

LEG. FINANCE - BILLS 1975 - 1976 510

SB78 cont.

February 20, 1975

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

Sincerely,

  
V. Kent Dawson, Director

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

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

DATE : February 27, 1975

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

SUBJECT:

Ron:

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

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

Legislative Billings for year 1974-75

Submitted November 22, 1974

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

Legislative Billings for year 1974-75

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Anchorage Daily Times	L-79415	12-22-70	11.70	8-15-74	06-21-3-263-325	Vendor Inv. not rcvd
Anchorage Daily Times	L-79156	6-24-71	67.20	5-30-74	06-21-3-263-325	" " " "
Anchorage Daily Times	L-79156	6-03-71	63.60	5-30-74	06-21-3-263-325	" " " "
<b>Corrections</b>						
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Health & Social Services						
TOTAL			13,016.37			

25 1973

10/22

NOV 17 1972

SEATTLE, WASHINGTON

952 907000

DATE	10 7 72	GL 50 11	10 5 72
CONTRACT NO.	53 515	APP	NOTE
SHIPPER OR CARRIER'S FILE NO.			
TYPE OF SERVICE	5 1		
CARRIER'S CONTROL NO.			
SHIPPER'S CONTROL NO.			
SHIPPER'S FILE NO.			
SHIPPER'S NAME	HAY-DIV-OF PUBLIC BLDG SECT OF LA35 627 E BOUNTY AVE ANCHORAGE ALASKA		
SHIPPER'S ADDRESS	LONDON COMMERCIAL REFRIGERATOR CO 2200 KENNEDY ST PHILA PA		
SHIPPER'S PHONE	B L T O		

**Sea-Land** *seam fast freight, inc.*

CONSIGNEE'S MEMO 6

SHIPMENT NO. 952 907000 9

SHIPPER: LONDON COMMERCIAL REFRIGERATOR CO  
2200 KENNEDY ST  
PHILA PA 19137

CONSIGNEE: SEALAND SERVICE INC  
SEATTLE WASH

DATE	AMOUNT	PAID	REMARKS
10 7 72	12375		12375

**FREIGHT BILL**

DESCRIPTION OF ARTICLES RECEIVED: 17 1/2 TON AVE ANCHORAGE ALASKA

DATE: 10 7 72

AMOUNT: 12375

PAID: 12375

REMARKS: NOT TO BE PAID TO SEATTLE ONLY

**SEA-LAND SERVICE, INC.**

CONTAINERS LOADED	CHECKER	NO. PCS.	FROM	TO	DATE
ZA D-66-100	620	1	AEF	53515	10/22

SPECIAL HANDLING	NET WT.	GROSS WT.	DECL. CHARGES
	47111	61225	2421

NEED FROM FREIGHTING	ORDER NOTES	11 GROSS WEIGHT	12 GROSS WEIGHT	13 CONSOLIDATION	14 IN TRANSIT DELIVERY	15 SPLIT DELIVERY	16 SPLIT PICKUP	17 STOP IN TRANSIT	18 STOPPAGE	19 OTHER	20 ADVANCE TRANSIT	21 DELAYED TRANSIT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL CHARGES: 8421

4 CASHIER

ALASKA  
FOR TRANSPORTATION  
NT OF

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

H022095 4

CAR WILL BE RETURNED TO: Anchorage, AK  
DATE: 6/6/77

(105) CAR NO. 111808 (109) CAR WILL BE RETURNED BY: [Signature]  
(106) CAR MAKE: Lincoln (107) STATE: AK (108) OWNING CITY NO. 810121010  
(103) MILEAGE DETERMINED BY READING FACTORY INSTALLED ODOMETER: 18535  
(113) MILES IN: 18535 (113) MILES OUT: 18514  
(127) TIME IN: 2:20 P.M. 6-6-77 (131) TIME OUT: 11:00 P.M. 6-6-77  
(137) MILES (41): 21 (138) MILES (42): 168  
(139) DAYS (43): 12.00 (140) WEEKS (43): 12.00  
(141) HOURS (44):  
(145) COMMISSIONABLE SOURCE:

(57) BILLING INFORMATION ONLY  
State TR 4  
348079

(68) NAME: Dept. of Health & Soc. Serv.  
(69) ADDRESS: Rm. 214 McKay Bldg.  
(71) CITY: Anchorage (72) STATE: Alaska (73) ZIP: 99501

(74) N.C.R. AMERICAN EXPRESS CARTE BLANCHE DINING BANK AMERICA FWA AMERICAN OIL MASTER CHARGE OTHER  
C.B. AX. BL. DN. BA. T.G. A.M. M.C.

MO. DAY YR. HEIGHT WEIGHT EYES HAIR C.D.W.

