

LEG. FINANCE - BILLS 1975 - 1976 571

SB 529 am cont., thru SB 530

1 divided or used for some other nonfarm purpose. The assessor shall
2 maintain records valuing the farm use land for both full and true
3 value and farm use value. Should the farm use land be sold, leased,
4 or otherwise disposed of [,] for uses incompatible with farm use
5 [OTHER THAN FARM USE PURPOSES] or be converted to a use incompatible
6 with farm use [NONFARM USE] by the owner, the owner shall be liable to
7 pay an amount equal to the additional tax at the current mill levy
8 together with eight [FIVE] per cent interest for the preceding seven
9 years, as though the land had not been assessed for farm use purposes.
10 Payment by the owner shall be made to the state to the extent of its
11 reimbursement for revenue loss under (e) of this section for the
12 preceding seven years. The balance of the payment shall be made to the
13 city or borough.

14 * Sec. 4. Section 3 of this Act is retroactive to January 1, 1975.

15 * Sec. 5. This Act takes effect immediately in accordance with AS 01.-
16 10.070(c).

More years & ... since ... will ... & ...

Lead Bob D. ✓

Original sponsor: Rules Committee
by request of the Governor

Offered: 4/27/76
Referred: Finance

1 IN THE SENATE

BY THE COMMUNITY AND
REGIONAL AFFAIRS COMMITTEE

2

HOUSE CS FOR SENATE BILL NO. 529

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

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NINTH LEGISLATURE - SECOND SESSION

5

A BILL

6

For an Act entitled: "An Act relating to property tax exemptions; and pro-

7

viding for an effective date."

8

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

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* Section 1. AS 29.53.020(g) and (h) are amended to read:

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(g) The state shall reimburse a borough or city, as appropriate, for the real property tax revenues lost to it by the operation of (e) of this section. However, reimbursement will be made to a borough or city for revenue lost to it only to the extent that the loss exceeds an exemption which was granted by the borough or city, or which upon proper application by an individual would have been granted by the borough or city, under sec. 25(a) of this chapter.

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(h) Except as provided in (g) of this section, nothing [NOTHING] in (e) - (i) of this section affects similar exemptions from property taxes granted by municipalities on September 10, 1972 or prevents municipalities from granting similar exemptions by ordinance as provided in sec. 25 of this chapter. [HOWEVER, UNDER (e) - (i) OF THIS SECTION ONLY THE AMOUNT OF REVENUE LOST TO THE MUNICIPALITY BY REASON OF THE EXEMPTION AUTHORIZED IN THOSE PROVISIONS MAY BE REIMBURSED TO THE MUNICIPALITY BY THE STATE.]

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* Sec. 2. AS 29.53.035(a) is amended to read:

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(a) Farm use lands included in a farm unit and not dedicated or being used for nonfarm purposes shall be assessed on the basis of full and true value for farm use, and shall not be assessed as if subdivided or used for some other nonfarm purpose. The assessor shall maintain

1 records valuing the farm use land for both full and true value and farm
2 use value. Should the farm use land be sold, leased, or otherwise
3 disposed of [,] for uses incompatible with farm use [OTHER THAN FARM USE
4 PURPOSES] or be converted to a use incompatible with farm use [NONFARM
5 USE] by the owner, the owner shall be liable to pay an amount equal to
6 the additional tax at the current mill levy together with eight [FIVE]
7 per cent interest for the preceding seven years, as though the land had
8 not been assessed for farm use purposes. Payment by the owner shall be
9 made to the state to the extent of its reimbursement for revenue loss
10 under (e) of this section for the preceding seven years. The balance
11 of the payment shall be made to the city or borough. The Department of
12 Community and Regional Affairs shall, at the time of reimbursement, file
13 a lien on each farm unit in favor of the state for that unit's pro rata
14 portion of the amount reimbursed under this section. Each lien is
15 effective for seven years after the date it is filed.

16 * Sec. 3. AS 29.53.035(b) and (c) are amended to read:

17 (b) An owner of farm use land must, to secure the assessment,
18 make application to the assessor before February 1 of each year in which
19 the assessment is desired, but during the same year the governing body
20 of the municipality for good cause shown may waive the claimant's failure
21 to make timely application for the exemption for that year and authorize
22 the assessor to accept the application as if timely filed. The appli-
23 cation shall be made upon forms prescribed by the state assessor for the
24 use of the local assessor and shall include information which may
25 reasonably be required to determine the entitlement of the applicant.
26 If the farm use land is leased for farm use purposes, the applicant
27 shall furnish to the assessor a copy of the lease bearing the signatures
28 of both lessee and lessor along with the completed application. The
29 applicant shall furnish the assessor a copy of the lease covering the

1 period for which the exemption is requested.

2 (c) In this section "farm use" means the use of land for raising
3 and harvesting crops or for the feeding, breeding and management of
4 livestock or for dairying or another agricultural use for profit or any
5 combination thereof. To be farm use land, the owner or the lessee must
6 be actively engaged in farming the land [,] and derive a minimum of \$25
7 gross farm income per acre yearly [AT LEAST 10 PER CENT OF HIS YEARLY
8 GROSS INCOME] from the farm use land. The provisions of this section do
9 not apply to land respecting which the owner has granted, and has
10 outstanding; a lease or option to buy the surface rights. A property
11 owner wishing to file for farm use classification having no history of
12 farm-related income may submit a declaration of intent at the time of
13 filing the application with the assessor setting out the intended use of
14 the land and the anticipated ^{Amount} [percentage] of income. An applicant using
15 this procedure shall file with the assessor before February 1 of the
16 following year a notarized statement of the ^{Amount} [percentage] of gross income
17 attributable to the farm use land. Failure to make the filing required
18 in this subsection forfeits the exemption.

19 * Sec. 4. Section 2 of this Act is retroactive to January 1, 1975.

20 * Sec. 5. This Act takes effect immediately in accordance with AS 01.10.-
21 070(c).

22
23 (d) In the event of a crop failure by an act of God the previous
24 year, the owner or lessee may submit an affidavit that [10 PERCENT OF
25 HIS GROSS INCOME] a minimum of \$25 gross farm income per acre was derived
26 for each of the past three years.
27 [WAS FROM FARMING]
28
29

May 5, 1976

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

Re: House CS for Senate Bill No. 529

Dear Mr. Malone:

House Bill No. 529 is now before the House Finance Committee for consideration.

The House Community and Regional Affairs Committee Amendment deleted the percentage of gross income eligibility formula in subsection (c) and adopted a more acceptable productivity formula.

The purpose of this letter is to call your attention to the need for deletion of all subsequent language in both subsection (c) and (d) of AS 29.53.035, which relates to the deleted percentage of income formula.

A copy of the bill with recommended additions and deletions to AS 29.53.035 is enclosed for your consideration.

Very truly yours,

S. Robert Dozier
State Assessor

SRD:gl

Enclosure:

1 period for which the exemption is requested.

2 (c) In this section "farm use" means the use of land for raising
3 and harvesting crops or for the feeding, breeding, and management of
4 livestock or for dairying or another agricultural use for profit or any
5 combination thereof. To be farm use land, the owner or the lessee must
6 be actively engaged in farming the land [,] and derive a minimum of \$25
7 gross farm income per acre yearly [AT LEAST 10 PER CENT OF HIS YEARLY
8 GROSS INCOME] from the farm use land. The provisions of this section do
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10 outstanding; a lease or option to buy the surface rights. A property
11 owner wishing to file for farm use classification having no history of
12 farm-related income may submit a declaration of intent at the time of
13 filing the application with the assessor setting out the intended use of
14 the land and the anticipated ^{Amount} [percentage] of income. An applicant using
15 this procedure shall file with the assessor before February 1 of the
16 following year a notarized statement of the ^{Amount} [percentage] of gross income
17 attributable to the farm use land. Failure to make the filing required
18 in this subsection forfeits the exemption.

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20 * Sec. 5. This Act takes effect immediately in accordance with AS 01.10.-

21 070(c).

22
23 (d) In the event of a crop failure by an act of God the previous
24 year, the owner or lessee may submit an affidavit that [10 PERCENT OF
25 HIS GROSS INCOME] a minimum of \$25 gross farm income per acre was derived
26 for each of the past three years.
27 [WAS FROM FARMING]
28
29



RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

James O. Smith
Signature of Camera Operator

2/8/90
Date

- FIVE -
STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

JAY S. HAMMOND, GOVERNOR

OFFICE OF THE COMMISSIONER

POUCH C - JUNEAU 99811

March 22, 1976

Honorable Bill Ray
Chairman, Senate Finance Committee
Alaska State Legislature
State Capitol - Pouch V
Juneau, Alaska 99811

Dear Senator Ray:

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

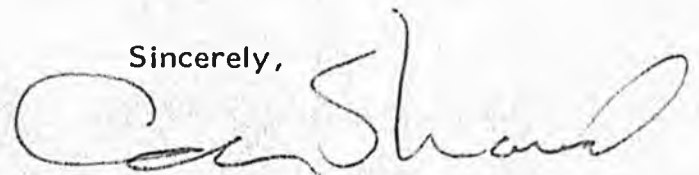
This change adds one additional stale dated warrant to the list provided in my letter of February 18 in the amount of \$50. A revised list is attached.

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

The revised amounts requested are as follows:

| | |
|--|---------------|
| Department of Health & Social Services | \$6,422.06 |
| Department of Commerce and Economic Development | 31.08 |
| Department of Revenue | <u>732.61</u> |
| Total | \$7,185.75 |

Sincerely,



Andrew S. Warwick
Chairman
Budget Review Committee

ASW/MO/co

MEMORANDUM

State of Alaska

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

DATE: March 10, 1976

FILE NO:

TELEPHONE NO:

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

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

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

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

Total \$732.61

REA:ge

COMMITTEE REPORT

1/19/76

SENATE

Mr. President:

Date 1/20/76

The Committee on FINANCE has had SB 530 special appropriation to Dept. Health & Social Services for vendor claims under consideration. A Majority of the members of the Committee

- recommends it DO PASS
- recommends it DO NOT PASS
- recommends it DO PASS WITH ATTACHED AMENDMENT(S)
- recommends it BE REPLACED WITH CS FOR _____ AND THAT
CS FOR _____ DO PASS
- "and" recommends it BE REFERRED TO THE _____
COMMITTEE
- reports it back WITHOUT RECOMMENDATION
- "other"

Members signing the Majority report:

[Signature] _____

[Signature] _____

[Signature] _____

[Signature] _____

Members NOT concurring in the Majority report:

[Signature] recommends: [Signature]

[Signature] recommends: [Signature]

[Signature] recommends: _____

[Signature] recommends: _____

[Signature] recommends: _____

[Signature] Chairman

*Return this original
to Lois Sturgeon (Rm. 415)
SB 530*

JAN 16 1976

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

Dear Mr. President:

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

Sincerely,

Jay S. Hammond
Governor

MISCELLANEOUS CLAIMS
 FOR
 LEGISLATIVE APPROVAL
 FOR
 FISCAL YEAR 1975

SB 530

Submitted November 17, 1975

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

RECEIVED
 NOV 20 1975
 Administrative Services
 Comptroller's Office

LEGISLATIVE BUDGETINGS FOR YEAR 1975-76

Submitted November 17, 1975

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

(continued)

LEGISLATIVE BILLINGS FOR YEAR 1975-76

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

Introduced: 1/19/76
Referred: Finance

1 IN THE SENATE

BY THE RULES COMMITTEE BY
REQUEST OF THE GOVERNOR

2

SENATE BILL NO. 530

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

NINTH LEGISLATURE - SECOND SESSION

5

A BILL

6

For an Act entitled: "An Act making a special appropriation to the

7

Department of Health and Social Services and the

8

Department of Commerce and Economic Development for

9

vendor claims; and providing for an effective date."

