

LEG. FINANCE - BILLS 1975 - 1976 572  
SB 530 cont., thru SB 531



ADC

CENTRAL OFFICE COPY

# STATE OF ALASKA

15 PROVIDER REF. Smith

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 74500 A

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

## NATURE OF ACCIDENT OR ILLNESS

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

11 SERVICES RENDERED					
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
3/7/73	OH	Em Rm Brief eval Hist ex treat	90500	32.80	
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	32.80
DO DOCTOR'S OFFICE	IL INDEPENDENT LAB	MEDICARE PAID	OTHER INS.	TOTAL	<i>1500</i>
H PATIENTS HOME	IH INPATIENT HOSPITAL			LESS	
OL OTHER LOCATION	NH NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL	
ECP EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL			UNPAID BALANCE	

## PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: <i>State Dated from Hospital Emergency Room</i> <i>33-6-150-380</i>
	<p>PROVIDER SIGNATURE: <i>P. Bosveld</i> DATE: <i>6-17-75</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Elmore Penn		RACE	The Alaska Clinic	
DATE OF BIRTH 6-19-23	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	PROVIDER I.D. NO. SAD 417	CATEGORY
CASE NO.	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) ALC 501		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
<p><i>Sprains &amp; Strains of back - History of enlarged heart R/o Ventral Hernia Status - Post Appendectomy Post Pancreatitis</i></p>			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
5/29/72	DO	<del>Brief Exam Eval A/O Treatment</del> CBC	85010	8.00			
5/9/72	DO	AMylase	82150	12.00			
5/9/72	DO	Chest 2 Views	71020	24.00			
6/6/72	DO	Brief Exam Eval A/O Treatment	90040	12.00			
10/25/72	DO	Brief Exam Eval A/O Treatment	90040	12.00			
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	68.00		
DO	DOCTORS OFFICE	MEDICARE PAIC	OTHER INS.	TOTAL			
IL	INDEPENDENT LAB						
H	PATIENTS HOME						
IH	INPATIENT HOSPITAL						
OL	OTHER LOCATION	MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL			
NH	NURSING HOME						
ECF	EXTENDED CARE FACILITY						
OH	OUTPATIENT HOSPITAL						
				UNPAID BALANCE			

PROVIDER CERTIFICATION

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	<p><i>unable to obtain coupon for back charges 33-6-350-380</i></p>		
<p>PROVIDER SIGNATURE <i>A DePalatis</i> DATE <i>6-19-75</i></p>	<table border="1"> <tr> <td>RESUBMITTAL INDICATOR</td> <td>MEDICAL REVIEW</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. 74732 A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT		RACE	The Alaska Clinic	
Elmore Penn			Dr. <del>DE</del> Palatis	
DATE OF BIRTH		ELIG. CODE	PROVIDER I.D. NO.	CATEGORY
6-19-73 M <input checked="" type="checkbox"/> SEX F <input type="checkbox"/>			SAD 417	
CASE NO.		RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE)	
			AIC 501	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
<p><i>Probable Early Acute Pancreatitis</i>  <i>Possible Posterior Perforation of Duodenal Ucer into Lesser Sac</i></p>			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
<del>2/15/72</del>	<del>DO</del>	<del>...</del>	<del>...</del>			
2/15/72	DO	V Pressure Cath Place Percutan	36480	32.00		
2/15/72	IH	Appendectomy	44950	380.00		
2/15/72	IH	ABD Drain Pancreatitis	48000	520.00		
5/9/72	DO	Brief Exam Eval A.O Treatment	90040	12.00		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	
DO	DOCTORS OFFICE	MEDICARE PAID	OTHER INS.	TOTAL	944.00	
IL	INDEPENDENT LAB					
H	PATIENTS HOME					
IH	INPATIENT HOSPITAL					
OL	OTHER LOCATION	MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH	NURSING HOME					
ECF	EXTENDED CARE FACILITY					
OH	OUTPATIENT HOSPITAL				UNPAID BALANCE	

PROVIDER CERTIFICATION

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	<p><i>Unable to obtain paper for back charges</i>  <i>53-6-350-380</i></p>
PROVIDER SIGNATURE: <i>Dr. Palatis MD</i>	RESUBMITTAL INDICATOR
DATE: 6-19-75	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 74733 A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Elmore Penn		RACE	The Alaska Clinic	
DATE OF BIRTH 6-19-75 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		ELIG. CODE	PROVIDER I.D. NO. VAC 419	CATEGORY
CASE NO.		RLSOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) AIC 501	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
Possible Pancreatitis; Possible Posterior Perforation of Duodenal Ulcer into Lesser Sac			SECONDARY
Probably Early Acute Pancreatitis			
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:			

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
2/15/72	DO	ABL Comp Inc Decub-Erect	74020	32.00		
2/15/72	DO	UA	81000	4.00		
2/15/72	DO	CBC	85010	8/00		
2/15/72	DO	Sed Rate	85650	6.00		
2/15/72	SO	Amulase	82150	12.00		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE		
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB						
H PATIENTS HOME				LESS		
IM INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL				UNPAID BALANCE		

PROVIDER CERTIFICATION

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PROVIDER SIGNATURE <i>W. Cates MD</i>	DATE 6-19-75	RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

NO. 74734 A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT		RACE	The Alaska Clinic	
Elmore Penn			Dr. Tomes	
DATE OF BIRTH	6-19-75 M <input checked="" type="checkbox"/> SEX F <input type="checkbox"/>	ELIG. CODE	PROVIDER I.D. NO.	CATEGORY
			PJT 189	
CASE NO.		RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE)	
			ALC 501	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
<p><i>Probably early Acute Pancreatitis</i>  <i>Possible Posterior Perforation of Duodenum</i>  <i>Went into Lesser Sac.</i></p>			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
2/19/78	IH	Hosp Vis W Brief Exam	90240	12.00		
2/20/78	IH	Hosp Vis W Brief Exam	90240	12.00		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	24.00
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	LESS	
IL INDEPENDENT LAB						
H PATIENTS HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY					UNPAID BALANCE	
OH OUTPATIENT HOSPITAL						

PROVIDER CERTIFICATION

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	<p><i>Unable to obtain coupon for back charges 33-6-350-380</i></p>		
PROVIDER SIGNATURE	DATE	RESUBMITTAL INDICATOR	MEDICAL REVIEW
<i>Dr. Tomes MD</i>	6-19-78		