DRIVERS LICENSE NO. 172870  
STATE: Alaska EXPIRATION DATE: 7/29/73  
NAME: Virginia M. Blamhord  
ADDRESS: 1507 Crescent Ave  
CITY: Anchorage Alaska STATE: Alaska ZIP: 99504  
LOCAL ADDRESS: PHONE NO.:

ACCEPTS DECLINES  
X X  
COLLISION DAMAGE WAIVER  
I HAVE READ THE TERMS AND CONDITIONS OF THIS RENTAL AGREEMENT AND AGREE TO WAIVE MY LIABILITY FOR DAMAGES CAUSED BY COLLISION AS PROVIDED IN PARAGRAPH 5 ON BACK OF PAGE 1 OF THIS RENTAL AGREEMENT BUT CUSTOMER SHALL BE FULLY LIABLE FOR ALL DAMAGES TO ANY VEHICLE IF THE VEHICLE DESCRIBED HEREIN SHALL BE OPERATED IN VIOLATION OF ANY OF THE PROVISIONS OF THIS RENTAL AGREEMENT.  
CUSTOMER ACCEPTS OR DECLINES PURCHASE OF C.D.W. AT RATE SPECIFIED C.D.W. IS APPLICABLE ONLY IF ACCEPTED.  
P.A.I. PERSONAL ACCIDENT INSURANCE  
ACCEPTS P.A.I. DECLINES P.A.I.  
X X  
CUSTOMER ACCEPTS OR DECLINES P.A.I. AT RATE SHOWN IN SEPARATE BROCHURE. WAIVER IS PROOF OF COVERAGE UNDER POLICY ISSUED TO LESSEE AS CONTAINED IN SEPARATE BROCHURE.

(46) SUB-TOTAL: 13.68  
(47) TOTAL TIME AND MILEAGE OR MINIMUM CHARGE: 13.68  
(49) INTER-CITY FEE:  
C. DAYS WEEKS (50):  
D. W. NO -  
(51) SUB-TOTAL: 13.68  
(52) TAX: %  
(53) TOTAL CHARGES: 13.68  
(56) LESS GAS, ETC.:  
(57) NET CHARGE:  
(59) LESS DEPOSIT:  
(60) AMOUNT DUE (U.S.): 13.68  
(61) PAID BY: CASH  CREDIT CARD  CHECK   
CUSTOMER INITIALS: DRB DATE: 6/6

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

RATE DOES NOT INCLUDE GAS

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

(17) ORIGINAL DEPOSIT: \$ (53) ADDITIONAL: \$  
(63) UNUSED DEPOSIT: \$  
(64) GAS, ETC.: \$  
(65) TOTAL REFUND: \$

(54) P. DAYS WEEKS: A. No -  
(55) TOTAL CHARGES: 13.68  
(56) LESS GAS, ETC.:  
(57) NET CHARGE:  
(59) LESS DEPOSIT:  
(60) AMOUNT DUE (U.S.): 13.68  
(61) PAID BY: CASH  CREDIT CARD  CHECK   
CUSTOMER INITIALS: DRB DATE: 6/6

COMMENTS:  
REFUND RECEIVED BY: (18) PREPARED BY: (19) COMPUTED BY:  
ISSUED: STAMPS BY: M 10 AM MAILED: DATE: 11



LICENSEE  
IN CANADA ITS TILDEN CAR RENTAL

CITY NAME AND ADDRESS

3000  
1300 EAST BROADWAY  
ANCHORAGE, ALASKA

RENTAL AGREEMENT NO.  
H022095 4

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

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

GOLDENROD - CUSTOMER MEMO  
PAGE 2

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

SUPVR. APPROVAL

AUTHORIZATION

ORIGINAL

BY

DEPARTMENT OF HEALTH AND WELFARE

DIVISION OF PUBLIC HEALTH

POUCH H JUNEAU, ALASKA 99801

SECTION OF CHILD HEALTH

AUTHORIZATION NO.

00426

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

DATE 7-28-72

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

Patient REID, Michael

Birthdate: 6-26-59

Address Sitka

Code: CSC 06-85-11-00

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

Please submit claims first to:

Mrs. Florence Ellertson

\$78.00

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

©263564

Authorized by \_\_\_\_\_  
PROGRAM REPRESENTATIVE CRIPPLED CHILDREN'S SERVICES

\* IMPORTANT NOTICE TO VENDOR

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

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

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

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

II

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

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

06 Ni

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 50973A

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

NATURE OF ACCIDENT OR ILLNESS

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

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

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: <i>State dated.</i> <i>33-6-150-380</i>
	<p>PROVIDER SIGNATURE <i>R. Bosveld MD</i> DATE <i>1/15/75</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
062672	DO	Upper GI without KUB	74240	56.00	
030372	DO	Upper GI Series	74240	56.00	
040472	DO	Upper GI Series	74240	56.00	
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	390.80
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	
IL INDEPENDENT LAB					
H PATIENT'S HOME					
IH INPATIENT HOSPITAL				LESS	312.32
OL OTHER LOCATIONS					
NH NURSING HOME		MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL	
ECF EXTENDED CARE FACILITY					
OH OUTPATIENT HOSPITAL				UNPAID BALANCE	78.08

PROVIDER CERTIFICATION

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

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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



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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

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

# THE ALASKA CLINIC

a professional corporation

825 L ST.  
ANCHORAGE, AK. 99501

PLEASE RETURN

THIS STUB WITH

YOUR PAYMENT

Phone 274-1303

For appt. 272-4551

ACCOUNT NUMBER

DEPT. OF HEALTH & SOCIAL SERVICES

GREG DARRACH

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

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

66.00

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 *m*

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: <i>Surgeon; Depleted</i> <i>State dated</i>
	<p>PROVIDER'S SIGNATURE <i>Dm Dietz M.D.</i> DATE <i>1/14/75</i></p>