10

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

11

* Section 1. The sum of \$5,669.32 is appropriated from the general fund

12

to the Department of Health and Social Services and the Department of

13

Commerce and Economic Development, for the purpose of paying miscellaneous

14

vendor claims, to be allocated as follows:

15

Department of Health and Social Services \$5,638.24

16

Department of Commerce and Economic Development 31.08

17

\$5,669.32

18

* Sec. 2. This Act takes effect immediately in accordance with AS 01.-

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10.070(c).

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Introduced: 1/19/76
Referred: Finance

BY THE RULES COMMITTEE BY
REQUEST OF THE GOVERNOR

1 IN THE SENATE

2 SENATE BILL NO. 530

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 NINTH LEGISLATURE - SECOND SESSION

5 A BILL

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

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

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

| | | |
|----|---|--------------|
| 15 | Department of Health and Social Services | \$5,638.24 |
| 16 | Department of Commerce and Economic Development | <u>31.08</u> |
| 17 | | \$5,669.32 |

18 * Sec. 2. This Act takes effect immediately in accordance with AS 01.-
19 10.070(c).

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SB 530

JAN 16 1976

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

Dear Mr. President:

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

Sincerely,

Jay S. Hammond
Governor

MISCELLANEOUS CLAIMS
 FOR
 LEGISLATIVE APPROVAL
 FOR
 FISCAL YEAR 1975

SB 530

Submitted November 17, 1975

| <u>DIVISION</u> | <u>INVOICE #</u> | <u>DATE OF SERVICE</u> | <u>AMOUNT</u> | <u>DATE RECEIVED</u> | <u>CODE</u> | <u>REASON FOR DELAY</u> |
|---|------------------|------------------------|-----------------|----------------------|--|---|
| <u>Social Svcs.</u> | | | | | | |
| Wien Airlines | 0042-4675 | 10-31-75 ⁷² | 488.25 | 7-17-75 | 06-21-3-409-350 06-21-3-509-350 06-21-3-61 ^a -350 06-21-3-2 -325 | Invoice not recvd. " " " " " " " " " |
| Anchorage Times | Neakok Children | 06-24-75 ⁷¹ | 67.20 | 6-09-75 | | |
| <u>Public Health</u> | | | | | | |
| ATZ Travel | STR 331895 | 08-27-73 | 154.55 | 10-27-75 | 06-31-1-870-211 | " " " |
| RCA | A8037 | 10-10-73 | 45.15 | 11-07-75 | 06-31-1-036-311 | " " " |
| RCA | A8037 | 11-11-73 | 37.20 | 11-07-75 | 06-31-1-036-311 | " " " |
| <u>Public Assistance</u> | | | | | | |
| ATZ Travel | STR 339313 | 08-27-75 ⁷³ | 40.64 | 10-27-75 | 06-33-6-180-215 | " " " |
| TOTAL General Bills (held in fiscal) | | | <u>832.99</u> | | | |
| TOTAL Medical Bills (detail attached) | | | <u>4,805.25</u> | | | |
| TOTAL Department of Health & Social Svcs. | | | <u>5,638.24</u> | | | |

RECEIVED
 NOV 20 1975
 Administrative Services
 Comptroller's Office

LEGISLATIVE BILLINGS FOR YEAR 1975-76

Submitted November 17, 1975

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

(continued)

LEGISLATIVE BILLINGS FOR YEAR 1975-76

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

Introduced: 1/19/76
Referred: Finance

1 IN THE SENATE

BY THE RULES COMMITTEE BY
REQUEST OF THE GOVERNOR

2

SENATE BILL NO. 530

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

NINTH LEGISLATURE - SECOND SESSION

5

A BILL

6

For an Act entitled: "An Act making a special appropriation to the

7

Department of Health and Social Services and the

8

Department of Commerce and Economic Development for

9

vendor claims; and providing for an effective date."

10

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

11

* Section 1. The sum of \$5,669.32 is appropriated from the general fund

12

to the Department of Health and Social Services and the Department of

13

Commerce and Economic Development, for the purpose of paying miscellaneous

14

vendor claims, to be allocated as follows:

15

Department of Health and Social Services \$5,638.24

16

Department of Commerce and Economic Development 31.08

17

\$5,669.32

18

* Sec. 2. This Act takes effect immediately in accordance with AS 01.-

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10.070(c).

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SB 530

JAN 16 1976

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

Dear Mr. President:

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

Sincerely,

Jay S. Hammond
Governor

MISCELLANEOUS CLAIMS
 FOR
 LEGISLATIVE APPROVAL
 FOR
 FISCAL YEAR 1975

58530

Submitted November 17, 1975

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

RECEIVED
 NOV 20 1975
 Administrative Services
 Comptroller's Office

LEGISLATIVE BUDGETINGS FOR YEAR 1975-76

Submitted November 17, 1975

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

(continued)

LEGISLATIVE BILLINGS FOR YEAR 1975-76

Submitted

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



RECORDS CERTIFICATION



I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

James O. Smith
Signature of Camera Operator

2/8/97
Date

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

COMMITTEE REPORT

1/26/76

HOUSE

Mr. Speaker:

Date Apr 5, 1976

The Committee on FINANCE has had SB 530

under consideration. A Majority of the members of the Committee

() recommends it DO PASS

() recommends it DO NOT PASS

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

() recommends it BE REPLACED WITH CS FOR H. FINANCE SB 530 AND THAT

H. FINANCE CS FOR SB 530 DO PASS

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

COMMITTEE

() reports it back WITHOUT RECOMMENDATION

() "other"

Members signing the Majority report:

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

Members NOT concurring in the Majority report:

_____ recommends:

_____ recommends:

_____ recommends:

_____ recommends:

_____ recommends:

[Signature] Chairman

WITH A NEW TITLE

Introduced: 1/19/76
Referred: Finance

1 IN THE SENATE

BY THE RULES COMMITTEE BY
REQUEST OF THE GOVERNOR

2 SENATE BILL NO. 530

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 NINTH LEGISLATURE - SECOND SESSION

5 A BILL

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

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

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

| | |
|--|---------------|
| 15 Department of Health and Social Services | \$5,638.24 |
| 16 Department of Commerce and Economic Development | <u>31.08</u> |
| | 17 \$5,669.32 |

18 * Sec. 2. This Act takes effect immediately in accordance with AS 01.-
19 10.070(c).

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STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

POUCH C - JUNEAU 99811

March 22, 1976

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

Dear Representative Malone:

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

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

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

The revised amounts requested are as follows:

| | |
|--|---------------|
| Department of Health & Social Services | \$6,422.06 |
| Department of Commerce and Economic Development | 31.08 |
| Department of Revenue | <u>732.61</u> |
| Total | \$7,185.75 |

Sincerely,



Andrew S. Warwick
Chairman
Budget Review Committee

ASW/MO/co

CS - approp to Dept Admin
allocated as above

MEMORANDUM

State of Alaska

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

DATE: March 10, 1976

FILE NO:

TELEPHONE NO:

FROM:

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

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

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

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

REA:ge

SB 530

FEB 19 1976

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF BUDGET & MANAGEMENT

POUCH C — JUNEAU 99801

JAY S. HAMMOND, Governor

February 18, 1976

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

Dear Representative Malone:

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

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

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

Sincerely,


V. Kent Dawson
Director

VKD/JC/lw

RECEIVED

JAN 27 1976

BUDGET & MANAGEMENT

MEMORANDUM

State of Alaska

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

DATE: January 27, 1976

FILE NO:

TELEPHONE NO:

FROM:

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

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

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

| | |
|--------------------------------|------------------|
| Mr. J. Glen Cassity | \$ 64.93 |
| J. H. Shelton | 19.74 |
| Richard K. Armstrong | 69.49 |
| Lorin T. Oldroyd | 152.25 |
| V. E. Baker | 22.50 |
| Eagle River Plumbing & Heating | 24.48 |
| Jeff C. Jeffers | 78.50 |
| Clifford W. Berry | 59.11 |
| Mrs. Ruth N. Jorgensen | 3.00 |
| Mrs. Ruth N. Jorgensen | 33.75 |
| Mrs. Ruth N. Jorgensen | 33.75 |
| Mrs. Ruth N. Jorgensen | 1.50 |
| First Virginia Bank | 49.41 |
| Mrs. Ruth N. Jorgensen | 2.50 |
| Paula Terrel | 67.70 |
| Total | <u>\$ 682.61</u> |

JMD:ge

STATE
of ALASKA

MEMORANDUM

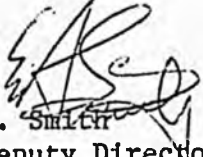
RECEIVED

FEB 4 1976

BUDGET & MANAGEMENT

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

DATE : February 3, 1976

FROM: Eugene A.  Smith
Acting Deputy Director
Division of Administrative Services
Dept. of Health & Social ServicesSUBJECT: Addition to Prior Year's
Claims Bill

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

50% fed available ?

Attachment

LEGISLATIVE BILLINGS FOR YEAR 1975-76 - SUPPLEMENTAL

SUBMITTED 1/20/76

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

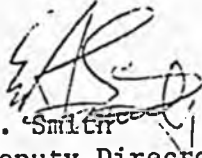
*2 months of this invoice covered by different explanation of benefits by Medicare.

STATE
of ALASKA

MEMORANDUM

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

DATE : February 3, 1976

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

SUBJECT: Addition to Prior Year's
Claims Bill

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

Attachment

LEGISLATIVE BILLINGS FOR YEAR 1975-76 - SUPPLEMENTAL

SUBMITTED 1/20/76

DIVISION

INVOICE #

SVC. DATE

AMOUNT

DATE RCVD.

CODE

DELAY REASON

PUBLIC ASSISTANCE

| | | | | | | |
|---------------------|---|-------------------|--------|----------|-----------------|--|
| Kent Medical Ctr. | | 12/29/72-2/13/73 | 273.60 | 06/18/75 | 06-33-6-150-380 | Out of State state-dated wt. still outstanding Revenue approval pay. |
| Anchorage Com Hosp. | 555072 | 07/01/73 | 114.64 | 12/15/75 | 06-33-6-120-380 | Provider unaware of patient elig- ibility. |
| Alaska Clinic | 58827, 55720 | 10/16/73-11/30/73 | 79.10 | 01/12/76 | 06-33-6-150-380 | As above - Medic |
| Alaska Clinic | *57689, 57687, 57688 | 01/10/74-01/26/74 | 31.41 | 01/12/76 | 06-33-6-150-380 | " " |
| Alaska Clinic | 185788, 60004, 185790, 185791, 185789 | 07/19/73-08/23/73 | 34.78 | 01/12/76 | 06-33-6-150-380 | " " |
| Alaska Clinic | 185792, 185787, 185786, 185785 | 07/19/73-08/15/73 | 42.13 | 01/12/76 | 06-33-6-150-380 | " " |
| Alaska Clinic | 60005 | 07/19/73 | 7.26 | 01/12/76 | 06-33-6-150-380 | " " |
| Alaska Clinic | *57689, 58826 | 10/11/73-11/18/73 | 9.45 | 01/12/76 | 06-33-6-150-380 | " " |
| Sub-Total | | | 592.37 | | | |

PUBLIC HEALTH

| | | | | | | |
|--------------------|--------|----------|--------|----------|-----------------|---------------|
| Alaska Orthopedics | 127395 | 11/01/73 | 39.65 | 07/01/75 | 06-31-1-687-470 | Invoices Lost |
| Alaska Orthopedics | 111596 | 07/24/73 | 151.80 | 07/01/75 | 06-31-1-687-470 | " " |
| | | | 191.45 | | | |

Grand Total

783.82

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

FAMILY
SYLVIA

PATIENT NO.