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96616A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Topper, Charles		RACE	Dr. Robert W. Taylor	
DATE OF BIRTH 12/05/16	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE APP	PROVIDER I.D. NO. RWT 424	CATEGORY
CASE NO. 76825	RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 881		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
ARTERIAL EMBOLISM AND THROMBOSIS			444
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
10/22/73	IH	SURGERY	32900	164.00	7200	
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	164.00	7200
IL INDEPENDENT LAB						
H PATIENTS HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
				UNPAID BALANCE		

PROVIDER CERTIFICATION

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	<p>11/73 Coupon # 30375 E X 33-6-150-380</p>
PROVIDER SIGNATURE: <i>D. Anney</i>	DATE: 11/1/74
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96637A

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

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
ACUTE AND SUBACUTE NECROSIS OF LIVER			570
FRACTURE OF VAULT OF SKULL			800
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
01/21/73	IH	E R BRIEF EET-NEW	90500	34.00	1770	
01/21/73	IH	BRIEF EET-5 @ 12.00	90240	60.00	6000	
01/21/73	IH	COMPR HE EV	90620	70.00	5900	
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	164.00	13670
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB						
H PATIENTS HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
				UNPAID BALANCE		

PROVIDER CERTIFICATION

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

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96652A

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

NATURE OF ACCIDENT OR ILLNESS

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

11 SERVICES RENDERED					
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY
09/25/72	DO	T-3 OR T-4 UPTAKE	83440	8.60	860
09/25/72	DO	SGOT. COLORIMETRIC OR FLUO	84455	8.60	860
09/25/72	DO	CHEST	71010	17.20	1720
09/25/72	DO	POTASSIUM. BLOOD	84140	10.30	1030
09/25/72	DO	SGPT, COLORIMETRIC OR FLUO	84465	8.60	860
09/25/72	DO	ABDOMEN, SINGLE VIEW-KUB	74000	17.20	1700
09/28/72	DO	BRIEF ET-EST	90040	12.00	1200
09/28/72	DO	EKG	93000	30.00	3000
09/28/72	DO	CYTOPATH, SMEARS, GENITAL	88100	12.90	600
09/28/72	DO	UPPER GASTROINTESTINAL TR	74240	60.00	6000
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	271.40
DO DOCTORS OFFICE	MEDICARE PAID		OTHER INS.	TOTAL	264.30
II INDEPENDENT LAB					
III PATIENTS HOME					
III INPATIENT HOSPITAL					
OI OTHER LOCATION	MEDICARE CO-INS.		MEDICARE DEDUCT	TOTAL	
NH NURSING HOME					
ECF EXTENDED CARE FACILITY					
OH OUTPATIENT HOSPITAL					
				UNPAID BALANCE	

PROVIDER CERTIFICATION

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		33-6-150-380	
PROVIDER SIGNATURE	DATE	RESUBMITTAL INDICATOR	MEDICAL REVIEW
<i>P. J. May</i>	11-8-74		

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96655A

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

NATURE OF ACCIDENT OR ILLNESS

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

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
11-18-72	IH	NEWBORN EXAM & CARE	90285	60.00	4850	
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	60.00	4850
IL INDEPENDENT LAB.						
H PATIENTS HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION						
NH NURSING HOME		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL					UNPAID BALANCE	

PROVIDER CERTIFICATION

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	<p>PROVIDER SIGNATURE: <u>J. May</u> DATE: <u>11-8-72</u></p>

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96682A

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

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST  CHRONIC SINUSITIS			PRIMARY  503
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:			

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
01/26/73	IH	E R INTER EFT-EST	90560	30.00	2000	
* PLACE OF SERVICE	12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	30.00	2000
DO DOCTORS OFFICE	MEDICARE PAID	OTHER INS.	TOTAL	LESS		
IL INDEPENDENT LAB						
H PATIENTS HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION	MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL			
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: 2/73 - Coupon # 41835C 150 33-6-350-380
	<p>PROVIDER SIGNATURE: <i>A. Amar</i> DATE: 11/1/73</p>

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96690A

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

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
VARICOSE VEINS OF LOWER EXTREMITIES			454
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED							
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
07/24/79	IH	SURGERY	37721	564.00	54380		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	564.00	54380
DO DOCTORS OFFICE	IL INDEPENDENT LAB	MEDICARE PAID	OTHER INS.	TOTAL	LESS		
H PATIENTS HOME	IH INPATIENT HOSPITAL	MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL	UNPAID BALANCE		
OL OTHER LOCATION	NH NURSING HOME						
ECF EXTENDED CARE FACILITY	OH OUTPATIENT HOSPITAL						

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE 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>7/23 for Mr. Towall Coupon #1 58027 B 33-6-150-380</p>
PROVIDER SIGNATURE: <i>P. Max</i>	DATE: 11/1/79
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

NO. 96701 A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER 72-301-41-923			NAME OF PROVIDER Dr. Charles W. Townsend	
NAME OF PATIENT Rynearson, Bert		RACE	PROVIDER I.D. NO. CWT 308	
DATE OF BIRTH 11/11/17	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE APD	CATEGORY	
CASE NO. 33029	RESOURCES	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 881		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST  BOIL AND CARBUNCLE		PRIMARY  680
		SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
10/30/72	DO	PT-WHIRLPOOL	97004	12.00	1200		
10/30/72	DO	SUPPLIES AND MATERIAL	99070	2.00	200		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	14.00	1400	
DO DOCTORS OFFICE	II INDEPENDENT LAB	MEDICARE PAID	OTHER INS.	TOTAL			
H PATIENTS HOME	III INPATIENT HOSPITAL			LESS			
OL OTHER LOCATION	IV NURSING HOME	MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL			
ELF EXTENDED CARE FACILITY	CH OUTPATIENT HOSPITAL			UNPAID BALANCE			

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>NOTH ABOVE  <del>Can not confirm</del>                  33-6-150-380                  eligibility</p>
PROVIDER SIGNATURE: <i>Phyllis Smart</i>	DATE: 11-8-74
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

NO. 96708A

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

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST DISEASES OF ESOPHAGUS, STOMACH AND DUODENUM			PRIMARY 530
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY		
09/14/72	DO	LIMITED EET-EST	90050	16.00	1600		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	16.00	1600
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	LESS		
II INDEPENDENT LAB							
III PATIENTS HOME							
IV INPATIENT HOSPITAL							
VI OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL			
VII NURSING HOME							
VIII EXTENDED CARE FACILITY					UNPAID BALANCE		
IX 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: 33-6-150-380
	<p>PROVIDER SIGNATURE: <i>P. J. Mayr</i> DATE: 11-8-74</p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96651 A