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 M

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

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <u>710 24075 A.</u>		RACE <u>W</u>	NAME OF PROVIDER <u>The Alaska Clinic</u>	
NAME OF PATIENT <u>LINDA J. HALL</u>			Dr. Depalatis	
DATE OF BIRTH <u>4 1 25 51</u>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE <u>21E</u>	PROVIDER ID. NO. <u>5AD 417</u>	CATEGORY <u>OS</u>
CASE NO. <u>75156-01</u>	RESOURCE <u>X</u>	PAYEE ID NO. (if different from above) <u>ALC 501</u>		

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <u>Depalatis MD</u> DATE <u>1/15/75</u></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 M

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE: <i>A. Depalatis MD</i> DATE: <u>1/15/75</u></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

# THE ALASKA CLINIC

a professional corporation

825 L ST.  
ANCHORAGE, AK. 99501

PLEASE RETURN  
THIS STUB WITH  
YOUR PAYMENT

Phone 274-1303

For appt. 272-4551

ACCOUNT NUMBER

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

ANTHONY HERRINGTON

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

*(Mother: Leonardine)*

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

*diag. 708 urticaria*

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*Call me for appt*

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## DEPARTMENT OF HEALTH & SOCIAL SERVICES

JUDY JONES

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

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

16.00

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

*Marian Merrill 4-5-74*

*Cystitis*

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

ADC-62191-01

Care or Med. Card No. Remarks

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ACCOUNT NUMBER

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

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

CRVS	AMOUNT
90040	12.00

Diagnosis: 470 Influenza, unqualified

*Not paid as of 5/17/74*

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For appl. 272-4551

ACCOUNT NUMBER

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

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

CRVS  
90640

AMOUNT

12.00

Diagnosis: 463 Acute tonsillitis

*not paid as of 5/17/73*

06 *M*

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

NO. 59549A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>110-57454 B</i>		RACE <i>U</i>	NAME OF PROVIDER <i>ALASKA CLINIC</i>	
NAME OF PATIENT <i>L. MIONI</i>			DR. <i>ARCHER</i>	
DATE OF BIRTH <i>4-8-16</i>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	EUG. CODE <i>21E</i>	PROVIDER I.D. NO. <i>GA 415</i>	CATEGORY <i>05</i>
CASE NO. <i>75362-01</i>	RESOURCE <i>X</i>	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) <i>ALC 501</i>		

NATURE OF ACCIDENT OR ILLNESS

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

11 SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: <i>LUCILLE - 75362</i> <i>no pending claims 9-18-72</i> <i>we never had 57-- service</i>
	<p>PROVIDER SIGNATURE <i>Clara A. Archer MD</i> DATE <i>12-30-73</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW <i>[Signature]</i>

# THE ALASKA CLINIC

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ANCHORAGE, AK. 99501

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For appl. 272-4551

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

RICHARD MUNDTS (<sup>DEANNA</sup> Emmett, ~~Dianna~~ Mother)

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

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

CRVS  
90040

AMOUNT  
12.00

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For appl. 272-4551

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

RICHARD NICHOLSON

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

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

~~192.00~~  
142.00

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Phone 274-1303

For appt. 272-4551

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

JOYCELYNE NIELSON

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

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

*Not paid as of 5-16-74*

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825 L ST.  
ANCHORAGE, AK. 99501

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For appl. 272-4351

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

**ALBERTA PERKINS**

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

DATE  
7.9/72

PATIENT/DOCTOR  
DR. JACKSON

DESCRIPTION  
EMER. ROOM

CRVS  
90500

AMOUNT  
20.00

# THE ALASKA CLINIC

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825 L ST.  
ANCHORAGE, AK. 99501

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Phone 274-1303

For appl. 272-4551

ACCOUNT NUMBER

*D. O. of Health & Soc. Secs.*

SHARON REID

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

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

23.00

*Not paid as of 5-16-74*

# THE ALASKA CLINIC

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825 L ST.  
ANCHORAGE, AK. 99501

Phone 274-1303

For appt. 272-4551

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ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

**DONNIE SHARP**

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

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

64.00

# THE ALASKA CLINIC

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Phone 274-1303

For appt. 272-4551

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

PHYLLIS SHORT

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

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

*Not paid as of 5-16-73.*

# THE ALASKA CLINIC

a professional corporation

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ANCHORAGE, AK. 99501

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Phone 274-1303

For appt. 272-4551

ACCOUNT NUMBER

DIV. OF HEALTH & SOCIAL SERVICES

AGNES SMITH

CURRENT	30-60	60-90	OVER 90	TOTAL DUE

TOTAL DUE

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

~~104.50~~

7.50

*paid*  
*paid*  
*paid*  
*paid*  
*paid*

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 82366 A

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

NATURE OF ACCIDENT OR ILLNESS

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

11	SERVICES RENDERED					
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
031372	DO	Brief exam eval a/o treatment	90040	12.00		
040572	DO	CBC	85010	8.00		
040572	DO	SEB	85650	6.00		
040572	DO	Intermed exam eval a/o treatment	90060	20.00		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	46.00	
IL INDEPENDENT LAB.						
H PATIENTS HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	No record of payment
PROVIDER SIGNATURE <i>Richard Curtis MD</i> DATE <i>9-12-74</i>	RESUBMITTAL INDICATOR <i>XXXX</i> MEDICAL REVIEW