DARVEILE SYLVIA
324 2ND ST
JUNEAU ALASKA

02

PLEASE RETURN THIS PORTION WITH PAYMENT

| DATE | REFERENCE | DR CODE | FAMILY MEMBER CODE | SERVICE CODE | CHARGES | CREDITS | BALANCE |
|-----------|---------------|---------|--------------------|--------------|-----------------|---------|---------|
| Jul-0 13 | 39,822 | 8 | 1 | 10 16 | 10.00 3.60 | | |
| Jul-0 13 | 7,392 | 8 | 4 | 35 | | | |
| Jul-0 13 | 1577-2727,392 | 8 | 1 | 4 12 | 35.00 200.00 | | 248.60 |
| Feb 13 13 | 40,818 | 8 | 1 | 10 16 | 10.00 15.00 | | 273.60 |

06-33-6-150-380

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

PROFESSIONAL SERVICE CODES

- 1 ASSIST SURGEON
- 2 CAST SPINE
- 3 COMPLETE TEAM
- 4 CONSULTATION
- 5 PHYSICS
- 6 X-RAY
- 7 CONTACT ROOM
- 8 ANALGHE - ARE
- 9 FIRST AID CALL
- 10 COLLECTOR CALL
- 11 GENERAL SURGE
- 12 DENTAL SURGE
- 13 DENTAL CALL
- 14 IMMUNIZATION
- 15 INDUCTION
- 16 LAB
- 17 MATERIAL & SUPPLIES
- 18 MEDICATION
- 19 MEDICAL REPORT
- 20 NEW BORN CARE
- 21 OBSTETRICS
- 22 OBSTETRIC THERAPY
- 23 SUPPLEMENT
- 24 OTHER SURGE
- 25 X-RAY
- 26 X-RAY

DOCTOR CODES

- 1 S. H. ROBERTSON, M.D.
- 2 J. A. PHILLIPS, M.D.
- 3 A. W. KEMP, M.D.
- 4 R. L. MACE, M.D.
- 5 D. A. DANCE, M.D.
- 6 D. S. UHM, M.D.
- 7 V. P. MUIR, M.D.
- 8 J. H. GALL, M.D.
- 9 J. H. RUSSELL, M.D.
- 10 C. C. MEDLOCK, JR., M.D.
- 11 R. Y. TOOT, M.D.
- 12 J. P. HENN, M.D.
- 13 R. W. KALE, M.D.
- 14 R. Y. YAU, M.D.

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

06

HEALTH CARE FACILITY INVOICE

NO. 555072

| | | | | |
|--|--|---|---|--------|
| 20 PATIENT INFORMATION | | STATE USE ONLY | PROVIDER INFORMATION | |
| COUPON OR AUTHORIZATION NUMBER <i>See attached Memo.</i> | | | NAME OF PROVIDER Anchorage Community Hospital 825 L Street Anchorage, Alaska 99501 | |
| NAME OF PATIENT Susan Harris | | RACE | PROVIDER ID NO. ACH 889 | |
| DATE OF BIRTH 3 / 26 / 53 | SEX: M <input type="checkbox"/> F <input checked="" type="checkbox"/> | ELIG. CODE 20P | CATEGORY 02 | |
| CASE NUMBER 76345-01 | | 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. Roberts | | ID NO. |
| COMMENTS: | | SERVICE PRE-AUTHORIZATION NO. (if applicable) | | |

| | | | | |
|---|-----------------|--|---|-------------|
| 21 DIAGNOSIS AND PROCEDURES | | | | |
| DATE OF ADMISSION 7 / 01 / 73 | REF. CODE 01 | SVC UNIT 05 | PRIMARY DIAGNOSIS Extension flexion injury to neck | CODE 845 |
| BILLING PERIOD 7 / 01 / 73 7 / 01 / 73 | TOT. DAYS 0 | SECONDARY DIAGNOSIS Contusion to hand | | CODE 425 |
| DATE OF DISCHARGE 7 / 01 / 73 | DIS. CODE 01 | PRIMARY PROCEDURE PERFORMED Non surgical emergency care | | CODE |
| CONSULTING PHYSICIAN | ID NO. | SECONDARY PROCEDURE PERFORMED | | CODE |

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

| PROVIDER CERTIFICATION | |
|--|--------------------|
| THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. | |
| TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCES ETC. | |
| PROVIDER'S SIGNATURE | <i>Miss Dorman</i> |
| DATE | 12/11/75 |
| REMARKS: | 06-33-6-120-380 |

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

| | |
|-----------------------------------|-------------|
| 23 COORDINATION OF OTHER BENEFITS | |
| OTHER BENEFITS | MEDICARE |
| MEDICARE PAID | COINSURANCE |
| UNEMPLOYMENT BENEFIT PAID | DEDUCTIBLE |
| TOTAL | TOTAL |

| | | | |
|--------------|--------|------|-----|
| TOTAL CHARGE | 157.04 | LESS | -0- |
|--------------|--------|------|-----|

| | |
|------------|--------|
| AMOUNT DUE | 157.04 |
|------------|--------|

73%

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

CUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 58827A

| | | | | |
|--|---|---|---------------------------------------|----------------|
| 10 PATIENT INFORMATION | | STATE USE ONLY | PROVIDER INFORMATION | |
| COUPON OR AUTHORIZATION NUMBER 7019453A U 10145B | | RACE W | NAME OF PROVIDER The Alaska Clinic | |
| NAME OF PATIENT Mildred R. Perez | | | Dr. Beacham | |
| DATE OF BIRTH 12-31-05 | SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/> | ELIG. CODE 30A | PROVIDER I.D. NO. WSB 105 | CATEGORY 05 |
| CASE NO. 41531 01 | RESOURCE J | PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) ALC 501 | | |

NATURE OF ACCIDENT OR ILLNESS

| | | | |
|--|--|--|-----------------------------------|
| DIAGNOSIS | | | DIAGNOSIS CODE (OPT.) |
| LIST PRIMARY DIAGNOSIS FIRST Diabetes Mellitus | | | PRIMARY 250 |
| HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | REFERRING OR CONSULTING PHYSICIAN |
| COMMENTS: | | SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE) | |

| 11 SERVICES RENDERED | | | | | | | |
|----------------------------|------------------|--|---------------------|--------|----------------|--------|--|
| DATE OF SERVICE | PLACE OF SERVICE | DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE | 1969 RVS PROC. CODE | CHARGE | STATE USE ONLY | | |
| 112873 | IH | HSP. COMP. | 90220 | 73.20 | 35.50 | i | |
| 112873 | IH | HOSP VISIT | 90240 | 12.55 | | 1 | |
| 112973 | IH | 2 HV @ 12.55 ea. | 90240 | 25.10 | 48.00 | 1 | |
| 113073 | IH | 2 HV @ 12.55 ea. | 90240 | 25.10 | | 1 | |
| PLACE OF SERVICE | | 12 COORDINATION OF OTHER BENEFITS | | | TOTAL CHARGE | | |
| DO DOCTOR'S OFFICE | | MEDICARE PAID | OTHER INS. | TOTAL | 237.75 | 155.50 | |
| II INDEPENDENT LAB | | 76.40 | | | LESS | 76.40 | |
| III PATIENT'S HOME | | | | | | | |
| IV INPATIENT HOSPITAL | | | | | | | |
| V OTHER LOCATION | | MEDICARE CO-INS. | MEDICARE DEDUCT | TOTAL | | | |
| VI NURSING HOME | | 19.10 | 60.00 | | UNPAID BALANCE | 141.35 | |
| VII EXTENDED CARE FACILITY | | | | | | 79.10 | |
| VIII OUTPATIENT HOSPITAL | | | | | | | |

PROVIDER CERTIFICATION

| | |
|---|---|
| <p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p> | REMARKS: 35 4-100 380 |
| | <p>PROVIDER SIGNATURE: Sherman Beacham, MD DATE: 12/27/73</p> |
| RE SUBMITTAL INDICATOR | MEDICAL REVIEW |

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 M

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 57689A

| | | | | |
|--|---|---|---------------------------------------|----------|
| 10 PATIENT INFORMATION | | STATE USE ONLY | PROVIDER INFORMATION | |
| COUPON OR AUTHORIZATION NUMBER 51179B | | | NAME OF PROVIDER THE ALASKA CLINIC | |
| NAME OF PATIENT RICHARD MILLER | | RACE W | DR. BEACHAM | |
| DATE OF BIRTH 08/04/44 | SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> | ELIG. CODE 20C | PROVIDER I.D. NO. WS6105 | CATEGORY |
| CASE NO. 52308-01 | RESOURCE J | PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) ALC 501 | | |

NATURE OF ACCIDENT OR ILLNESS

| | | |
|---|--|--|
| DIAGNOSIS | | DIAGNOSIS CODE (OPT.) |
| LIST PRIMARY DIAGNOSIS FIRST | | PRIMARY |
| HEADACHE | | 791 |
| | | SECONDARY |
| | | 000 |
| | | 000 |
| HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE) |
| COMMENTS: | | REFERRING CONSULTING PHYSICIAN |

| 11 SERVICES RENDERED | | COORDINATION OF OTHER BENEFITS | | TOTAL CHARGE | UNPAID BALANCE |
|----------------------------|------------------|--|---------------------|---------------|----------------|
| DATE OF SERVICE | PLACE OF SERVICE | DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE | 1969 RVS PROC. CODE | CHARGE | STATE USE ONLY |
| 011074 | DO | LIM EXAM EVAL A/G TREATMENT | 90050 | 16.75 / 12.75 | |
| 112373 | DO | Fluax given | 00047 | 4.00 | |
| 112373 | DO | Exam | 90050 | 16.75 | |
| 111873 | OH | Emergency treatment | 90500 | 20.95 | |
| PLACE OF SERVICE | | MEDICARE PAID | | LESS | |
| DO DOCTOR'S OFFICE | 12 | OTHER INS. | TOTAL | 288.95 | 157.05 |
| IL INDEPENDENT LAB | | | | 125.64 | |
| PH PATIENTS HOME | | | | | |
| IN INPATIENT HOSPITAL | | | | | |
| OL OTHER LOCATION | | | | | |
| NH NURSING HOME | | | | | |
| ECF EXTENDED CARE FACILITY | | | | | |
| CH OUTPATIENT HOSPITAL | | | | | |
| | | TOTAL | | 163.31 | 31.41 |

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>Myasthenia gravis 05-536-00-100 8/21 billed</p> |
| PROVIDER SIGNATURE: <i>Shirley Beacham</i> DATE: 11/8/76 | RESUBMITAL INDICATOR |
| | MEDICAL REVIEW |

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

adj 11/21

| | | | |
|---|--------------------------|---------------|---|
| Inpatient Radiology and Pathology Physicians Charges Not Subject To A Deductible and 20% Coinsurance (Medicare Pays 100%) ▶ | | MEDICARE PAID | This is a statement of the action taken on your Medicare Claim. Be sure to read the important information on the back of the notice. 0000 0000 |
| Total Allowed Charges Subject To The \$50. Deductible and 20% Coinsurance. ▶ | 173.90 | | |
| This Amount Went Toward The \$50 Deductible. ▶ | .00 | | You have met \$60.00 of the deductible for 1973 |
| Allowed Charges Over The Deductible. (Medicare Pays 80%) ▶ | 173.90 | 139.12 | IMPORTANT When Writing Please Refer To Both HI # 574-01-9929A CO # 3283-80115 328 |
| Date CCT 12, 1973 | Total Medicare Payment ▶ | 139.12 | |

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

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

Beneficiary or Representative
DCRA P LARSON
600 FAIRBANKS ST
ANCHORAGE AK

06-336-150 380 34.78

10/29/73

(MR-69392)

THIS IS NOT A BILL — KEEP THIS COPY FOR YOUR RECORDS

Printed in U.S.A.