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

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
MALIGNANT HYPERTENSION			400
INFLUENZA, UNQUALIFIED			470
ACUTE ARTHRITIS DUE TO PYOGENIC ORGANISMS			710
DISEASES OF ESOPHAGUS			530
CONGENITAL DISORDERS OF AMINO-ACID METABOLISM			SECONDARY 270
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

11		SERVICES RENDERED				
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RYS PROC. CODE	CHARGE	STATE USE ONLY	
09/25/72	DO	CREATININE, BLOOD	82565	8.60	860	
09/25/72	DO	LATEX, FIX, RHEUMATOIC FACT	86360	8.60	860	
09/25/72	DO	BLOOD COUNT, COMPLETE	85010	10.30	1030	
09/25/72	DO	T-3 OR T-4 UPTAKE	83440	8.60	860	
09/25/72	DO	SEDIMENTATION RATE	85650	6.00	600	
09/25/72	DO	LDH	83615	8.60	860	
09/25/72	DO	UREA NITROGEN, BLOOD	84520	9.50	950	
09/25/72	DO	BRIEF ET-EST	90040	12.00	1200	
09/25/72	DO	URINALYSIS, ROUTINE, COMPLE	81000	5.20	520	
09/25/72	DO	URIC ACID, BLOOD, CHEMICAL	84550	8.60	860	
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE		
DO DOCTOR		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB						
H PATIENTS HOME						
III INPATIENT HOSPITAL						
OI OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECS EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>PROVIDER SIGNATURE <i>P. J. Mans</i> DATE <i>11-8-74</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

NO. 96717A

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

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
GASTRITIS AND DUODENITIS			535
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
03/01/73	DO	BRIEF ET-EST	90040	12.00	1200	
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	12.00	1200
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
II INDEPENDENT LAB						
H PATIENTS HOME						
III INPATIENT HOSPITAL						
Q1 OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS: 2/73 Coupon # 41-0 12776 X 33-6-150-380
	<p>PROVIDER SIGNATURE <u>G. Gray</u> DATE <u>11/1/74</u></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

NO. 96683A

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

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST OTHER DISEASES OF LIVER			PRIMARY 573
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)	
COMMENTS:		REFERRING OR CONSULTING PHYSICIAN	

SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
11/21/72	DO	BILIRUBIN, BLOOD, TOTAL	82250	10.30	1030	
11/21/72	DO	SGOT, COLORIMETRIC OR FLUO	84455	8.60	855	
11/21/72	DO	BRIEF ER-EST	90040	12.00	1200	
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	30.90	3085
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB						
H PATIENTS HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p><i>Can not confirm eligibility</i> <i>33-6-350-380</i></p>
PROVIDER SIGNATURE: <i>Olson Janet R.</i>	DATE: 11-8-74
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96693A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER			NAME OF PROVIDER	
NAME OF PATIENT Mitchell, Nicholas		RACE Keweenaw	Dr. James H. Jordan	
DATE OF BIRTH 10-10-71	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE GPM	PROVIDER I.D. NO. HJJ 467	CATEGORY
CASE NO. 52700		RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 881	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
OTHER AND UNSPECIFIED LACERATION OF HEAD			873
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED? YES <input type="checkbox"/> NO <input type="checkbox"/>		SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)	REFERRING OR CONSULTING PHYSICIAN
COMMENTS:			

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
07/21/73	DO	SURGERY	12120	37.60	2240	
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	37.60	2240
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
II INDEPENDENT LAB.						
H PATIENTS HOME						
III INPATIENT HOSPITAL						
OI OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECH EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:  336-350-380
	<p>PROVIDER SIGNATURE: <i>P. Mayh</i> DATE: 11/1/74</p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96696A

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

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
BUNION			730
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
02/21/72	IH	SURGERY	27332	158.00		
02/21/72	IH	DISCOUNT	1005	7.90-		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	150.10
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	LESS	
IL INDEPENDENT LAB						
H PATIENTS HOME						
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL					UNPAID BALANCE	

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:
	<p>33-6-350-380</p>
PROVIDER SIGNATURE <i>P. May</i>	DATE 11-8-74
RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

NO. 96697A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>see attached</i>			NAME OF PROVIDER Dr. Edwin Lindig	
NAME OF PATIENT Zdanovec, Richard G.		RACE		
DATE OF BIRTH	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	PROVIDER I.D. NO. ELM 831	CATEGORY
CASE NO.		RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 881	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST			PRIMARY
BUNION			730
SPRAINS AND STRAINS OF SHOULDER AND UPPER ARM			840
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
02/21/72	DO	EKG	93000	30.00		
02/21/72	DO	DISCOUNT	01005	2.70-		
02/21/72	DO	DISCOUNT	01005	31.50-		
02/21/72	IH	SURGERY	27332	630.00		
02/21/72	DO	CHEST, 2 VIEWS	71020	24.00		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	649.80	
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
IL INDEPENDENT LAB						
IH INPATIENT HOSPITAL						
OH OUTPATIENT HOSPITAL						
DI OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL						
				UNPAID BALANCE		

PROVIDER CERTIFICATION

<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>		REMARKS: <i>33-6-350-380</i>	
PROVIDER SIGNATURE <i>P. J. [unclear]</i>	DATE <i>11-8-74</i>	RESUBMITTAL INDICATOR	MEDICAL REVIEW

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

OUTPATIENT HOSPITAL • PRACTITIONER • HOME HEALTH AGENCY INVOICE

NO. 96711 **A**

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER <i>see attached</i>			NAME OF PROVIDER Dr. Edwin Lindig	
NAME OF PATIENT Zdanovec, Richard G.		RACE	PROVIDER I.D. NO. ELM 831	
DATE OF BIRTH	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ELIG. CODE	CATEGORY	
CAS. NO.		RESOURCE	PAYEE I.D. NO. (IF DIFFERENT FROM ABOVE) FMS 881	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSIS			DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST SPRAINS AND STRAINS OF SHOULDER AND UPPER ARM			PRIMARY 840
			SECONDARY
HAVE ALL OTHER PAYMENT SOURCES BEEN EXHAUSTED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	SERVICE PRE-AUTHORIZATION NUMBER (IF APPLICABLE)
COMMENTS:			REFERRING OR CONSULTING PHYSICIAN