59736-42-38


ALASKAN OPTICIANS INC.  
2520 C Street  
ANCHORAGE, ALASKA 99503

# INVOICE

NO 2785

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

DATE	May 3, 1972
CUSTOMER ORDER NO.	
SALESMAN	
VIA	

4/6/72	<b>GIRSH, Sharon</b>  Feminine Frames w/single vision lenses  <i>Appearing in ledger</i>	\$10.70	<i>State of Alaska</i> <i>we want you</i> 
--------	--	---------	---

33-6-411-380

QUADRUPPLICATE

Thank You!

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

Send white & canary copies w/ payment.

25 R01-39058  
 Provider Ref Elwell, M

06

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
 Health Care Facility Invoice

Nº 504999 **B**

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

21 DIAGNOSIS AND PROCEDURES

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

22 STATEMENT OF SERVICES RENDERED

Blood Pts. Supplied	Pints Replaced	Not Replaced	Charge Per Pint	Charge
1				
Accommodation		Days	Rate	
2	1 Bed			
3	2 Beds			
4	3 or More Beds			
5	Intensive Care			
6	Self Care			
7	Nursery			
8	Operating Room			
9	Anesthesia			
10	Outpatient Services			
11	Blood Administration			
12	Pharmacy & I.V.		70.90	
13	Radiology		24.00	
14	Laboratory		32.00	
15	Medical & Surgical Supplies		8.60	
16	Physical Therapy			
17	Occupational Therapy			
18	Speech Therapy			
19	Inhalation Therapy & Oxygen		198.50	
20	Other (Specify) EKG		30.25	
21				
22				

PROVIDER CERTIFICATION

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

To the best of my knowledge no other resource exists.

Signature S. Kallas Date 8/17/74

Remarks:  
33-6-310-380

Resubmittal Indicator	Medical Review
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23 COORDINATION OF OTHER BENEFITS

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

Total Charge	868.25	Less	308.25	Amount Billed	560.00
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06

HEALTH CARE FACILITY INVOICE

NO. 534242

B

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

DIAGNOSIS AND PROCEDURES

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

STATEMENT OF SERVICES RENDERED

	BLOOD PINTS FURNISHED	PINTS REPLACED	NOT REPLACED	CHARGE PER PINT	CHARGE
1	ACCOMMODATION		DAYS	RATE	
2	1 BED				
3	2 BEDS		4	72.00	288.00
4	3 OR MORE BEDS		8 2	66.60	133.20
5	INTENSIVE CARE		13 hours	7.60	98.80
6	SELF CARE				
7	NURSERY				
8	OPERATING ROOM				247.20
9	ANESTHESIA				244.83
10	OUTPATIENT SERVICES				
11	BLOOD ADMINISTRATION				
12	PHARMACY				191.10
13	RADIOLOGY				48.00
14	LABORATORY				216.50
15	MEDICAL & SURGICAL SUPPLIES				100.95
16	PHYSICAL THERAPY				
17	OCCUPATIONAL THERAPY				
18	SPEECH THERAPY				
19	INHALATION THERAPY				74.00
20	OTHER (SPECIFY) IV's				103.65
21					
22					

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."

TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE B. Simpson

DATE 9-4-74

REMARKS: *This was prior to coupon days.*

RESUBMITTAL INDICATOR	MEDICAL REVIEW
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COORDINATION OF OTHER BENEFITS

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

TOTAL CHARGE 1746.23 LESS 00.00

AMOUNT BILLED 1746.23



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

Send White & carry copies for payment.

15 Provider Ref. FRIEDE, P

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

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

**NATURE OF ACCIDENT OR ILLNESS**

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

**SERVICES RENDERED**

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY		
12-1/12/70	IH	Hosp Visits 26 2/12	90240	312.00			
				Total Charge	312.00		
				Less	208.00		
				Unpaid Balance	104.00		

*Place of Service DO Doctor's Office IL Independent Lab H Patient's Home IH Inpatient Hospital OL Other Location NH Nursing Home ECF Extended Care Fac. OH Outpatient Hosp.	<b>12</b> Coordination of Other Benefits			Total Charge
	M/Care Pd.	Other Paid	Total	
	M/Care CoIn	M/Care Ded.	Total	

**PROVIDER CERTIFICATION**

"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."  
 To the best of my knowledge no other resource exists.