EXPLANATION OF MEDICARE BENEFITS

DETACH ON DOTTED LINE

| SERVICES WERE PROVIDED BY | FROM | | TO | | | CHARGES SUBMITTED | CHARGES ALLOWED | REASON CHARGE NOT ALLOWED MEDICARE DOES NOT PAY FOR: | SET OFF RECEIVED |
|---------------------------|------|-----|-----|-----|-----|-------------------|-----------------|---|------------------|
| | MO. | DAY | MO. | DAY | YR. | | | | |
| BEACHAM | | | 07 | 19 | 3 | 70.00 | 35.50 | MORE THAN THE ALLOWABLE AMOUNT | 3 A |
| BEACHAM | | | 07 | 20 | 3 | 24.60 | 16.95 | MORE THAN THE ALLOWABLE AMOUNT | 3 A |
| BEACHAM | | | 07 | 22 | 3 | 12.30 | 9.60 | MORE THAN THE ALLOWABLE AMOUNT | 3 A |
| BEACHAM | 07 | 25 | 08 | 04 | 3 | 172.20 | 118.65 | MORE THAN THE ALLOWABLE AMOUNT | 3 A |
| BEACHAM | | | 08 | 02 | 3 | 36.90 | 16.95 | MORE THAN THE ALLOWABLE AMOUNT | 3 A |
| BEACHAM | | | 08 | 15 | 3 | 12.30 | 10.00 | MORE THAN THE ALLOWABLE AMOUNT | 1 A |
| BEACHAM | | | 08 | 15 | 3 | 4.50 | 3.00 | MORE THAN THE ALLOWABLE AMOUNT | 1 A |
| Totals | | | | | | 332.80 | 210.65 | | |

1-2
= 122.15 adj 3/15

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

122.15 You have met \$60.00 of the deductible for 197.

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

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

06-33-6-150-380

Beneficiary or Representative
DORA P LARSON
600 FAIRBANKS ST
ANCHORAGE AK

06 11

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

NO. 60005A

| | | | | |
|--|--|-------------------|---|----------------|
| 10 PATIENT INFORMATION | | STATE USE ONLY | PROVIDER INFORMATION | |
| COUPON OR AUTHORIZATION NUMBER 74244D | | | NAME OF PROVIDER THE ALASKA CLINIC | |
| NAME OF PATIENT DORA LARSON | | RACE W. | DR. WEBB | |
| DATE OF BIRTH M <input type="checkbox"/> F <input type="checkbox"/> | | ELIG. CODE 30A | PROVIDER I.D. NO. DIW392 | CATEGORY 05 |
| CASE NO. 074636-01 | | RESOURCE J | PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) ALC 501 | |

NATURE OF ACCIDENT OR ILLNESS

| | | | |
|---|--|--|--|
| DIAGNOSIS | | | DIAGNOSIS CODE (OPT.) |
| LIST PRIMARY DIAGNOSIS FIRST | | | PRIMARY |
| ASYMPTOMATIC ISCHEMIC HEART DISEASE | | | 414 |
| | | | SECONDARY |
| HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <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 | |
| 071973 | DO | ELECTROLYTES | 84290 | 26.65 | 7400 | 6 |
| 071973 | DO | BRIEF EXAM EVAL A/G TREATMENT | 90040 | 12.30 | 1230 | 1 |
| * PLACE OF SERVICE | | 12 COORDINATION OF OTHER BENEFITS | | | TOTAL CHARGE | |
| DO DOCTOR'S OFFICE | | MEDICARE PAID | OTHER INS. | TOTAL | 3542 | 3630 |
| DI INDEPENDENT LAB | | 2904 | | 2904 | | |
| DH PATIENT'S HOME | | | | | LESS | 2904 |
| DH INPATIENT HOSPITAL | | | | | | |
| DL OTHER LOCATION | | MEDICARE CO-INS. | MEDICARE DEDUCT | TOTAL | | |
| DH NURSING HOME | | | | | UNPAID BALANCE | 726 |
| ELI EXTENDED CARE FACILITY | | 726 | | 726 | | |
| OH OUTPATIENT HOSPITAL | | | | | | |

PROVIDER CERTIFICATION

| | |
|--|--|
| <p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE ACCURATE AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS</p> | REMARKS: 06-33-6-150-3 |
| | <p>PROVIDER SIGNATURE: _____ DATE: 11/16</p> |
| RESUBMITAL INDICATOR | MEDICAL REVIEW |

06 17

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 58826A

| | | | | | | | |
|--|--|---|--|---------------------------------------|--|---|----------------|
| 10 PATIENT INFORMATION | | | | STATE USE ONLY | | PROVIDER INFORMATION | |
| COUPON OR AUTHORIZATION NUMBER 71049 113B | | | | NAME OF PROVIDER THE ALASKA CLINIC | | | |
| NAME OF PATIENT Richard Miller | | | | RACE U | | DR. CATES | |
| DATE OF BIRTH 8-4-44 | | SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> | | ELIG. CODE JOC | | PROVIDER I.D. NO. VAC 419 | CATEGORY C5 |
| CASE NO. 5230801 | | | | RESOURCE X | | PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) ALC 501 | |

NATURE OF ACCIDENT OR ILLNESS

| | | |
|---|--|---|
| DIAGNOSIS | | DIAGNOSIS CODE (OPT.) |
| LIST PRIMARY DIAGNOSIS FIRST Motor Neurone Disease | | PRIMARY 348 |
| Headache Migraine, Rule out. | | SECONDARY 791 |
| HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE) R10 |
| COMMENTS: | | REFERRING OR CONSULTING PHYSICIAN |

SERVICES RENDERED

| DATE OF SERVICE | PLACE OF SERVICE | DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE | 1969 RVS PROC. CODE | CHARGE | STATE USE ONLY | |
|-----------------|------------------|--|---------------------|----------------|----------------|--------|
| 10/17/73 | DD | OFFICE CALL RECHECK | 90030 | 8.20 | 870 | 1 |
| | | | | TOTAL CHARGE | 50.50 | 117.25 |
| | | | | LESS | | 37.80 |
| | | | | UNPAID BALANCE | | 44.5 |

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. 32-6-151-20 | |
| | PROVIDER SIGNATURE [Signature] | DATE 11/17/76 |

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

DEPARTMENT OF HEALTH AND WELFARE

SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH

AUTHORIZATION NO.

POUCH H JUNEAU, ALASKA 99801

02764

SECTION OF CHILD HEALTH

FAMILY

DATE November 6, 1973

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

Patient HAZE, Russell
Address Palmer

Birthdate: 06-26-72

Code: SCRO-Appliance-Ortho

06-P "W" #739

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

| DATE(S) SERVICE RENDERED | DESCRIPTION OF SERVICE (ITEMIZE) | PRICE |
|--------------------------|--|---|
| 1 11-73 ^ | (^{23.50} Dennis Browne) bar and (^{15.50} pre-walker shoes) <i>padding</i> | \$39.00 <i>.65</i> \$39.65 |

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

Please submit claims first to:

Aetna Insurance--Group policy
Douglas HAZE--father

ja
12/20/73
Date
06-31-1-687-470
3-Digit Account Code
W
3-Digit Object Code

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.

©20564

Authorized by *[Signature]*
PROGRAM REPRESENTATIVE CRIPPLED CHILDREN'S SERVICES

* IMPORTANT NOTICE TO VENDOR

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

No record of this order.

AUTHORIZATION

DEPARTMENT OF HEALTH AND WELFARE SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH

AUTHORIZATION NO.

POUCH H JUNEAU, ALASKA 99801

01922

SECTION OF CHILD HEALTH

FAMILY

DATE July 5, 1973

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

#11596

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

Patient TALBOT, Yolanda Gail
Anchorage

MA 1365, 11/1/73.

Birthdate: 12
11-11-73

Address

06-P white

Code: SCRO-Ortho-Appliance

| DATE(S) SERVICE RENDERED | DESCRIPTION OF SERVICE (ITEMIZE) | PRICE |
|--------------------------|--|----------|
| 7/24/73 | Arm prosthesis Below elbow prosthesis, Right with passive unit | \$359.00 |
| | Pro. pair | 207.00 |
| | Cal. brace | 151.80 |

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

Signature: *J.C.* Date: 9/26/73

06-31-1-687-470
3-Digit Object Code: GA-749-815-A

Case or Med. Card No. _____ Remarks _____

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

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

Authorized by: *[Signature]*
PROGRAM REPRESENTATIVE CRIPPLED CHILDREN'S SERVICES

* IMPORTANT NOTICE TO VENDOR

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

0042 4675

33.004

PREPAID COLLECT

4100 INTERNATIONAL AIRPORT ROAD
ANCHORAGE, ALASKA 99502

FAT NO 113 NO 114 NO 115 NO 116 NO 117 NO 118 NO 119 NO 120 NO

When Consolidated Airlines, Inc.



| | | | | | | | |
|---|--|------------------------------|--|--|--|----------------------------|--|
| 2/ CONSIGNEE'S ACCOUNT NUMBER | | ↓ CONSIGNEE ↓ | | CHARGE CODES: PX - PREPAID CREDIT PP - PREPAID CASH CC - COLLECT CG - COLLECT G.B.L. CP - COLLECT CASH CX - COLLECT CREDIT MX - PART-PREPAID, PARTIAL COLLECT CREDIT MP - PART-PREPAID, PARTIAL COLLECT CASH PG - PREPAID G.B.L. AND/OR OIR | | CARRIER USE ONLY | |
| NAME WELFARE OFFICE | | CITY MOUNTAIN VILLAGE, AK | | RATE 7 | | WEIGHT CHARGES A 165.00 | |
| STREET ADDRESS M. Price DON PRICE | | STATE AK | | CLASSIFICATION 120 | | PICK UP B 405.00 | |
| CITY | | ZIP CODE | | DELIVERY C | | EXCESS VALUE D | |

10 3/ SPECIAL INSTRUCTIONS, INCLUDING CUSTOMER REFERENCE NUMBER
CHG TO STATE OF AK, DEPT HEALTH & SOCIAL SERVICES 601 BARNET, FAY

| | | | | | | | | | | | | | | | |
|-----------------------------|--|------------------------|--|--------------------------|--|--|--|---------------|--|-------------|--|-----------------------|--|--------------|--|
| 4/ SHIPPER'S ACCOUNT NUMBER | | ↓ SHIPPER ↓ | | PIECES/PAGES | | LENGTH | | WIDTH | | DEPTH | | CUBIC FEET | | EXCESS VALUE | |
| NAME STATE OF ALASKA | | CITY FORT YUKON, AK | | DIMENSIONAL WEIGHT - LBS | | C.O.D. SHIPMENT IF AMOUNT ENTERED HERE BY SHIPPER | | ADVANCES E | | ORIGIN F | | SHIPPER'S C.O.D. G | | COLLECT H | |