11 SERVICES RENDERED						
DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF MEDICAL OR SURGICAL PROCEDURE	1969 RVS PROC. CODE	CHARGE	STATE USE ONLY	
03/02/72	DO	PT-EXERCISE & WHIRLPOOL	97050	13.00		
03/02/72	DO	BRIEF ET-EST	99040			
03/02/72	DO	DISCOUNT	01005	.75-		
03/02/72	DO	ACE BANDAGES	99071	2.00		
03/03/72	DO	DISCOUNT	01005	.65-		
03/03/72	DO	PT-EXERCISE & WHIRLPOOL	97050	13.00		
* PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS			TOTAL CHARGE	
DO DOCTORS OFFICE		MEDICARE PAID	OTHER INS.	TOTAL	26.60	
IL INDEPENDENT LAB						
H PATIENTS HOME					LESS	
IH INPATIENT HOSPITAL						
OL OTHER LOCATION		MEDICARE CO-INS.	MEDICARE DEDUCT	TOTAL		
NH NURSING HOME						
ECF EXTENDED CARE FACILITY						
OH OUTPATIENT HOSPITAL					UNPAID BALANCE	

PROVIDER CERTIFICATION

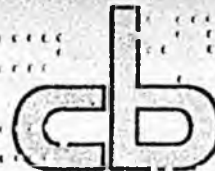
<p>"THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE, AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS." TO THE BEST OF MY KNOWLEDGE NO OTHER RESOURCE EXISTS.</p>	REMARKS:  <i>33-6-350-380</i>
	<p>PROVIDER SIGNATURE <i>P. Inari</i> DATE <i>11-8-74</i></p>
RESUBMITTAL INDICATOR	MEDICAL REVIEW





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

FROM:



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

SUBJECT:

DATE: May 6, 1975

MESSAGE

Dear Sirs,

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

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

Thank you.

SIGNED

REPLY

*G. M. Muschie*  
G. M. Muschie, Collection Dept.

66-4-112-380

SIGNED

DATE

THIS COPY FOR PERSON ADDRESSED

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

Send white & canary copies for payment.

15 Provider Ref

KN

**06** ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
 Outpatient Hospital-Practitioner-Home Health Agency Invoice No 111698A

<b>10</b> PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number <b>Crippled Children's Services</b>		Face <b>W</b>	Name of Provider <b>Susan Clark</b>	
Name of Patient <b>Lombard, Patrick</b>			Visual Therapist	
Date of Birth <b>08 / 22 / 71</b>	Sex <b>M</b> <input checked="" type="checkbox"/> <b>F</b> <input type="checkbox"/>	Elig. Code <b>30P</b>	Provider ID No. <b>SUC 242</b>	Category <b>14</b>
Case No. <b>672-310</b>	Resource <b>X</b>	Payee ID No. (if different from above) <b>ATC 964</b>		

**NATURE OF ACCIDENT OR ILLNESS**

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First  <b>Blindness</b>		Primary <b>379</b>
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Referring or Consulting Physician
Comments:		Service Preauthorization No. (if applicable) <b>01388</b>
		<b>Dr Manwiller</b>

**SERVICES RENDERED**

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
06/28/73	OL	Visual Therapy	92065	10.00	1000
07/05/73	OL	Visual Therapy	92065	12.50	1090
07/12/73	OL	Visual Therapy	92065	12.50	1090
07/19/73	OL	Visual Therapy	92065	12.50	1090
07/26/73	OL	Visual Therapy	92065	12.50	1090
*Place of Service		<b>12</b> Coordination of Other Benefits	Total Charge	60.00	531.0
DO Doctor's Office		M/Care Pd. Other Paid Total	Less		
IL Independent Lab					
H Patient's Home					
IH Inpatient Hospital					
OL Other Location					
NH Nursing Home		M/Care CoIn M/Care Ded. Total	Unpaid Balance	60.00	531.0
EC Extended Care Fac.					
OH Outpatient Hosp.					

**PROVIDER CERTIFICATION**

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
	<p>Signature <i>Pete L. ...</i> Date <b>10-05-73</b></p>

74. State File  
75. State Suspense  
76. Provider's Copy

Send white & carbon copies for payment.

15 Provider Ref **COMBARD**

06 P

**ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES**  
**Outpatient Hospital-Practitioner-Home Health Agency Invoice No 111900 A**

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number <b>Crippled Children Services</b>		Name of Patient <b>Lombard, Patrick</b>	Name of Provider <b>Alaska Treatment Center</b>	
Name of Patient			3710 E 20th Avenue Anch Ak 99504	
Date of Birth <b>08 / 22 / 71</b>	Sex <b>M</b> <input type="checkbox"/> <b>F</b> <input type="checkbox"/>	Elig. Code <b>30P</b>	Provider ID No. <b>SUC 242</b>	Category <b>14</b>
Case No. <b>682-390</b>	Resource <b>X</b>	Payee ID No. (if different from above) <b>ATC 964</b>		

**NATURE OF ACCIDENT OR ILLNESS**

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First  <b>Blindness</b>		Primary  <b>379</b>
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) <b>01388</b>
Comments:		Referring or Consulting Physician <b>Dr Manwiller</b>

**SERVICES RENDERED**

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY		
09/05/73	OL	Visual Therapy	92065	12.50			
09/10/73	OL	Visual Therapy	92065	12.50			
09/12/73	OL	Visual Therapy	92065	12.50			
09/14/73	OL	Visual Therapy	92065	12.50			
09/17/73	OL	Visual Therapy	92065	12.50			
*Place of Service DG Doctor's Office IL Independent Lab P Patient's Home IH Inpatient Hospital OL Other Location NH Nursing Home RCF Extended Care Fac. OH Outpatient Hosp.		12 Coordination of Other Benefits	Total Charge				
		N/Care Pd. Other Paid Total	62.50				
		N/Care CoIn N/Care Ded. Total	Less				
			Unpaid Balance		62.50	5450	

**PROVIDER CERTIFICATION**

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
	<p>Signature <u>Play Rogers</u> Date <u>11-5-73</u></p>
Resubmittal Indicator	Medical Review

WHILE: State File  
 CARRY: State Suspense  
 MARK: Provider's Copy

Send white & canary copies for payment.