Signature A.P. Blankenship MD/AG Date 1-30-74

Remarks:  
33-6-350-380

Resubmittal Indicator	Medical Review
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STEFFENS

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96612A

06

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER A1072-327-41-773			NAME OF PROVIDER Dr. Glen Straatsma	
NAME OF PATIENT Steffens, Gladys		RACE W	PROVIDER I.D. NO. GWS 318	
DATE OF BIRTH 03/17/24		ELIG. CODE ZOP		
CASE NO. OSTOR4-01		RESOURCE X	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 881	
			CATEGORY 05	

NATURE OF ACCIDENT OR ILLNESS

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

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
11/13/72	DO	COMPR HE EV	90620	70.00	5000	4 01
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	70.00	5000
II INDEPENDENT LAB						
III PATIENTS HOME						
IV INPATIENT HOSPITAL						
VI OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
VII NURSING HOME						
VIII EXTENDED CARE FACILITY						
IX OUTPATIENT HOSPITAL						
				UNPAID BALANCE	70.00	50.00

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
PROVIDER SIGNATURE <i>Glen Straatsma</i>	DATE 11-12-74
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96778A

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

NATURE OF ACCIDENT OR ILLNESS

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

11	SERVICES RENDERED					
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
07/21/72	IH	SURGERY (HA)	27506	855.00		
07/21/72	IH	SURGERY (HA)	27594	315.00		
07/21/72	IH	SURGERY (HA)	27598	630.00		
07/21/72	IH	SURGERY (LINDIG)	15100	33.75		
07/21/72	IH	SURGERY (LEE)	27594	139.20		
07/21/72	IH	DISCOUNT (LINDIG)	01005	14.88-		
07/21/72	IH	SURGERY (LEE)	27506	180.00		
07/21/72	IH	E R EXTENDED RE-EXAM (HANEK)	90570	55.00		
07/21/72	IH	DISCOUNT (HA)	01005	132.75-		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	3520.88	
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB						
H PATIENT'S HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>		REMARKS:	
PROVIDER SIGNATURE	<i>P. Gray</i>	DATE	11/1/74
		RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96777A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT		RACE	Dr. Edwin Lindig, Jr.	
Anderson, Cherie <i>page 1</i>			Dr. Robert D. Hanek	
DATE OF BIRTH	SEX	ELIG. CODE	PROVIDER I.D. NO.	CATEGORY
5/24/50	M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
CASE NO.	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE)		
		FMS S81		

NATURE OF ACCIDENT OR ILLNESS

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

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

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>		REMARKS:	
<p>PROVIDER SIGNATURE <i>P. Oray</i> DATE <i>11/1/74</i></p>		RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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

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

NATURE OF ACCIDENT OR ILLNESS

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

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>		<p>REMARKS:</p> <p><del>April 26, 27, 28, 29 - 1971</del></p> <p>April 26, 27, 28, 29 - 1971</p> <p>Brief Eet - 1971</p>	
PROVIDER'S SIGNATURE	DATE	RESUBMITTAL INDICATOR	MEDICAL REVIEW
James Lopez	3-4-74		

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."	REMARKS: Limited eet not dup. billing
	PROVIDER'S SIGNATURE <i>James J. Hayes</i> DATE 3-4-74

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

11	3-4-74	SERVICES RENDERED					
DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
05-05-71	III	Surgery (cholecyst = Cholangiograph) <i>Assist.?</i> <i>surgery assist</i>	47605-81	30.00			
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	30.00	
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	LESS		
IL INDEPENDENT LAB.							
H PATIENT'S HOME							
IM INPATIENT HOSPITAL							
OL OTHER LOCATIONS							
NH NURSING HOME		MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL			
ECP EXTENDED CARE FACILITY							
OH OUTPATIENT HOSPITAL					UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1954 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: <i>what service was performed</i>
	<p>PROVIDER'S SIGNATURE <i>James Spis</i> DATE <i>3-4-74</i></p>

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Jarock John		RACE	Dr Joseph Ribar	
DATE OF BIRTH ___/___/___	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO. JNR 304	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above) FMS 381		

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: <i>what service was performed</i>
	<p>PROVIDER'S SIGNATURE <i>James Lopez</i> DATE <i>3-4-74</i></p>
	RESUBMITTAL INDICATOR
	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

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

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DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

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

06

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

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

NATURE OF ACCIDENT OR ILLNESS

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

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

I AM TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR MISREPRESENTATION OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.  TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.	REMARKS: <i>Possible follow up care</i> <i>Surg 5/6/71 7/14 = 45 days</i> <i>1972</i>
	PROVIDER'S SIGNATURE <i>Janne Spies</i> DATE <i>3-4-74</i>

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DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>Joannes Apis</i> DATE <u>3-4-74</u></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

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

06

A

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>James Lypie</i> DATE <i>3-5-74</i></p>	RESUBMITTAL INDICATOR

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

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PROVIDER'S SIGNATURE	DATE	
<i>James D. [Signature]</i>	3-5-74	
RESUBMITTAL INDICATOR	MEDICAL REVIEW	

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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

A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Georgie Monigold		RACE	Ha	
DATE OF BIRTH ___/___/___	SEX M <input type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	PROVIDER ID. NO.	CATEGORY
CASE NO.	RESOURCE	PAYEE ID NO. (if different from above)		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST		PRIMARY
710 840		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SERVICE PRE-AUTHORIZATION NO. (if applicable)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

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

PROVIDER CERTIFICATION

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	<p>PROVIDER'S SIGNATURE <i>James Lopez</i> DATE <u>3-5-74</u></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: <i>continued</i>
	<p>PROVIDER'S SIGNATURE _____ DATE _____</p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

A

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:	
	<p>PROVIDER'S SIGNATURE <i>James ...</i> DATE <u>3-5-74</u></p>	RESUBMITTAL INDICATOR