19 5/ PICK UP / ORIG. ADVANCE CHGS. DESCRIPTION OF ORIGIN ADVANCE CHARGES (DHS) ADVANCE CHGS. DESCRIPTION OF DESTINATION ADVANCE CHARGES
COLLECT. NO 06-26-3-100-0-13-8000

21 6/ OTHER CHARGES DESCRIPTION OF OTHER CHARGES G.B.L. NUMBER
425.25 100.25

| NO. PCS | WEIGHT | DESCRIPTION OF PIECES AND CONTENTS PACKING, MARKS, NUMBER | CARRIER COM. BY GROUP NO. | CARRIER COM. BY GROUP NO. | SHIPPER COM. BY GROUP NO. |
|---------|--------|---|---------------------------|---------------------------|---------------------------|
| 1 | 1500 | SAFE | / | / | / |
| - | - | - | / | / | / |
| - | - | - | / | / | / |
| - | - | - | / | / | / |

| | | | | | | | | | | | | | | | |
|------|----------------|---|---------|---|----------|---|--------------|---|----------|---|--------|---|------------------|---|---------|
| 8/ A | WEIGHT CHARGES | B | PICK UP | C | DELIVERY | D | EXCESS VALUE | E | ADVANCES | F | ORIGIN | G | SHIPPER'S C.O.D. | H | COLLECT |
| | 165.00 | | | | | | | | | | | | | | |

| | | | | | | | | |
|------|-------|---|---------------|----------|----------|----------|----------------|--------------|
| 9/ I | TAX | T | TOTAL CHARGES | 1st RATE | 2nd RATE | 3rd RATE | 11/1st PREPAID | SHIPPER PAYS |
| | 25.25 | | 488.25 | | | | | |

| | | | | |
|-------|---------|----------|----------------|--------------|
| 10/ I | DATE | TIME | 11/2nd COLLECT | SHIPPER PAYS |
| | FYU/DAH | 10-31-72 | 2:30 P.M. | |

CARRIER ACCOUNTING COPY

012 0042 4675

STATEMENT

7717

Anchorage Times Publishing Co.

ALASKA'S LARGEST NEWSPAPER

POST OFFICE BOX 40

ANCHORAGE, ALASKA

June 24, 1971

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

TERMS: ALL ACCOUNTS DUE THE FIRST OF EACH MONTH

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

June 2, 9, 16, 23

4x 56 lines \$67.20

PROOF OF PUBLICATION ATTACHED.

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

ANCHORAGE TIMES PUBLISHING CO.

By *Patti White* Clerk

6/2/75
Subject to next
Approval of State
Legislature
(Invoice in original
of 2 years old)
Lynn Hoffman
Fiscal

Complete and return to Fiscal

- Authorized Signature
- Valid Account Code
- Certification Stamp

has not been paid
6-2-75

Proof of Publication

ANCHORAGE DAILY TIMES

Janice Mays being duly sworn, according

to law declares: That he is the Legal Advertising Dept. of The Anchorage

Daily Times, a daily newspaper published in the town of Anchorage, in the Third Judicial Divi-
sion, State of Alaska; that the notice of A Minor Under 18

a copy of which is hereto attached, was published

June 2 9 16 23

in said Anchorage Daily Times, beginning with the issue of June 2, 19 71

and ending with the issue of June 23, 19 71

Janice T Mays

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

Rebecca M. Nicholas

Notary Public for the State of Alaska.

My Commission Expires 12-14, 19 77

IN THE SUPERIOR COURT
FOR THE STATE
OF ALASKA
THIRD JUDICIAL DISTRICT
AT ANCHORAGE
FAMILY DIVISION
In the Matter of:
NEAKOK CHILDREN - DONNA,
EVA MARIE and
THOMAS,
Minor Children under the
Age of Eighteen (18)
Years.
No. CP 1088, 1089 and 1840
NOTICE TO ABSENT PARTY
TO: Mrs. Frances Neukok
You a party in the above entitled
children's proceeding, are hereby
summoned and required to appear in
the Superior Court, Family Division,
at Anchorage, Alaska, on the 8th day
of July, 1971, at the hour of 9:00 a.m.,
to answer to the petition filed in the
above entitled children's proceeding in
this Court.
If you fail to appear and answer, the
Court will proceed to hearing of the
above entitled case without further
process.
The proceeding could result in the
termination of parental rights in the
above named children.
You may be represented at the hearing
by an attorney of your desire. In
the event you have no funds to employ
an attorney and satisfy the Court in
this regard, an attorney will be ap-
pointed to represent you. You may
also waive the presence of an attorney
in such proceeding.
DATED at Anchorage, Alaska, this
17 day of May, 1971.
A. M. Vokacek
Clerk of the
Superior Court
By: (s) M. Ryan
Deputy
PUB.: June 2, 9, 16, 23, 1971



TRAVEL

BRANCH OFFICES

WASHINGTON: SEATTLE ANACORTES MOUNT VERNON OAK HARBOR

ALASKA: JUNEAU KENAI KODIAK

HOME OFFICE

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

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

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

OCTOBER 24, 1975

Excursion rates must be used when available

STATE OF ALASKA
REQUEST FOR TRANSPORTATION

No. 331895

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

ATZ

Company to furnish Transportation

54.55
40.64
13.00

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

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

08.19

Form No. 8407625896 Ticket No. Frank P. Pauls.
(Signature of Traveler)

Value \$ 154.55 (No tax payable) Chief, Sect. of Laboratories.
Tourist class fare (See instruction #1 on reverse side) (To be inserted by carrier).
(Title)

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

02-019

Account Code 05 31 1 870-211

Excursion rates must be used when available.
STATE OF ALASKA

REQUEST FOR TRANSPORTATION

No. 339313

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

ATZ Travel

Company to furnish Transportation

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

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

Form No. 8103 Ticket No. 449 101 Rudolph Sunberg
(Signature of Traveler)

Value \$ 40.64 (No tax payable) Social Worker III
Tourist class fare (See instruction #1 on reverse side) (To be inserted by carrier).
(Title)

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

02-019

Sunberg, Rudolph
APR 04 1975 Account Code 06 33 6 150 215 211

442-3270

KOTZEBUE

OCT 73

Billing No 442-3270

Page 1

(B)

| Date of Call | Mon | Day | From Place | To Place | Words or Minutes | Class | Type of Call | Calling Number | Called Number | Serial Number | Amount |
|-------------------|-----|-----|------------|---------------|------------------|-------|--------------|----------------|---------------|---------------|--------|
| 09 | 06 | | UKLACY OK | KOTZEBUE ALAS | 33 | SN | 4 | 547-5943 | 907-442-3K70 | XR2672011 | 2.85 |
| 09 | 23 | | UKLACY OK | KOTZEBUE ALAS | 12 | SD | 4 | 686-4447 | 907-442-3K70 | XR2841340 | 1.970 |
| 10 | 08 | | NOME ALS | KOTZEBUE ALAS | 3 | SD | 4 | 443-2922 | 907-442-3270 | Q428214044 | .80 |
| 10 | 10 | | NOME ALS | KOTZEBUE ALAS | 3 | SD | 4 | 443-2922 | 907-442-3270 | Q428515594 | .80 |
| TELEPHONE CHARGES | | | | | | | | | | ***45.15 | |

45.15 unpaid

Amount

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

Form P-0501-2

10 26 KOTZEBUE ALS COLLE BAY ALAS 32 SN 2 442-3270

CURRENT CHARGES

TOTAL AMOUNT DUE

06-31-1-036-311

unpaid

RECEIVED
 NOV 7 10 17 AM '73
 FISCAL SERVICES
 BUREAU

Alaska Communications

For information regarding this bill please refer to 629 E Street, Anchorage, Alaska 99501 Telephone (907) 272-8411

ALASKA STATE PUBLIC HEALTH NURSE
 P.O. BOX 170
 KOTZEBURG ALASKA 99752

Date 11/30/73

Account Number 88037

Page 1

All Bills Are Due When Rendered

Statement

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

PREVIOUS BALANCE

10 29 KOTZEBURG'S COLO HAY ALAS 32 SN 2 442-3255 907-532-2481 0433020004

8.00

CURRENT CHARGES

TOTAL AMOUNT DUE

*Held
 This has been
 submitted for
 department approval*

unpaid

RECEIVED
 NOV 7 10 17 AM '73
 FISCAL SERVICES
 BUREAU

KOTZEBUE

NOV 73

442-3270

Billing No.

Page

1

| From Place | To Place | Words or Minutes | Class | Type of Call | Calling Number | Called Number | Serial Number | Amount |
|-------------------|---------------|------------------|-------|--------------|----------------|---------------|---------------|--------|
| BETHNY DK | KOTZEBUE ALAS | 23 | SE | 4 | 787-7414 | 907-442-3270 | XR29912871 | 2160 |
| NUHE ALS | KOTZEBUE ALAS | 1 | PD | 4 | 443-2925 | 907-442-3270 | G429715375 | 160 |
| TELEPHONE CHARGES | | | | | | | ***29.20 | |

*Hold
This has been
Submitted for
Legislative approval*

\$29.20 unpaid

Amount

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

and Telegram Statement

Form F-0101-3

10 20 KOTZEBUE ALS CCLC BAY ALAS 32 SN 3 442-3270 907-552-2487 6437000004

CURRENT CHARGES
TOTAL AMOUNT DUE

8.00 ✓
6.00
2.00

*Hold
This has been
Submitted for
Legislative approval*

unpaid

RECEIVED
NOV 7 10 17 AM '73
FISCAL SERVICES
BUREAU

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 102628

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

3/16/75 *left work down*

NATURE OF ACCIDENT OR ILLNESS

| | | |
|---|--|---|
| DIAGNOSES | | DIAGNOSIS CODE (OPT.) |
| LIST PRIMARY DIAGNOSIS FIRST | | 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 | DATE OF SERVICE | PLACE OF SERVICE* | DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE | 1969 RVS PROC. CODE | CHARGE | STATE USE ONLY | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| *PLACE OF SERVICE | | 12 COORDINATION OF OTHER BENEFITS | | | TOTAL CHARGE | | | |
| DO DOCTOR'S OFFICE | | MEDICARE PAID | OTHER INS. | TOTAL | LESS | | | |
| IL INDEPENDENT LAB | | | | | | | | |
| H PATIENT'S HOME | | | | | | | | |
| IH INPATIENT HOSPITAL | | | | | | | | |
| OL OTHER LOCATIONS | | MEDICARE CO-INS. | MEDICARE DEDUCT. | TOTAL | | | | |
| NH NURSING HOME | | | | | | | | |
| ECF EXTENDED CARE FACILITY | | | | | UNPAID BALANCE | | | |
| OH OUTPATIENT HOSPITAL | | | | | 25.42 | | | |

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><i>State Paid</i></p> <p>31-1-694-380</p> | | |
| PROVIDER'S SIGNATURE | DATE | RESUBMITTAL INDICATOR | MEDICAL REVIEW |