15 Provider Ref

KK

06

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

2161223

A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number Crippled Children Services		NAME W	Name of Provider Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504	
Name of Patient Lombard, Patrick			ELIS. CODE 30P	Provider ID No. SUC 242
Date of Birth 08 / 22 / 71	Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Resource	Payee ID No. (if different from above) ATC 964	
Case No. 112-380				

**NATURE OF ACCIDENT OR ILLNESS**

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First Blindness		Primary 379
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Referring or Consulting Physician Dr Manwiller
Comments:		Service Preauthorization No. (if applicable) 01388

**SERVICES RENDERED**

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STAMP USE ONLY		
10-17-73	OL	Group Visual Therapy	92080	9.00	900		
10-19-73	OL	Visual Therapy	92080	12.50	1090		
10-22-73	OL	Group Visual Therapy	92080	9.00	900		
10-24-73	OL	Group Visual Therapy	92080	9.00	900		
10-26-73	OL	Visual Therapy	92080	12.50	1090		
*Place of Service		12 Coordination of Other Benefits		Total Charge	52.00		
DO Doctor's Office	M/Care Pd.	Other Paid	Total	Less			
IL Independent Lab							
H Patient's Home							
IH Inpatient Hospital							
OL Other Location							
NH Nursing Home	M/Care CoIn	M/Care Ded.	Total	Unpaid Balance	52.00	52.00	
ECF Extended Care Fac.							
OH Outpatient Hosp.							

**PROVIDER CERTIFICATION**

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
	<p>Signature <u>J. Allen</u> Date <u>1-4-74</u></p>
Resubmittal Indicator	Medical Review

WHITE: State File  
 CANCEL: State Suspense  
 FCM: Provider's Copy

Send white & canary copies for payment.

15 Provider Ref

RR

06 P

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

161229

A

10 PATIENT INFORMATION			STATE USE ONLY	PROVIDER INFORMATION		
Coupon or Authorization Number Crippled Children Services			Name of Provider Alaska Treatment Center	3710 E 20th Avenue Anch Ak 99504		
Name of Patient Lombard, Patrick			Race W	Provider ID No. SUC 242		
Date of Birth 08 / 22 / 71		Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Elig. Code 30P	Provider ID No. SUC 242		Category 14
Case No. 672-380			Resource X	Payee ID No. (if different from above) ATC 964		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)	
List Primary Diagnosis First Blindness		Primary 379	
		Secondary	
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) 01388	Referring or Consulting Physician Dr Manwiller
Comments:			

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY		
10-29-73	OL	Group Visual Therapy	92080	9.00			
10-31-73	OL	Group Visual Therapy	92080	9.00			
*Place of Service		12 Coordination of Other Benefits		Total Charge	18.00		
DC Doctor's Office	IL Independent Lab	M/Care Pd.	Other Paid	Total			
H Patient's Home	IH Inpatient Hospital						
OL Other Location	NH Nursing Home						
ECF Extended Care Fac.	OH Outpatient Hosp.	M/Care CoIn	M/Care Ded.	Total			
				Unpaid Balance	18.00		

PROVIDER CERTIFICATION

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."          To the best of my knowledge no other resource exists.</p>		Remarks:	
Signature <i>J. Allen</i>		Date <i>1-4-74</i>	
		Resubmittal Indicator	Medical Review

NOTE: State File  
 CANARY: State Suspense  
 COPY: Provider's Copy

Send white &  
 canary copies  
 for payment.

15 Provider Ref

RR

06

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

161342 A

10 PATIENT INFORMATION				STATE USE ONLY		PROVIDER INFORMATION	
Coupon or Authorization Number Crippled Children Services				Name of Provider Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504			
Name of Patient Lombard, Patrick				Race W			
Date of Birth 8 / 22 / 71		Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>		Elig. Code 30P		Provider ID No. SUC 242	Category 14
Case No. 682-380				Resource X		Payee ID No. (if different from above) ATC 964	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)	
List Primary Diagnosis First Blindness		Primary 379	
		Secondary	
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) 01388	Referring or Consulting Physician Dr Manwiller
Comments:			

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY		
Nov 28 73	OL	Group Visual Therapy	92080	9.00			
Nov 30 73	OL	Visual Therapy	92080	12.50			
Dec 3 73	OL	Group Visual Therapy	92080	9.00			
Dec 5 73	OL	Group Visual Therapy	92080	9.00			
Dec 12 73	OL	Group Visual Therapy	92080	9.00			
*Place of Service DO Doctor's Office II Independent Lab H Patient's Home IH Inpatient Hospital OL Other Location NH Nursing Home ECF Extended Care Fac. OH Outpatient Hosp.		12 Coordination of Other Benefits		Total Charge			
		M/Care Pd.	Other Paid	Total			
				Less			
		M/Care CoIn	M/Care Ded.	Total			
				Unpaid Balance	48.50	1690	

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:	
Signature <i>J. Allen</i>		Date <i>2-1-74</i>	
		Resubmittal Indicator	Medical Review

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

Send white &  
 canary copies  
 for payment.

15 Provider Ref.

KK

06

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital-Practitioner-Home Health Agency Invoice 161343

A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number Crippled Children Services		Rate VV	Name of Provider Alaska Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504	
Name of Patient Lombard, Patrick			Provider ID No. SUC 242	Category 14
Date of Birth 8 / 22 / 71	Sex MXX <input type="checkbox"/> F <input type="checkbox"/>	Elig. Code 20P	Payee ID No. (if different from above) ATC 2964	
Case No. 682-380		Resource X		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First BLINDNESS		Primary 379
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) 01388
Comments:		Referring or Consulting Physician Dr Manwiller

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STAMP USE ONLY
Dec 17 73	OL	Group Visual Therapy	92080	9.00	
Dec 19 73	OL	Group Visual Therapy	92080	9.00	
*Place of Service DO Doctor's Office IL Independent Lab H Patient's Home IH Inpatient Hospital OL Other Location h. Nursing Home ECF Extended Care Fac. OH Outpatient Hosp.		12 Coordination of Other Benefits M/Care Pd. Other Paid Total		Total Charge	18.00
		M/Care CoIn M/Care Ded. Total		Less	
				Unpaid Balance	18.00

PROVIDER CERTIFICATION

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."          To the best of my knowledge no other resource exists.</p>	Remarks:
	<p>Signature <i>J Allen</i> Date <i>2-1-74</i></p>
Resubmittal Indicator	Medical Review

State File  
 State Suspense  
 Provider's Copy

Send white & ganary copies for payment.