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 *M*

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <i>P. May</i> DATE <i>1/10/74</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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

A

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <u><i>P. Murphy</i></u> DATE <u><i>1/10/74</i></u></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06 M

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

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

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 *M*

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <i>P. Maye</i> DATE <i>1/10/74</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06 *M*

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

A

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
10/6/71	DQ	BLOOD COUNT	85010	9.60	960	6	
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	48.00	24.40	
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB	IN INPATIENT HOSPITAL	OL OTHER LOCATIONS	NH NURSING HOME	ECP EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL	
MEDICARE PAID		OTHER INS.	TOTAL	LESS	1952	1952	
MEDICARE CO-INS.		MEDICARE DEDUCT.	TOTAL	UNPAID BALANCE	2849	4.88	
4.88			4.88				

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <i>D. Maye</i> DATE <i>1/10/74</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06 *M*

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PA' 'ENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <i>P. Gray</i> DATE <i>1/10/74</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
9/29/71	DO	1 MODALITIE	97000	12.00	850	1 01
9/29/71	DO	SUPPLIES MATERIAL	99070	10.00	10.00	1
9/30/71	DO	1 MODALITIE	97000	12.00	850	1 01
9/30/71	DO	SUPPLIES MATERIAL	99070	10.00	10.00	1
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	103.90	93.40
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB.	MEDICARE PAID	OTHER INS.	TOTAL		
H PATIENT'S HOME	IH INPATIENT HOSPITAL	7472		7472		
OL OTHER LOCATIONS	NH NURSING HOME	MEDICARE CO-INS. MEDICARE DEDUCT.		TOTAL		
ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL	1868		1868		
				UNPAID BALANCE	29.18	18.68

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <u>A. Gray</u> DATE <u>11/10/74</u></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

## DEPARTMENT OF HEALTH &amp; SOCIAL SERVICES

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

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>attached 41-099999X</i>		RACE <i>AW</i>	NAME OF PROVIDER  DR. JOHNSON	
NAME OF PATIENT GENES, IMOGENE J			PROVIDER ID. NO. JKJ 309	
DATE OF BIRTH <i>01/04/06</i>	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	ELIG. CODE <i>FOA</i>	PAYEE ID NO. (if different from above) FMS 881	CATEGORY <i>05</i>
CASE NO. <i>57369-51 BAA</i>		RESOURCE <i>J</i>		

## NATURE OF ACCIDENT OR ILLNESS

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

## SERVICES RENDERED

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

## PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:			
	PROVIDER'S SIGNATURE <i>J. May</i>	DATE <i>1/10/74</i>	RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 M

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

A

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER'S SIGNATURE <i>P. Gray</i> DATE <i>1/10/74</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06 M

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96703 A

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

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST		PRIMARY
ABORTION INDUCED FOR MEDICAL INDICATIONS		640
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
07/20/72	IH	SURGERY	59850	180.00	180.00	2
PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	180.00	180.00
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB						
H PATIENT'S HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
CH OUTPATIENT HOSPITAL						
				UNPAID BALANCE	180.00	180.00

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER SIGNATURE <i>DD May</i> DATE 11/1/74</p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96901 A

06 m

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

NATURE OF ACCIDENT OR ILLNESS

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

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
11-12-72	IH	SURGERY	25412	180.00	12240	3 01
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE		
DO DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB						
H PATIENT'S HOME				LESS		
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECP EXTENDED CARE FACILITY				UNPAID BALANCE		
OH OUTPATIENT HOSPITAL				180.00	122.40	

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: RESUBMISSION OF OLD 1972 CHARGES NEVER PAID - PLEASE HOLD FOR SPECIAL LEGISLATIVE APPROVAL
	<p>PROVIDER SIGNATURE: <i>P. Gray</i> DATE: 10/29/74</p>

06 M

NO. 96702 A

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

NATURE OF ACCIDENT OR ILLNESS

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

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

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>		REMARKS:	
PROVIDER SIGNATURE D. Mayr	DATE 11/1/74	RESUBMITTAL INDICATOR	MEDICAL REVIEW

06 M

NO. 96704 A

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

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST  ABORTION INDUCED FOR MEDICAL INDICATIONS		PRIMARY  640
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SECONDARY
COMMENTS:	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)	REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
07/20/72	IH	SURGERY-ANESTHESIA	59850	79.20	<del>6300</del>	2 01
07/20/72	IH	DISCOUNT	01005	3.96		
* PLACE OF SERVICE			12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	
DO DOCTOR'S OFFICE	II INDEPENDENT LAB	III PATIENT'S HOME	IV INPATIENT HOSPITAL	VI OTHER LOCATION	VII NURSING HOME	VIII EXTENDED CARE FACILITY
IX OUTPATIENT HOSPITAL			MEDICARE PAID	OTHER INS.	TOTAL	UNPAID BALANCE
				396	396	7920
			MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL	75.24
						6300
						396
						396
						7524
						59.04

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: 3 Bu 4 Tu 7 X 9
	<p>PROVIDER SIGNATURE: P-9max DATE: 11/1/74</p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06 M

