOOD PROCESSING FEE
RX - DRUG CHARGES UNDER SUNDRY

5th Billing for unpaid X-Ray
on 5/18/69 (next page)

PROVIDENCE HOSPITAL
Anchorage, Alaska

STATEMENT

Barbara LaComa
WELFARE DO NOT BILL

Cascade

KINDLY RETURN THIS STUB WITH REMITTANCE

DATE	CHARGES	CREDITS	BALANCE	OLD BALANCE
5-9-69 ER	75.00			
5-20-69	1061.60		1136.60	
69OCT 5 LACOMA WELFARE 82731		1096.60	40.00	1136.60

1969

Barrara J La Coma
Girdwood, Alaska
99587

X RAY · 3955

05/08/69

1:25pm

PROVIDENCE HOSPITAL
Anchorage, Alaska

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

OF DISCHARGE

Date _____ 19____ Signed B. Barrara J. La Coma
INSURED

DATE	DESCRIPTION	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
69MAY 9	DR WRIGHT				35.00 40.00				75.00	
SUB TOTALS								TOTAL CHARGES		

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

Terms

EXPLANATION OF SYMBOLS

- | | | | | |
|----------------------------|--------------------------------------|----------------------------|---------------------|-------------------------------|
| ADM - ADMINISTRATION | DEL } DELIVERY ROOM | IS - ISOTOPES | PEN - PENICILLIN | BURBANK SYMBOLS ONLY |
| AL - ALLOWANCE | DR } DIATHERMY | IV - INTRAVENOUS | PHY } PHYSIOTHERAPY | C/S - CENTRAL SUPPLY |
| ANES - ANESTHESIA | EC - ERROR CORRECTION | N - NARCOTICS, ENTIRE STAY | PHO - PHOTOGRAPHS | - CHARGES UNDER SUNDRY |
| BIO - ANTIDIOTICS | EEG - ELECTROENCEPHALOGRAM | NO2 - NEWBORN OXYGEN | PL - PLASMA | ER - EMERGENCY ROOM |
| BLO - BLOOD | EKG - ELECTROCARDIOGRAM | OR - OPERATING ROOM | REF - REFUND | I/PPB - INTERMITTENT POSITIVE |
| BMR - BASAL METABOLISM | ES - EMERGENCY SURGERY (OR SERVICES) | O2 } OXYGEN | TEL - TELEPHONE | R/C FEE - RED CROSS BLOOD |
| CBC - COMPLETE BLOOD COUNT | EST - ELECTRIC SHOCK TR. | OX TH - OXYGEN THERAPY | TI - TISSUE | - PRESSURE BENNETT MACHINE |
| CI - CIRCUMCISION | HC - HEART CENTER | PAR - RECOVERY ROOM | TR - TRANSFUSION | - RED CROSS BLOOD |
| CV - CLINIC VISIT | IC - INTENSIVE CARE | PE - PERISTALTIC ENEMA | UR - URINALYSIS | - PROCESSING FEE |
| CY - CYSTOSCOPY | ID - IDENTIFICATION | | XT - X-RAY THERAPY | - DRUG CHARGES UNDER SUNDRY |
| DAN - DELIVERY ANESTHETIC | | | | |

LA COMA BARBARA 311

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 & TIME OF DISCHARGE

5-20-69 1:20 PM

Date _____ 19____ Signed _____

IF INJURED

DATE	DESCRIPTION	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
69MAY 19			28.75				60.00			
69MAY 19	LACOMA SAFEKEEPING REFUND				77205			20.00		
									1,068.25	959.50
69MAY 22			6.65						1,061.60	1,068.25
SUB TOTALS								TOTAL CHARGES		