15 Provider Ref

RR

06 P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital-Practitioner-Home Health Agency Invoice 161353

A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number Crippled Children Services		Race W	Name of Provider Alaska S Treatment Center 3710 E 20th Avenue Anch Ak 99504	
Name of Patient Lombard, Patrick			Elig. Code 30P	Provider ID No. SUC 242
Date of Birth 8 / 22 / 71	Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Resource X	Payee ID No. (if different from above) ATC 964	
Case No. 672-380				

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First Blindness		Primary 379
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Referring or Consulting Physician Dr Manwiller
Comments:		Service Preauthorization No. (if applicable) 01388

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
11-02-73	OL	Visual Therapy	92080	12.50	OL
11-05-73	OL	Group Visual Therapy	92080	9.00	OL
11-09-73	OL	Visual Therapy	92080	12.50	OL
11-21-73	OL	Group Visual Therapy	92080	9.00	OL
*Place of Service DO Doctor's Office IL Independent Lab H Patient's Home IH Inpatient Hospital OL Other Location NH Nursing Home ECF Extended Care Fac. OH Outpatient Hosp.			12 Coordination of Other Benefits		
			M/Care Pd.	Other Paid	Total
			Total Charge 43.00		
			Less		
			M/Care CoIn	M/Care Ded.	Total
			Unpaid Balance 43.00		

PROVIDER CERTIFICATION

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
	<p>Signature <u>J. Callen</u> Date <u>1-21-74</u></p>
Resubmittal Indicator	Medical Review

22

WRITE: State File  
PRIMARY: State Suspense  
FILE: Provider's Copy  
Send white & carbon copies for payment.

15 Provider Ref

06 P

# ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

## Outpatient Hospital-Practitioner-Home Health Agency Invoice 161479 A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number <b>Crippled Children Services</b>		Name of Provider <b>Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504</b>	Name of Provider	
Name of Patient <b>Lombard, Patrick</b>			Provider ID No. <b>SUC 242</b>	
Date of Birth <b>08 / 22 / 71</b>	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Elig. Code <b>30P</b>	Provider ID No. <b>SUC 242</b>	Category <b>14</b>
Case No. <b>682-380</b>		Resource <input checked="" type="checkbox"/> X	Payee ID No. (if different from above) <b>ATC 964</b>	

### NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First <b>Blindness</b>		Primary <b>379</b>
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) <b>01388</b>
Comments:		Referring or Consulting Physician <b>Dr Manwiller</b>

### SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
09-24-73	OL	Visual Therapy	92080	12.50	
09-26-73	OL	Visual Therapy	92080	12.50	
10-01-73	OL	Visual Therapy	92080	12.50	
10-03-73	OL	Visual Therapy	92080	12.50	
10-05-73	OL	Visual Therapy	92080	12.50	
*Place of Service DO Doctor's Office IL Independent Lab H Patient's Home IH Inpatient Hospital OL Other Location OH Nursing Home ECF Extended Care Fac. OH Outpatient Hosp.		12 Coordination of Other Benefits	Total Charge	62.50	
		M/Care Pd. Other Paid Total	Less		
		M/Care CoIn M/Care Ded. Total	Unpaid Balance	62.50	54.50

### PROVIDER CERTIFICATION

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
	<p>Signature <u>Play Boyer Jr</u> Date <u>11-20-73</u></p>

06

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital-Practitioner-Home Health Agency Invoice 161480 A

10 PATIENT INFORMATION				STATE USE ONLY		PROVIDER INFORMATION			
Coupon or Authorization Number <b>Crippled Children Services</b>				Name of Provider <b>Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504</b>		Provider ID No. <b>SUC 242</b>		Category <b>14</b>	
Name of Patient <b>Lombard, Patrick</b>									
Date of Birth <b>08 / 22 / 71</b>		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		Bill Code <b>30P</b>		Payee ID No. (if different from above) <b>ATC 964</b>			
Case No. <b>682-380</b>				Resource <input checked="" type="checkbox"/>					

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES			Diagnosis Code (opt.)	
List Primary Diagnosis First <b>Blindness</b>			Primary <b>379</b>	
			Secondary	
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			Service Preauthorization No. (if applicable) <b>01388</b>	
Comments:			Referring or Consulting Physician <b>Dr Manwiller</b>	

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY		
10-08-73	OL	Group Visual Therapy	92080	9.00			
10-10-73	OL	Group Visual Therapy	92080	9.00			
*Place of Service		12 Coordination of Other Benefits		Total Charge	18.00		
DO Doctor's Office	IL Independent Lab	M/Care Pd.	Other Paid	Total			
N Patient's Home	IH Inpatient Hospital						
OL Other Location	OH Other Location						
NH Nursing Home	ECF Extended Care Fac.	M/Care CoIn	M/Care Ded.	Total			
OH Outpatient Hosp.							
				Unpaid Balance	18.00	18.00	

PROVIDER CERTIFICATION

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."          To the best of my knowledge no other resource exists.</p>		Remarks:	
Signature <i>Philip Rogers Jr</i>		Date <i>11-20-73</i>	
		Resubmittal Indicator	
		Medical Review	
Revised 5/1/73 06 7014			

STATE: State File  
 FEDERAL: State Receipt  
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15 Provider Ref: **LOMBARD**

06 P

**ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES**  
**Outpatient Hospital-Practitioner-Home Health Agency Invoice** 101637 **A**

10 PATIENT INFORMATION				STATE USE ONLY	PROVIDER INFORMATION			
Coupon or Authorization Number <b>Crippled Children Services</b>				Name of Provider <b>Alaska Treatment Center</b> <b>3710 E 20th Avenue</b> <b>Anch Ak 99504</b>	Provider ID No. <b>SUC 242</b>			
Name of Patient <b>Lombard, Patrick</b>					Category <b>14</b>			
Date of Birth <b>08 / 22 / 71</b>		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		Elig. Code <b>30P</b>		Payee ID No. (if different from above) <b>ATC 964</b>		
Case No. <b>682-350</b>				Resource <input checked="" type="checkbox"/>				

**NATURE OF ACCIDENT OR ILLNESS**

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First		Primary
<b>Blindness</b>		<b>379</b>
Secondary		
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) <b>01388</b>
Comments:		Referring or Consulting Physician <b>Dr Manwiller</b>

**SERVICES RENDERED**

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY		
09/19/73	OL	Visual Therapy	92065	12.50	1090		
09/21/73	OL	Visual Therapy	92065	12.50	1090		
*Place of Service		12 Coordination of Other Benefits		Total Charge	25.00	2180	
DO Doctor's Office	IL Independent Lab	M/Care Pd.	Other Paid	Total			
H Patient's Home	IH Inpatient Hospital						
OL Other Location	NH Nursing Home	M/Care CoIn	M/Care Ded.	Total			
ECF Extended Care Fac.	GH Outpatient Hosp.				Unpaid Balance	25.00	2180

**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:
Signature <b>Ploy Rogers Jr</b>	Date <b>11-5-73</b>	
		Resubmittal Indicator
		Medical Review

WRITE: State File  
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 for payment.