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96810A

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

NATURE OF ACCIDENT OR ILLNESS

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

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
11-12-72	IH	SURGERY	26418	45.00	2448	4 01
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	4500 2448	
00 DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
01 INDEPENDENT LAB						
02 PATIENT'S HOME				LESS		
03 INPATIENT HOSPITAL						
04 OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
05 NURSING HOME						
06 EXTENDED CARE FACILITY						
07 OUTPATIENT HOSPITAL				UNPAID BALANCE	4500 2448	

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: RESUBMISSION OF OLD 1972 CHARGES NEVER PAID - PLEASE HOLD FOR SPECIAL LEGISLATIVE APPROVAL.
	<p>PROVIDER SIGNATURE: <i>P. Jones</i> DATE: 10/29/74</p>

FAIRBANKS MEDICAL & SURGICAL CLINIC

BOX 1330 1 922 FIFTH AVENUE

FAIRBANKS, ALASKA 99701

message DATE 12-6-73

reply DATE

Re: MARK DALEY

OAA 32866

INVOICE # 63958 PD 683393  
63959 VO 87.20 MS55\*

63964 225.00 ✓

63965 990.00 ✓

63966 100.00 ✓

63967 PD 683393 25.60 - 5.12\*

63960 12.00 ✓

63961 60.00 ✓

63962 1651.50 ✓

63963 315.00 ✓

TOTAL 3466.30

3466.30  
 MEDICARE DISALLOWED (985.70) 985.71

MEDICARE PD. (2124.63)-

DUE MEDICAID 360.86

\* - 16.67

344.29

CIRCLE FOLLOW-UP DATE AND FILE

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

SENT BY \_\_\_\_\_

ANSWERED BY \_\_\_\_\_

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

SENDER'S FOLLOW-UP COPY

DALY, MARK

TOTAL CHARGES 3466.30  
MEDICARE DISALLOWED - 985.71

2480.59

MEDICARE PAID - 2119.63

360.96

MEDICAID PAID VO 683393

- 16.67

344.29

33-6-350-380

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

**A**

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

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

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

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

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

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

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

0 - Not an accident.  
1 - An accident, no third party involvement  
2 - An accident, possible third party liability

**The Laboratory does not have the diagnosis**

PRIMARY DIAGNOSIS      CODE      SECONDARY DIAGNOSIS      CODE

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

**PLACE OF SERVICE**

1 - INPATIENT HOSPITAL  
2 - OUTPATIENT HOSPITAL  
3 - PRACTITIONER'S OFFICE  
4 - PATIENT'S HOME  
5 - DRIVING HOME

AMBULANCE  
OTHER

← MEDICARE - TITLE VIII →

12 **CO-INS**      **PERCENT**      **PAID**      **ILL PAID**      **REASON CODE**

**WARRANTY CERTIFICATION:**

I HEREBY CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PROHIBITS EXCLUSION OR DISCRIMINATION ON THE BASIS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR OMISSIONS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

ON THE BASIS OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

**RESULTS OF OTHER INVESTIGATION**

APPROVED BY:                 

DATE:      TIME:      SIGNATURE:

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 M

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

11	DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
	8/17/72	IL	Tissue	8903	\$ 21.00	17.70	6 01
*PLACE OF SERVICE			12 COORDINATION OF OTHER BENEFITS	TOTAL CHARGE	21.00	17.70	
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB	H PATIENT'S HOME	IH INPATIENT HOSPITAL	OL OTHER LOCATIONS	NH NURSING HOME	ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL
			MEDICARE PAID	OTHER INS.	TOTAL		
			14.16		14.16		
			MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL		
			3.54		3.54		
				UNPAID BALANCE	6.84	3.54	

PROVIDER CERTIFICATION

" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS		REMARKS:	
PROVIDER'S SIGNATURE <u>[Signature]</u>		DATE <u>6/31/72</u>	
RESUBMITTAL INDICATOR	XX	MEDICAL REVIEW	

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 M

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

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: <u>MC-EOB not available</u> <u>EOB rec'd by request</u>
	<p>PROVIDER'S SIGNATURE <u>[Signature]</u> DATE <u>2 Jan 74</u></p>

OHLSON PSYCHOLOGICAL SERVICES  
140 EAGLE STREET SUITE 103  
P.O. BOX 3295  
ANCHORAGE, ALASKA 99501  
TELEPHONE (907) 272-7924

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

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

January 31, 1974

Department of Corrections  
Box 3811  
Kenai, Alaska 99611

Attention: Keith Armstrong  
Re: FREEL, Roy CP-72-154

STATEMENT

November 1, 1972 \*  
Diagnostic Interview  
Psychological Report

\$ 40.00  
16.00

Total Charges \$ 56.00

Please Remit: \$ 56.00

\* Please note the date of services rendered.

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

Send white & primary copies for payment.