06

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

| | | | | |
|--|---|--|--|----------|
| 10 PATIENT INFORMATION | | STATE USE ONLY | PROVIDER INFORMATION | |
| COUPON OR AUTHORIZATION NUMBER <i>Children's Children's</i> | | RACE | NAME OF PROVIDER <i>William Farnon MD</i> | |
| NAME OF PATIENT <i>John Jones</i> | | | PROVIDER ID. NO. <i>WHL 420</i> | |
| DATE OF BIRTH <i>2/1/70</i> | SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> | ELIG. CODE | PROVIDER ID. NO. | CATEGORY |
| CASE NO. <i>694-380</i> | RESOURCE | PAYEE ID NO. (if different from above) <i>WHL 401</i> | | |

3/4/75 Retired

NATURE OF ACCIDENT OR ILLNESS.

| | | |
|---|--|-----------------------|
| DIAGNOSES | | DIAGNOSIS CODE (OPT.) |
| LIST PRIMARY DIAGNOSIS FIRST <i>arteriosclerosis</i> | | PRIMARY <i>350</i> |
| | | 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>12-4-72</i> | <i>111</i> | <i>ambulatory visit</i> | <i>91240</i> | <i>12.30</i> | | |
| <i>12-6-72</i> | <i>111</i> | <i>ambulatory visit</i> | <i>91240</i> | <i>12.30</i> | | |
| <i>12-7-72</i> | <i>111</i> | <i>ambulatory visit</i> | <i>91240</i> | <i>12.30</i> | | |
| <i>12-7-72</i> | <i>111</i> | <i>ambulatory visit</i> | <i>91240</i> | <i>12.30</i> | | |
| <i>12-8-72</i> | <i>111</i> | <i>ambulatory visit</i> | <i>91240</i> | <i>12.30</i> | | |
| *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 | <i>179.32</i> | |
| | | | | UNPAID BALANCE | <i>46.33</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>State Paid</i> | | | | | |
| | PROVIDER'S SIGNATURE <i>William Farnon</i> | DATE <i>3/4/75</i> | <table border="1"> <tr> <td>RESUBMITTAL INDICATOR</td> <td>MEDICAL REVIEW</td> </tr> <tr> <td></td> <td></td> </tr> </table> | RESUBMITTAL INDICATOR | MEDICAL REVIEW | |
| RESUBMITTAL INDICATOR | MEDICAL REVIEW | | | | | |
| | | | | | | |

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

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

NATURE OF ACCIDENT OR ILLNESS

| | | |
|--|--|---|
| DIAGNOSES | | DIAGNOSIS CODE (OPT.) |
| LIST PRIMARY DIAGNOSIS FIRST | | PRIMARY |
| | | SECONDARY |
| HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? | | 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 | | |
|----------------------------|-------------------|--|---------------------|----------------|----------------|--|--|
| 11-2-78 | 11 | ... | 90215 | 7.25 | | | |
| 12-1-78 | 14 | ... | 90240 | 12.30 | | | |
| 12-1-78 | 14 | ... | 90240 | 12.30 | | | |
| 12-1-78 | 14 | ... | 90240 | 12.30 | | | |
| 12-1-78 | 14 | ... | 90240 | 12.30 | | | |
| *PLACE OF SERVICE | | 12 COORDINATION OF OTHER BENEFITS | | TOTAL CHARGE | | | |
| DO DOCTOR'S OFFICE | | MEDICARE PAID | OTHER INS. | TOTAL | | | |
| IL INDEPENDENT LAB | | | | | | | |
| H PATIENT'S HOME | | | | | | | |
| IH INPATIENT HOSPITAL | | | | | | | |
| OL OTHER LOCATIONS | | | | | | | |
| NH NURSING HOME | | MEDICARE CO-INS. | MEDICARE DEDUCT. | TOTAL | | | |
| ECF EXTENDED CARE FACILITY | | | | | | | |
| OH OUTPATIENT HOSPITAL | | | | | | | |
| | | | | UNPAID BALANCE | | | |

PROVIDER CERTIFICATION

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

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 182630

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

NATURE OF ACCIDENT OR ILLNESS

| | | |
|--|--|---|
| DIAGNOSES | | DIAGNOSIS CODE (OPT.) |
| LIST PRIMARY DIAGNOSIS FIRST | | 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 | | |
|----------------------------|-------------------|--|---------------------|--------------|----------------|--|--|
| 12-3-72 | 1H | Hospital visit | 90240 | 12.30 | | | |
| 12-4-72 | 1H | Hospital visit | 90240 | 12.30 | | | |
| 12-4-72 | 1H | Hospital visit | 90240 | 12.30 | | | |
| 12-5-72 | 1H | Hospital visit | 90240 | 12.30 | | | |
| 12-5-72 | 1H | Hospital visit | 90240 | 12.30 | | | |
| *PLACE OF SERVICE | | 12 COORDINATION OF OTHER BENEFITS | | TOTAL CHARGE | | | |
| DD DOCTOR'S OFFICE | | MEDICARE PAID | OTHER INS. | TOTAL | | | |
| IL INDEPENDENT LAB | | | | | | | |
| H PATIENT'S HOME | | | | | | | |
| IH INPATIENT HOSPITAL | | | | | | | |
| OL OTHER LOCATIONS | | | | | | | |
| NH NURSING HOME | | MEDICARE CO-INS. | MEDICARE DEDUCT. | TOTAL | | | |
| ECF EXTENDED CARE FACILITY | | | | | | | |
| OH OUTPATIENT HOSPITAL | | | | | UNPAID BALANCE | | |

PROVIDER CERTIFICATION

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

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 P

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

A

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

NATURE OF ACCIDENT OR ILLNESS

| | | |
|--|--|--|
| DIAGNOSES | | DIAGNOSIS CODE (OPT.) |
| LIST PRIMARY DIAGNOSIS FIRST Cleft Lip & Palate | | PRIMARY 749 |
| | | SECONDARY |
| HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | SERVICE PRE-AUTHORIZATION NO. (if applicable) 04971 |
| 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 | | |
| | Oct. 72 | | Debanding & Retainer fee | | \$200.00 | | | |
| *PLACE OF SERVICE | | 12 | COORDINATION OF OTHER BENEFITS | | TOTAL CHARGE | 950.00 | | |
| DO | DOCTOR'S OFFICE | | MEDICARE PAID | OTHER INS. | TOTAL | LESS | 810.00 | |
| IL | INDEPENDENT LAB. | | | Champus | | | | |
| 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 | 140.00 | |

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 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: 4 of 4 31-1-694-380 |
| | <p>PROVIDER'S SIGNATURE <u>Richard L. Day, D.D.S.</u> DATE <u>4-14-75</u></p> |

DEPARTMENT OF HEALTH & SOCIAL SERVICES

06 P

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE NO. 210981

A

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

NATURE OF ACCIDENT OR ILLNESS

| | | |
|--|---|--|
| DIAGNOSES | | DIAGNOSIS CODE (OPT.) |
| LIST PRIMARY DIAGNOSIS FIRST Cleft Lip & Palate | | PRIMARY 749 |
| | | SECONDARY |
| HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | SERVICE PRE-AUTHORIZATION NO. (if applicable) 04971 |
| 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 | | |
|----------------------------|-------------------|--|---------------------|----------------|----------------|--|--|
| May 72 | | Treatment | | \$50.00 | | | |
| June 72 | | " | | \$50.00 | | | |
| July 72 | | " | | \$50.00 | | | |
| August 72 | | " | | \$50.00 | | | |
| Sept. 72 | | " | | \$50.00 | | | |
| *PLACE OF SERVICE | | 12 COORDINATION OF OTHER BENEFITS | | TOTAL CHARGE | | | |
| DO DOCTOR'S OFFICE | | MEDICARE PAID | OTHER INS. | | | | |
| IL INDEPENDENT LAB. | | | TOTAL | | | | |
| H PATIENT'S HOME | | | | LESS | | | |
| IH INPATIENT HOSPITAL | | | | | | | |
| OL OTHER LOCATIONS | | MEDICARE CO-INS. | MEDICARE DEDUCT. | | | | |
| NH NURSING HOME | | | 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: 3 of 4 |
| | <p>PROVIDER'S SIGNATURE _____ DATE _____</p> |
| RESUBMITTAL INDICATOR | MEDICAL REVIEW |

06 P

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

A

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

NATURE OF ACCIDENT OR ILLNESS

| | | |
|--|--|--|
| DIAGNOSES | | DIAGNOSIS CODE (OPT.) |
| LIST PRIMARY DIAGNOSIS FIRST | | PRIMARY |
| Cleft Lip & Palate | | 749 |
| | | SECONDARY |
| HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | SERVICE PRE-AUTHORIZATION NO. (if applicable) 04971 |
| 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 | | |
|----------------------------|-------------------|--|---------------------|--------------|----------------|--|--|
| Dec. 71 | | Treatment | | \$50.00 | | | |
| Jan. 72 | | " | | \$50.00 | | | |
| Feb. 72 | | " | | \$50.00 | | | |
| March 72 | | " | | \$50.00 | | | |
| April 72 | | " | | \$50.00 | | | |
| *PLACE OF SERVICE | | 12 COORDINATION OF OTHER BENEFITS | | TOTAL CHARGE | | | |
| DO DOCTOR'S OFFICE | | MEDICARE PAID | OTHER INS. | | | | |
| IL INDEPENDENT LAB. | | | | | LESS | | |
| H PATIENT'S HOME | | | | | | | |
| IH INPATIENT HOSPITAL | | | | | UNPAID BALANCE | | |
| OL OTHER LOCATIONS | | | | | | | |
| NH NURSING HOME | | MEDICARE CO-INS. | MEDICARE DEDUCT. | TOTAL | | | |
| ECF EXTENDED CARE FACILITY | | | | | | | |
| OH OUTPATIENT HOSPITAL | | | | | | | |

PROVIDER CERTIFICATION

| | | |
|--|---------------------------------------|-----------------------|
| <p>" THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."</p> <p>TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p> | REMARKS: 2 of 4 | |
| | PROVIDER'S SIGNATURE _____ DATE _____ | RESUBMITTAL INDICATOR |

06 P

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

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

NATURE OF ACCIDENT OR ILLNESS

| | | |
|--|--|--|
| DIAGNOSES | | DIAGNOSIS CODE (OPT.) |
| LIST PRIMARY DIAGNOSIS FIRST Cleft Lip & Palate | | PRIMARY 749 |
| | | SECONDARY |
| HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | SERVICE PRE-AUTHORIZATION NO. (if applicable) 04971 |
| 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 | |
| | July 71 | | Treatment | | \$50.00 | | |
| | Aug. 71 | | " | | \$50.00 | | |
| | Sept. 71 | | " | | \$50.00 | | |
| | Oct. 71 | | " | | \$50.00 | | |
| | Nov. 71 | | " | | \$50.00 | | |
| *PLACE OF SERVICE | | 12 COORDINATION OF OTHER BENEFITS | | TOTAL CHARGE | | | |
| DO DOCTOR'S OFFICE | | MEDICARE PAID | OTHER INS. | TOTAL | LESS | | |
| IL INDEPENDENT LAB | | | | | | | |
| H PATIENT'S HOME | | | | | | | |
| IH INPATIENT HOSPITAL | | | | | | | |
| OL OTHER LOCATIONS | | MEDICARE CO-INS. | MEDICARE DEDUCT. | TOTAL | | | |
| NH NURSING HOME | | | | | | | |
| ECF EXTENDED CARE FACILITY | | | | | UNPAID BALANCE | | |
| OH OUTPATIENT HOSPITAL | | | | | | | |