15 Provider Ref

06

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

161209 A

10 PATIENT INFORMATION				STATE USE ONLY		PROVIDER INFORMATION			
Coupon or Authorization number Crippled Children Services				Name of Provider Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504		Provider ID No. SMM 560		Category 14	
Name of Patient Evans, Margaret (Missy)									
Date of Birth 02/ 19 / 69		Sex M <input type="checkbox"/> F <input checked="" type="checkbox"/>		Phys. Code 30P		Payee ID No. (if different from above) ATC 964			
Case No. 126-380				Resource 2C					

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (cpt.)	
List Primary Diagnosis First Cerebral Palsy		Primary 343	
		Secondary	
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) 01867	
Comments:		Referring or Consulting Physician Dr Brown	

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY	
10-16-73	OL	Physical Therapy	97100	14.40	1440	
10-18-73	OL	Group Hydro Conditioning	97240	3.00	300	
10-18-73	OL	Physical Therapy 1 HR	97100	28.80	2880	
10-23-73	OL	Physical Therapy 1 HR	97100	28.80	2880	
10-25-73	OL	Physical Therapy 1 HR	97100	28.80	2880	
*Place of Service DO Doctor's Office IL Independent Lab H Patient's Home IH Inpatient Hospital OL Other Location N Nursing Home ECF Extended Care Fac. OH Outpatient Hosp.		12 Coordination of Other Benefits M/Care Pd. Other Paid Total		Total Charge	103.80	10260
		M/Care CoIn M/Care Ded. Total		Less		
				Unpaid Balance	103.80	10260

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:	
Signature <i>[Signature]</i>		Date <i>4-74</i>	
		Resubmittal Indicator	
		Medical Review	

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15 Provider Ref.

06

**ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES 161211**  
**Outpatient Hospital-Practitioner-Home Health Agency Invoice**

**A**

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number Crippled Children Services			Name of Provider Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504	
Name of Patient Evans, Margaret (Missy)		Rate M	Provider ID No. SMM 560	
Date of Birth 02 / 19 / 69	Sex M <input type="checkbox"/> F <input checked="" type="checkbox"/>	Elig. Code 30P	Category 14	
Case No. 686-380		Resource CC	Payee ID No. (if different from above) ATC 964	

**NATURE OF ACCIDENT OR ILLNESS**

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First Cerebral Palsy		Primary 343
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) 01867
Comments:		Referring or Consulting Physician Dr Brown

**SERVICES RENDERED**

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY		
10-30-73	OH	Physical Therapy	07100	14.40			
*Place of Service DO Doctor's Office IL Independent Lab H Patient's Home IH Inpatient Hospital OL Other Location NH Nursing Home ECF Extended Care Fac. OH Outpatient Hosp.		17 Coordination of Other Benefits M/Care Pd. Other Paid Total		Total Charge	14.40		
		M/Care CoIn M/Care Ded. Total		Less			
				Unpaid Balance	14.40	14.40	

**PROVIDER CERTIFICATION**

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."          To the best of my knowledge no other resource exists.</p>		Remarks:	
Signature <i>J. Allen</i>	Date 1-4-74	Resubmittal Indicator	Medical Review

WHITE: State File  
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15 Provider Ref

06 P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
 Outpatient Hospital-Practitioner-Home Health Agency Invoice 161275 A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number Crippled Children Services		Race: W	Name of Provider Alaska Treatment Center	
Name of Patient Evans, Margaret (Missy)			3710 E 20th Avenue Anch Ak 99504	
Date of Birth 2 / 19 / 69	Sex M <input type="checkbox"/> F <input checked="" type="checkbox"/>	Elig. Code 30P	Provider ID No. SMM 560	Category 74
Case No. 686-382		Resource C	Payee ID No. (if different from above) ATC 964	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First  Cerebral Palsy		Primary  343
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) 01867
Comments:		Referring or Consulting Physician Dr Brown

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
Nov 29 73	OL	Physical Therapy 1 HR	97100	28.80 <del>14.40</del>	2840
Dec 4 73	OL	Physical Therapy 1 HR	97100	28.80	2840
Dec 6 73	OL	Physical Therapy 1 HR	97100	28.80	2840
Dec 6 73	OL	Pool Therapy	97240	3.00	300
Dec 13 73	OL	Physical Therapy 1 HR	97100	28.80	2840
*Place of Service		12 Coordination of Other Benefits	Total Charge	118.20	11660
DO Doctor's Office	IL Independent Lab	M/Care Pd. Other Paid Total	Less		
H Patient's Home	IH Inpatient Hospital				
OL Other Location	NH Nursing Home	M/Care CoIn M/Care Ded. Total	Unpaid Balance	118.20	11660
ECF Extended Care Fac.	OH Outpatient Hosp.				

PROVIDER CERTIFICATION

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."          To the best of my knowledge no other resource exists.</p>	Remarks:
	<p>Signature <u>J. Allen</u> Date <u>2-1-74</u></p>
Resubmittal Indicator	Medical Review

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15 Provider Ref

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P

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Outpatient Hospital-Practitioner-Home Health Agency Invoice

161276

A

10 PATIENT INFORMATION				STATE USE ONLY		PROVIDER INFORMATION	
Coupon or Authorization Number Crippled Children Services				Name of Provider Alaska Treatment Center		3710 E 20th Avenue Anch Ak 99504	
Name of Patient Evans, Margaret (Missy)				Race W		Provider ID No. SMM 560	
Date of Birth 2 / 19 / 69		Sex M <input type="checkbox"/> F <input checked="" type="checkbox"/>		Elig. Code 30P		Category 14	
Case No. 186 502				Resource		Payee ID No. (if different from above) ATC 964	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First  Cerebral Palsy		Primary  343
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Referring or Consulting Physician Dr Brown
Comments:		Service Preauthorization No. (if applicable) 018678

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
Dec 18 73	OI	Physical Therapy 1 HR	97100	28.80	2880
*Place of Service		12 Coordination of Other Benefits		Total Charge	28.80
DO Doctor's Office	M/Care Pd.	Other Paid	Total	Less	
IL Independent Lab	M/Care CoIn	M/Care Ded.	Total	Unpaid Balance	28.80
H Patient's Home					2880
IH Inpatient Hospital					
Other Location					
NH Nursing Home					
ECF Extended Care Fac.					
OH Outpatient Hosp.					