15 Provider Ref. Jorgenson

OS P

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

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

**NATURE OF ACCIDENT OR ILLNESS**

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First		Primary
<u>Cerebellar Dysfunction</u>		<u>438</u>
<u><del>Linear Fracture</del></u>		<u>428</u>
<u>Congenital Heart Disease</u>		Secondary
		<u>746</u>
		<u>429</u>
Have all other payment sources been exhausted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Service Preauthorization No. (if applicable) <u>F001</u>
Comments:		Referring or Consulting Physician

**SERVICES RENDERED**

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY	
5-2-71	DO	<u>Brief</u>	90040	20.00	1110	1 01
6-7-71	DO	<u>Medial</u>	90030	8.00	710	1 01
3-21-71	DO	<u>Brief</u>	90040	12.00	1110	1 01
6-16-71	DO	<u>Medial</u>	90030	14.00	710	1 01
6-18-71	DO	<u>Medial</u>	90030	8.00	710	1 01
*Place of Service		<b>12</b> Coordination of Other Benefits		Total Charge		
DO Doctor's Office	IL Independent Lab	M/Care Pd.	Other Paid	Total		
H Patient's Home	IH Inpatient Hospital			<u>62.00</u>	<u>43.50</u>	
OL Other Location	NH Nursing Home			<u>LESS</u>	<u>20.00</u>	
ECF Extended Care Fac.	CH Outpatient Hosp.	M/Care CoIn	M/Care Ded.	Total		
				Unpaid Balance	<u>62.00 - 20.00 = 42.00</u>	

**PROVIDER CERTIFICATION**

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
	<p>Signature <u>[Signature]</u> Date <u>4-11-74</u></p>
Resubmittal Indicator	Medical Review

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

Send white & copy copies for payment.

15 Provider Ref: Jorgensen

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

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

**NATURE OF ACCIDENT OR ILLNESS**

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

**SERVICES RENDERED**

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 FVS Proc. Code	Charge	DRUGS	LABS	OTHER
<i>8-5-71</i>	<i>DO</i>	<i>Limited</i>	<i>90050</i>	<i>16.00</i>			
<i>12-15-71</i>	<i>DO</i>	<i>Limited</i>	<i>90050</i>	<i>16.00</i>			
<i>3-17-72</i>	<i>DO</i>	<i>Brief</i>	<i>90040</i>	<i>12.00</i>			
<i>4-26-72</i>	<i>DO</i>	<i>Minimal</i>	<i>90030</i>	<i>8.00</i>			
<i>5-23-72</i>	<i>DO</i>	<i>Brief</i>	<i>90040</i>	<i>12.00</i>			
*Place of Service DO Doctor's Office IL Independent Lab H Patient's Home IH Inpatient Hospital OL Other Location NH Nursing Home ECF Extended Care Fac. OH Outpatient Hosp.		<b>12</b> Coordination of Other Benefits	Total Charge	<i>64.00</i>			
		M/Care Pd. Other Paid Total	Less				
		M/Care CoIn M/Care Ded. Total	Unpaid Balance	<i>64.00</i>			

**PROVIDER CERTIFICATION**

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

To the best of my knowledge no other resource exists.

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

Remarks:

Resubmittal Indicator:  Medical Review:

Revised 6/1/73 06 7014

*Welfare*

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

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

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

BLUE CROSS  
 GRP 7500-01 M574-16-8382

(JOANNE WOODS)

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

DATE \_\_\_\_\_  
 SIGNED *Jo Ann Judeen*

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

HOSPITAL FILE

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

*Welfare*

SS AD: NONE

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

EMP/OCCUP.  
 WORK  
 COMP/INS.

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

(K MC GOWEN)

DATE \_\_\_\_\_  
 SIGNATURE J. Ann Judeen

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

HOSPITAL FILE

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

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

PROVIDENCE HOSPITAL  
 Anchorage, Alaska

IRS-92-0016429N

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

DATE & TIME OF DISCHARGE

Date 7-22-72 7:30 PM 19 72 Signed THOMAS E. REYNOLDS INSURED

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

EXPLANATION OF SYMBOLS

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

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

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

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

Thomas E. Reynolds 5-7-74  
 Signature Date

MA-06 0001-371-33 6 350  
 06-22-3 320-364-71-0180  
 8-Digit Account Code 3-Digit Output Code

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

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

A

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

NATURE OF ACCIDENT OR ILLNESS

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

SERVICES RENDERED

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

PROVIDER CERTIFICATION

<p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p> <p>covered by Welfare at the time &amp; if you can still pay on this we would sure appreciate it.</p> <p>PROVIDER'S SIGNATURE <i>Joseph H. Clair</i> DATE <u>6/24/74</u></p>	REMARKS: Medicare was billed repeatedly on this with no results & no answer to our notes. I finally called the Soc. Sec. office and they found that the check had been sent to the patient. We had just written this off, but he was			
	<table border="1"> <tr> <td>RESUBMITTAL INDICATOR</td> <td></td> <td>MEDICAL REVIEW</td> <td></td> </tr> </table>	RESUBMITTAL INDICATOR		MEDICAL REVIEW
RESUBMITTAL INDICATOR		MEDICAL REVIEW		

Seward General Hospital - Box 365 - Seward, Alaska 99664

PATIENT NAME McCall, Patrizia NMI

HOSPITAL NO. 72-25930

DATE ADMITTED 7-18-72

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

ADDRESS Box 158

SOCIAL SECURITY NO.

ADDRESS Box 3613

INSURANCE COMPANY

CITY, STATE Anchor Point, Alaska 99556

DOCTOR J. L. NOYES M.D.

CITY, STATE Kenai, Alaska 99611

DECS

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

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

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

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