PROVIDER CERTIFICATION

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

FAIRDANK MEMORIAL HOSPITAL

1247 FOWLER ST., FAIRDANK, ALASKA 99701

Joseph E. Block
 14 Mile Street NW
 Fairbanks, Alaska 99701

DATE: 7-10-73
 AMOUNT: 600
 004-378
 ACCT. NO.

| DATE | DESCRIPTION | AMOUNT | CREDIT | BALANCE | DATE | DESCRIPTION | AMOUNT | CREDIT | BALANCE |
|------|-------------|--------|--------|---------|----------|-------------|--------|--------|---------|
| | | | | | 02-02-73 | | 64.00 | | 64.00 |
| | | | | | 02-03-73 | | 64.00 | | 128.00 |
| 8.51 | | 4.50 | 20.00 | 70.00 | 02-04-73 | | 64.00 | | 132.00 |
| | | | | 159.00 | 02-05-73 | | 64.00 | | 196.00 |
| | | | | 40.00 | 02-06-73 | | | | 156.00 |
| | | | | 8.15 | 02-08-73 | | | | 147.85 |
| | | | | 8.25 | 02-10-73 | | | | 139.60 |
| | 87302MFB | | | | 02-11-73 | | | | 139.60 |
| | | | | | 02-12-73 | | | | 139.60 |
| | | | | | 03-01-73 | | | | 139.60 |
| | | | | | 03-02-73 | | | | 139.60 |
| | | | | | 03-03-73 | | | | 139.60 |
| | | | | | 03-04-73 | | | | 139.60 |
| | | | | | 03-05-73 | | | | 139.60 |
| | | | | | 03-06-73 | | | | 139.60 |
| | | | | | 03-07-73 | | | | 139.60 |
| | | | | | 03-08-73 | | | | 139.60 |
| | | | | | 03-09-73 | | | | 139.60 |
| | | | | | 03-10-73 | | | | 139.60 |
| | | | | | 03-11-73 | | | | 139.60 |
| | | | | | 03-12-73 | | | | 139.60 |
| | | | | | 04-01-73 | | | | 139.60 |
| | | | | | 04-02-73 | | | | 139.60 |
| | | | | | 04-03-73 | | | | 139.60 |
| | | | | | 04-04-73 | | | | 139.60 |
| | | | | | 04-05-73 | | | | 139.60 |
| | | | | | 04-06-73 | | | | 139.60 |
| | | | | | 04-07-73 | | | | 139.60 |
| | | | | | 04-08-73 | | | | 139.60 |
| | | | | | 04-09-73 | | | | 139.60 |
| | | | | | 04-10-73 | | | | 139.60 |
| | | | | | 04-11-73 | | | | 139.60 |
| | | | | | 04-12-73 | | | | 139.60 |
| | | | | | 05-01-73 | | | | 139.60 |
| | | | | | 05-02-73 | | | | 139.60 |
| | | | | | 05-03-73 | | | | 139.60 |
| | | | | | 05-04-73 | | | | 139.60 |
| | | | | | 05-05-73 | | | | 139.60 |
| | | | | | 05-06-73 | | | | 139.60 |
| | | | | | 05-07-73 | | | | 139.60 |
| | | | | | 05-08-73 | | | | 139.60 |
| | | | | | 05-09-73 | | | | 139.60 |
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| | | | | | 06-02-73 | | | | 139.60 |
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| | | | | | 12-08-73 | | | | 139.60 |
| | | | | | 12-09-73 | | | | 139.60 |
| | | | | | 12-10-73 | | | | 139.60 |
| | | | | | 12-11-73 | | | | 139.60 |
| | | | | | 12-12-73 | | | | 139.60 |

06-33-6-110-380

87.00

06

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES
 Health Care Facility Invoice

| | | | | |
|--|--|---|---|----------------|
| 20 PATIENT INFORMATION | | STATE USA ONLY | PROVIDER INFORMATION | |
| Coupon or Authorization Number DPA: OMA 32037 | | Race | Name of Provider Fairbanks Memorial Hospital | |
| Name of Patient ANDERSON, Peter A. | | | Provider ID Number TNU 290 | Category 01 |
| Date of Birth 06 / 22 / 02 | Sex: M <input type="checkbox"/> F <input checked="" type="checkbox"/> | Phys. Code | Payee ID Number (if different from above) | |
| Case Number | Resource | Attending Physician Raymond Evans, MD | | ID Number |
| Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | Service Pre-Authorization No. (if applicable) | | |
| Comments: | | | | |

DIAGNOSIS AND PROCEDURES

| | | | | |
|--|-----------------|--|---|---------------|
| Date of Admission 06 / 13 / 71 | Ref. Code 3 | Svc. Unit 1 | Primary Diagnosis Chronic Bronchiectasis | Code 1518 |
| Billing Period 06 / 13 / 71 thru 06 / 26 / 71 | Tot. Days 13 | Secondary Diagnosis | | Code |
| Date of Discharge 06 / 26 / 71 | Dis. Code 1 | Primary Procedure Performed Non surg inpatient care | | Code 90199 |
| Consulting Physician | ID Number | Secondary Procedure Performed | | Code |

STATEMENT OF SERVICES RENDERED

| | Blood Pts. Furnished | Pints Replaced | Not Re-placed | Charge Per Pint | Charge |
|----|-----------------------------|----------------|---------------|-----------------|--------|
| 1 | | | | | |
| | Accommodation | | Days | Rate | |
| 2 | 1 Bed | | | | |
| 3 | 2 Beds | | 13 | 58.00 | 754.00 |
| 4 | 3 or More Beds | | | | |
| 5 | Intensive Care | | | | |
| 6 | Self Care | | | | |
| 7 | Nursery | | | | |
| 8 | Operating Room | | | | |
| 9 | Anesthesia | | | | |
| 10 | Outpatient Services | | | | |
| 11 | Blood Administration | | | | |
| 12 | Pharmacy | | | | 120.99 |
| 13 | Radiology | | | | 30.00 |
| 14 | Laboratory | | | | 71.00 |
| 15 | Medical & Surgical Supplies | | | | 77.65 |
| 16 | Physical Therapy | | | | |
| 17 | Occupational Therapy | | | | |
| 18 | Speech Therapy | | | | |
| 19 | Inhalation Therapy | | | | |
| 20 | Other (Specify) | | | | |
| 21 | | | | | |
| 22 | | | | | |

PROVIDER CERTIFICATION

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

To the best of my knowledge no other resource exists.

Signature: *Raymond Evans* Date: 10/24/73

Remarks:
see attached ledger copy

06-33-6-310-380

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

COORDINATION OF OTHER BENEFITS

| | | | |
|------------------|-------|----------|-------|
| Other Benefits | | Medicare | |
| Medicare Paid | 993.5 | Co-Ins. | 0 |
| Ins. or Other Pd | 0 | Ded. | 60.00 |
| Total | 993.5 | Total | 60.00 |

| | | | | | |
|--------------|---------|------|-------|---------------|-------|
| Total Charge | 1053.55 | Less | 993.5 | Amount Billed | 60.00 |
|--------------|---------|------|-------|---------------|-------|

06

HEALTH CARE FACILITY INVOICE

NO. 527378

B

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

DIAGNOSIS AND PROCEDURES

| | | | | |
|--------------------------------------|----------------|---|----------------------------------|--------------|
| 21 DATE OF ADMISSION 12 / 28 / 72 | REF. CODE 3 | SVC UNIT 5 | PRIMARY DIAGNOSIS chest x-ray | CODE 788 |
| BILLING PERIOD 12 / 28 / 72 | TOT. DAYS 1 | SECONDARY DIGANOSIS | | CODE |
| DATE OF DISCHARGE 12 / 28 / 72 | DIS. CODE 1 | PRIMARY PROCEDURE PERFORMED non surgical outpatient care | | CODE 0290 |
| CONSULTING PHYSICIAN | ID NO. | SECONDARY PROCEDURE PERFORMED | | CODE |

STATEMENT OF SERVICES RENDERED

PROVIDER CERTIFICATION

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

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

TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE _____
DATE 7-1-74

REMARKS:
Billed 7-1-74

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

| | |
|-----------------------------------|----------|
| 23 COORDINATION OF OTHER BENEFITS | |
| OTHER BENEFITS | MEDICARE |
| MEDICARE PAID | CO-INS. |
| INSURANCE OR OTHER PAY. | DED. |
| TOTAL | TOTAL |

| | | | | |
|--------------|-------|-------|------|---|
| TOTAL CHARGE | 24.00 | 24.00 | LESS | 0 |
|--------------|-------|-------|------|---|

| | | |
|---------------|-------|------|
| AMOUNT BILLED | 24.00 | 1920 |
|---------------|-------|------|

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

HEALTH CARE FACILITY INVOICE

NO. 527379

B

| | | | | |
|--|--|---|---|---|
| 20 PATIENT INFORMATION | | STATE USE ONLY | PROVIDER INFORMATION | |
| COUPON OR AUTHORIZATION NUMBER 44758 C | | RACE | NAME OF PROVIDER Providence Hospital | |
| NAME OF PATIENT Pnatages, John C. <i>ADC</i> | | | PROVIDER ID NO. PRH 409 | |
| DATE OF BIRTH 05 / 06 / 71 | | ELIG. CODE | CATEGORY 02 | SEX: <input checked="" type="checkbox"/> M <input type="checkbox"/> F |
| 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. B. Hunter | | ID NO. |
| COMMENTS: | | SERVICE PRE-AUTHORIZATION NO. (if applicable) | | |

DIAGNOSIS AND PROCEDURES

| | | | | |
|---|----------------|---|----------------------------------|---------------|
| 21 DATE OF ADMISSION 12 / 26 / 72 | REF. CODE 3 | SVC UNIT 5 | PRIMARY DIAGNOSIS Chest x-ray | CODE 288 |
| BILLING PERIOD 12 / 26 / 72 - 12 / 26 / 72 | TOT. DAYS 1 | SECONDARY DIGANOSIS | | CODE |
| DATE OF DISCHARGE 12 / 26 / 72 | DIS. CODE 1 | PRIMARY PROCEDURE PERFORMED non surgical outpatient care | | CODE 90290 |
| CONSULTING PHYSICIAN | ID NO. | SECONDARY PROCEDURE PERFORMED | | CODE |

STATEMENT OF SERVICES RENDERED

PROVIDER CERTIFICATION

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

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

TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE *[Signature]*

DATE 7-1-74

REMARKS:
Billed 7-1-74

38-6-120-380

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

COORDINATION OF OTHER BENEFITS

| | | | | |
|--------------------|-------------------------|-------|----------|---|
| 20 OTHER (SPECIFY) | OTHER BENEFITS | | MEDICARE | |
| | MEDICARE PAID | S | CO-INS. | S |
| | INSURANCE OR OTHER PAY. | | DED. | |
| 21 | TOTAL | TOTAL | | |

| | | | | |
|--------------|-------|-------|------|---|
| TOTAL CHARGE | 24.00 | 24.00 | LESS | 0 |
|--------------|-------|-------|------|---|

| | | |
|---------------|-------|-------|
| AMOUNT BILLED | 24.00 | 19.20 |
|---------------|-------|-------|

PROVIDER

25 PROVIDER REF. Mc Farland, Kerry

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

HEALTH CARE FACILITY INVOICE

NO. 527385

B

| | | | | |
|--|--|---|---|--------|
| 20 PATIENT INFORMATION | | STATE USE ONLY | PROVIDER INFORMATION | |
| COUPON OR AUTHORIZATION NUMBER 44746 A | | RACE | NAME OF PROVIDER Providence Hospital | |
| NAME OF PATIENT Mc Farland, Kerry S. <i>ADC</i> | | | PROVIDER ID NO. PRI 409 | |
| DATE OF BIRTH 07 / 03 / 63 | SEX: M <input checked="" type="checkbox"/> F <input type="checkbox"/> | ELIG. CODE | CATEGORY 02 | |
| 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. D. Roberts | | ID NO. |
| COMMENTS: | | SERVICE PRE-AUTHORIZATION NO. (if applicable) | | |