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 *Handwritten*

EXPLANATION OF SYMBOLS

- | | | | | |
|----------------------------|--------------------------------------|----------------------------|---------------------|----------------------|
| ADM - ADMINISTRATION | DEL - DELIVERY ROOM | IS - ISOTOPES | PEN - PENICILLIN | BURBANK SYMBOLS ONLY |
| AL - ALLOWANCE | DI - DIATHERMY | IV - INTRAVENOUS | PHY - PHYSIOTHERAPY | |
| ANES - ANESTHESIA | EC - ERROR CORRECTION | N - NARCOTICS, ENTIRE STAY | PHO - PHOTOGRAPHS | |
| BID - ANTIBIOTICS | EEG - ELECTROENCEPHALOGRAPH | NO2 - NEWBORN OXYGEN | PL - PLASMA | |
| BID - BLOOD | EXG - ELECTROCARDIOGRAM | ◇ - DEPARTMENTAL CREDIT | REF - REFUND | |
| BMR - BASAL METABOLISM | ES - EMERGENCY SURGERY (OR SERVICES) | OR - OPERATING ROOM | TEL - TELEPHONE | |
| CUC - COMPLETE BLOOD COUNT | EST - ELECTRIC SHOCK 'R. | O2 - OXYGEN | TI - TISSUE | |
| CI - CIRCUMCISION | HC - HEART CENTER | OX TH - OXYGEN THERAPY | TR - TRANSFUSION | |
| CV - CLINIC VISIT | IC - INTENSIVE CARE | PAR - RECOVERY ROOM | UR - URINALYSIS | |
| CY - CYSTOSCOPY | ID - IDENTIFICATION | PE - PERISTALTIC ENEMA | XT - X-RAY THERAPY | |
| BAN - DELIVERY ANESTHETIC | | | | |
| | | | | |
| | | | | |
| | | | | |

LA COMA, BARBARA J
GIRDWOOD, ALASKA 99587

311 69-2079 05/13/69 3:15pm

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 & TIME OF DISCHARGE

Date _____ 19____ Signed *Barbara J. La Coma*
INSURED

DATE	DESCRIPTION	SUNDRY	DRUGS	MEDICAL & SURGICAL SUPPLY	X-RAY	LAB.	DAILY HOSPITAL SERVICE	CREDITS	BALANCE	OLD BALANCE
5-13-69			9.60	5.50			60.00			
5-13-69		LA COMA	SK DEPOS	76993				20.00*	85.10	
69MAY 14							60.00		115.10	55.10
69MAY 15	RECRM DR WRIGHT FEE	7.00	3.75	4.00	37.00					
					38.00	20.00	60.00		284.85	115.10
69MAY 16	ORRM	200.00								
69MAY 16	ANES	40.00								
69MAY 16	ORMAT	32.00								
69MAY 16	RECRM	7.00								
69MAY 16	REC MAT IV	250	.25	9.00						
				1.40						
				9.00						
	TR			15.00						
	TR			58.00						
	TR			18.00						
						40.00	60.00		757.00	284.85
69MAY 17					73.50					
	READING				9.00		60.00		899.50	757.00
69MAY 18							60.00		959.50	899.50
	SUB TOTALS							TOTAL CHARGES		

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 | BUBANK SYMBOLS ONLY |
| AL - ALLOWANCE | DR - DIATHERMY | IV - INTRAVENOUS | PHY - PHYSIOTHERAPY | C/S - CENTRAL SUPPLY |
| ANES - ANESTHESIA | DIA - DIATHERMY | H - NARCOTICS, ENTIRE STAY | PT - PHOTOGRAPHS | ER - EMERGENCY ROOM |
| BIO - ANTIBIOTICS | EC - ERROR CORRECTION | NO2 - NEWBORN OXYGEN | PL - PLASMA | IPPD - INTERMITTENT POSITIVE |
| BLD - BLOOD | EEG - ELECTROENCEPHALOGRAPH | ◇ - DEPARTMENTAL CREDIT | REF - REFUND | P/B - PLEASURE BENNETT MACHINE |
| BMR - BASAL METABOLISM | EKG - ELECTROCARDIOGRAM | OR - OPERATING ROOM | TEL - TELEPHONE | R/C FEE - RED CROSS BLOOD |
| CBC - COMPLETE BLOOD COUNT | ES - EMERGENCY SURGERY (OR SERVICES) | O2 - OXYGEN | TI - TISSUE | PR - PROCESSING FEE |
| CI - CIRCUMCISION | EST - ELECTRIC SHOCK TR. | OX TH - OXYGEN THERAPY | TR - TRANSFUSION | RX - DRUG CHARGES UNDER |
| CV - CLINIC VISIT | HC - HEART CENTER | PAR - RECOVERY ROOM | UR - URINALYSIS | SUNDRY |
| CY - CYSTOSCOPY | IC - INTENSIVE CARE | PE - PERISTALTIC ENEMA | | |
| DAM - DELIVERY ANESTHETIC | ID - IDENTIFICATION | | | |