DIAGNOSIS AND PROCEDURES

| | | | | |
|---|----------------|---|---|---------------|
| 21 DATE OF ADMISSION 12 / 30 / 72 | REF. CODE 3 | SVC UNIT 5 | PRIMARY DIAGNOSIS outpatient labwork | CODE 788 |
| BILLING PERIOD 12 / 30 / 72 - 12 / 30 / 72 | TOT. DAYS 1 | SECONDARY DIGANOSIS | | CODE |
| DATE OF DISCHARGE 12 / 30 / 72 | DIS. CODE 1 | PRIMARY PROCEDURE PERFORMED non surgical outpatient care | | CODE 90290 |
| CONSULTING PHYSICIAN | ID NO. | SECONDARY PROCEDURE PERFORMED | | CODE |

STATEMENT OF SERVICES RENDERED

PROVIDER CERTIFICATION

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

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

TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS

PROVIDER'S SIGNATURE *[Signature]*
DATE 7-1-74

REMARKS:
Billed 7-1-74

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

23 COORDINATION OF OTHER BENEFITS

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

| | | | | |
|--------------|-------|-------|------|---|
| TOTAL CHARGE | 10.00 | 10.00 | LESS | 0 |
|--------------|-------|-------|------|---|

| | | |
|---------------|-------|-----------|
| AMOUNT BILLED | 10.00 | <i>80</i> |
|---------------|-------|-----------|

PROVIDER

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

HEALTH CARE FACILITY INVOICE

NO. 527432

B

| | | | | |
|---|---|--|---|----------------|
| 20 PATIENT INFORMATION | | STATE USE ONLY | PROVIDER INFORMATION | |
| COUPON OR AUTHORIZATION NUMBER 45219 A | | | NAME OF PROVIDER Providence Hospital | |
| NAME OF PATIENT Tritt, Verlin W. <i>APC</i> | | RACE | | |
| DATE OF BIRTH 11 / 21 / 55 | SEX: M <input type="checkbox"/> F <input type="checkbox"/> | ELIG. CODE | PROVIDER ID NO. PRI 409 | CATEGORY 02 |
| CASE NUMBER | RESOURCE | PAYEE ID NO. (if different from above) | | |
| HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | ATTENDING PHYSICIAN L. Jones, H.D. | | ID NO. |
| COMMENTS: | | SERVICE PRE-AUTHORIZTION NO. (if applicable) | | |

DIAGNOSIS AND PROCEDURES

| | | | | |
|--------------------------------------|----------------|---|--|---------------|
| 21 DATE OF ADMISSION 11 / 10 / 72 | REF. CODE 3 | SVC UNIT 5 | PRIMARY DIAGNOSIS 1" laceration wound medial (R) foot | CODE 201 |
| BILLING PERIOD 11 / 10 / 72 | TOT. DAYS 1 | SECONDARY DIGANOSIS | | CODE |
| DATE OF DISCHARGE 11 / 10 / 72 | DIS. CODE 1 | PRIMARY PROCEDURE PERFORMED suture wound | | CODE 12120 |
| CONSULTING PHYSICIAN | ID NO. | SECONDARY PROCEDURE PERFORMED | | CODE |

STATEMENT OF SERVICES RENDERED

PROVIDER CERTIFICATION

| | BLOOD PINTS FURNISHED | PINTS REPLACED | NOT REPLACED | CHARGE PER PINT | CHARGE |
|-------------------------------|-----------------------|----------------|--------------|-----------------|--------|
| 1 ACCOMMODATION | | | DAYS | RATE | |
| 2 1 BED | | | | | |
| 3 2 BEDS | | | | | |
| 4 3 OR MORE BEDS | | | | | |
| 5 INTENSIVE CARE | | | | | |
| 6 SELF CARE | | | | | |
| 7 NURSERY | | | | | |
| 8 OPERATING ROOM | | | | | |
| 9 ANESTHESIA | | | | | |
| 0 OUTPATIENT SERVICES | | | | 25.50 | 25.50 |
| 1 BLOOD ADMINISTRATION | | | | | |
| 2 PHARMACY | | | | | |
| 3 RADIOLOGY | | | | | |
| 4 LABORATORY | | | | | |
| 5 MEDICAL & SURGICAL SUPPLIES | | | | | |
| 6 PHYSICAL THERAPY | | | | | |
| 7 OCCUPATIONAL THERAPY | | | | | |
| 8 SPEECH THERAPY | | | | | |
| 9 INHALATION THERAPY | | | | | |
| 0 OTHER (SPECIFY) | | | | | |
| 1 | | | | | |
| 2 | | | | | |

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

TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.

PROVIDER'S SIGNATURE _____

DATE 11 / 10 / 72

REMARKS:
33-6-120-380

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

COORDINATION OF OTHER BENEFITS

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

| | | | | |
|--------------|-------|--------------|------|---|
| TOTAL CHARGE | 25.50 | <i>25.50</i> | LESS | 0 |
|--------------|-------|--------------|------|---|

| | | |
|---------------|-------|--------------|
| AMOUNT BILLED | 25.50 | <i>20.40</i> |
|---------------|-------|--------------|

80%

PROVIDER

25 PROVIDER REF. Mueller, Judy

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

06

HEALTH CARE FACILITY INVOICE

NO. 527450

B

| | | | | |
|--|---|---|---|--------|
| 20 PATIENT INFORMATION | | STATE USE ONLY | PROVIDER INFORMATION | |
| COUPON OR AUTHORIZATION NUMBER 44756 A | | RACE | NAME OF PROVIDER Providence Hospital | |
| NAME OF PATIENT Mueller, Judy (ADC) | | | PROVIDER ID NO. PRH 409 | |
| DATE OF BIRTH 10 / 12 / 45 | SEX: M <input type="checkbox"/> FL <input checked="" type="checkbox"/> | ELIG. CODE | CATEGORY 02 | |
| 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 Brownsberger | | ID NO. |
| COMMENTS: | | SERVICE PRE-AUTHORIZATION NO. (if applicable) | | |

DIAGNOSIS AND PROCEDURES

| | | | | |
|--------------------------------------|----------------|--|--------------------------------|---------------|
| 21 DATE OF ADMISSION 12 / 14 / 72 | REF. CODE 3 | SVC UNIT 5 | PRIMARY DIAGNOSIS misc. lab | CODE 788 |
| BILLING PERIOD 12 / 14 / 72 | TOT. DAYS 1 | | SECONDARY DIGANOSIS | CODE |
| DATE OF DISCHARGE 12 / 14 / 72 | DIS. CODE 1 | PRIMARY PROCEDURE PERFORMED Outpatient care | | CODE 90290 |
| CONSULTING PHYSICIAN | ID NO. | SECONDARY PROCEDURE PERFORMED | | CODE |

STATEMENT OF SERVICES RENDERED

PROVIDER CERTIFICATION

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

" 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 Christina Hodge
DATE 7/5/74

REMARKS:
Billed 7-5-74

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

23 COORDINATION OF OTHER BENEFITS

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

| | | | | | | | |
|--------------|-------|-------|------|-----|---------------|-------|-------|
| TOTAL CHARGE | 25.00 | 25.00 | LESS | .00 | AMOUNT BILLED | 25.00 | 20.00 |
|--------------|-------|-------|------|-----|---------------|-------|-------|

Fairbanks Memorial Hospital

1650 Cowles
FAIRBANKS, ALASKA 99701

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

507685
STATE STD.

May 31, 1975

Dear Sir:

Patient: Anderson, Peter A.

ID# DPW OAA 32037

Group Name: MAID

Admission Date: April 13, 1971

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

Sincerely,

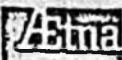
Cathy Harris
for

Mrs. Rhonda Newman
Insurance

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

REPLY:

NO



BASIC PLUS MAJOR MEDICAL PLAN

EXPLANATION OF BENEFIT PAYMENT

Key 80 Control No. 338000 Suf 10

Year 23

Sheet No. Statistics

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

Policyholder: [Signature]

Employee: M J Stevens Cert. No. 489329570

Dependent (First Name): William

| See Comment No. | CHARGES BY | DATES INCURRED | AMOUNT OF CHARGES | EXPENSES NOT COVERED | COVERED EXPENSES | BASIC BENEFITS |
|--------------------------|---------------|----------------|-------------------|----------------------|------------------|----------------|
| <input type="checkbox"/> | Rx | 1/5 | \$ 7.20 | \$ | \$ 7.20 | - |
| <input type="checkbox"/> | Alaska Clinic | 1/16 | 12.30 | 0 | 12.30 | |
| <input type="checkbox"/> | | | | | | |
| <input type="checkbox"/> | | | | | | |
| <input type="checkbox"/> | | | | | | |
| <input type="checkbox"/> | | | | | | |
| <input type="checkbox"/> | | | | | | |
| <input type="checkbox"/> | | | | | | |

COMMENTS: Applies toward deductible

TOTALS (A) 19.50 (B)

BASIC BENEFIT PAYMENT

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

PAYMENTS MADE TO:

| | |
|--|----|
| | \$ |
| | \$ |
| | \$ |
| | \$ |

| | | | | | |
|-----------|------------|----------|-----------|---------|---------|
| SCD 92 | S. S. Suf. | State 34 | Climt 2 | Code 00 | |
| Class DCI | Amount | Special | Class DCI | Amount | Special |
| Class DCI | Amount | Special | Class DCI | Amount | Special |

REMARKS:

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

EXPENSES APPLIED TO MEET YOUR MAJOR MEDICAL DEDUCTIBLE FOR 73 YEAR

(A) COVERED EXPENSES Less (B) BASIC BENEFITS

This Worksheet \$ 19.50

Previous Worksheets \$

TOTAL FOR YEAR TO DATE \$ 19.50

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

Processor [Signature] Date 2/2/3

| Climt | Age | Salary |
|--------|---------------|-------------|
| | | |
| Disa | Type Claim | Ded |
| | | |
| c/over | Days Confined | Days Pvt Rm |
| | | |

MAJOR MEDICAL BENEFITS

Sum of 1 thru 6 =

| |
|---------------|
| Total Hosp |
| K Allow |
| Inv |
| Surg Fees |
| Phys Fees |
| Nurses |
| Drugs |
| All Other |
| Total Covered |
| Basic Ben |

(A) COVERED EXPENSES Less (B) BASIC BENEFITS \$ PLUS

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

TOTAL EXPENSE ELIGIBLE UNDER MAJOR MEDICAL \$ LESS

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

Benefit Calculation \$ @ % = \$ MAJOR MEDICAL BENEFIT PAYMENT

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

TOTAL CHARGED AGAINST MAXIMUM (PLAN LIMIT OF) \$