PROVIDER CERTIFICATION

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
	<p>Signature <u>J. Allen</u> Date <u>2-1-74</u></p>
Resubmittal Indicator	Medical Review

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15 Provider Ref

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ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
 Outpatient Hospital-Practitioner-Home Health Agency Invoice 161380 A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization number Crippled Children Services		Rate W	Name of Provider Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504	
Name of Patient Evans, Margaret (Missy)			Elig. Code 30P	Provider ID No. SMM 560
Date of Birth 2 / 19 / 699	Sex M <input type="checkbox"/> F <input checked="" type="checkbox"/>	Payee ID No. (if different from above) ATC 964		
Case No.	Resource C*			

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First Cerebral Palsy		Primary 343
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) 01867
Comments:		Referring or Consulting Physician Dr Brown

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
11-01-73	OL	Group Hydro Conditioning Therapy	97240	3.00	3.00
11-01-73	OL	Physical Therapy	97100	14.40	14.40
11-02-73	OL	Physical Therapy	97100	14.40	14.40
11-06-73	OL	Physical Therapy 1 HR	97100	28.80	28.80
11-08-73	OL	Group Hydro Conditioning Therapy	97240	3.00	3.00
*Place of Service		12 Coordination of Other Benefits	Total Charge	63.60	63.60
DO Doctor's Office	M/Care Pd.	Other Paid	Less		
IL Independent Lab		Total	Unpaid Balance	63.60	63.60
H Patient's Home					
IH Inpatient Hospital	M/Care CoIn	M/Care Ded.			
OL Other Location		Total			
NH Nursing Home					
ESF Extended Care Fac.					
OH Outpatient Hosp.					

PROVIDER CERTIFICATION

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
Signature <i>J. Allen</i> Date 12/1/73	Resubmittal Indicator
	Medical Review

WHITZ: State File  
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ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
 Outpatient Hospital-Practitioner-Home Health Agency Invoice

161361

A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number Crippled Children Services		NAME N	Name of Provider Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504	
Name of Patient Evans, Margaret (Missy)			Provider ID No. SMM 560	Category 14
Date of Birth 2 / 19 / 69	Sex M <input type="checkbox"/> F <input checked="" type="checkbox"/>	Elig. Code 30P	Payee ID No. (if different from above) ATC 964	
Case No.	6812-374	Resource C		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (cpt.)
List Primary Diagnosis First Cerebral Palsy		Primary 343
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) 01867
Comments:		Referring or Consulting Physician Dr Brown

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY		
11-13-73	OL	Physical Therapy	97100	14.40			
*Place of Service		17 Coordination of Other Benefits		Total Charge	14.40		
DO Doctor's Office	IL Independent Lab	M/Care Pd.	Other Paid	Total			
H Patient's Home	IH Inpatient Hospital						
OL Other Location	NH Nursing Home						
ECF Extended Care Fac.		M/Care CoIn	M/Care Ded.	Total			
OH Outpatient Hosp.					Unpaid Balance	14.40	

PROVIDER CERTIFICATION

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
	<p>Signature <u>J. Allen</u> Date <u>1-21-74</u></p>
Resubmittal Indicator	Medical Review

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

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15 Provider Ref.

06

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

161462

A

10 PATIENT INFORMATION				STATE USE ONLY		PROVIDER INFORMATION	
Coupon or Authorization Number <b>Crippled Children Services</b>				Name of Provider <b>Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504</b>		Provider ID No. <b>SMM 560</b>	
Name of Patient <b>Evans, Margaret (Missy)</b>							
Date of Birth <b>02 / 19 / 609</b>		Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		Phys. Code <b>30P</b>		Category <b>14</b>	
Case No. <b>686-302</b>				Resource <b>30</b>		Payee ID No. (if different from above) <b>ATC 964</b>	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First <b>Cerebral Palsy</b>		Primary <b>343</b>
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Referring or Consulting Physician <b>Dr Brown</b>
Comments:		Service Preauthorization No. (if applicable) <b>01867</b>

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
09-27-73	OL	Group Hydro Conditioning	97240	3.00	
09-27-73	OL	Physical Therapy	97100	14.40	
10-04-73	OL	Physical Therapy	97100	28.80	
10-04-73	OL	Group Hydro Conditioning	97240	3.00	
10-11-73	OL	Group Hydro Conditioning	97240	3.00	
*Place of Service		IT Coordination of Other Benefits		Total Charge	
DO Doctor's Office		M/Care Pd.	Other Paid	Total	
IL Independent Lab					
H Patient's Home					
IN Inpatient Hospital					
OL Other Location					
NH Nursing Home		M/Care CoIn	M/Care Ded.	Total	
ECF Extended Care Fac.					
OH Outpatient Hosp.					
				Unpaid Balance	52.20

PROVIDER CERTIFICATION

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
	<p>Signature <u>Ph. Brown</u> Date <u>11-20-73</u></p>

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

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15 Provider Ref. *MME*

06 *P*

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

4161696

A

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization number Crippled Children Services		Name of Provider Alaska Treatment Center 3710 E 20th Avenue Anch Ak 99504	Provider ID No. * 14	
Name of Patient Evans, Margaret (Missy)				
Date of Birth 02 / 19 / 69	Sex M <input type="checkbox"/> F <input checked="" type="checkbox"/>	Elig. Code 30P	Category	
Case No. <i>696-38</i>	Resources <i>X</i>	Payor ID No. (if different from above) ATC 964		

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First cerebral palsy		Primary 343
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) 01867
Comments:		Referring or Consulting Physician Dr Brown

SERVICES RENDERED

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
12-27-73	OL	Physical Therapy	97100	28.80	
01-08-74	OL	Physical Therapy	97100	28.80	
01-10-74	OL	Physical Therapy	97100	28.80	
01-15-74	OL	Physical Therapy	97100	28.80	
01-17-74	OL	Physical Therapy	97100	28.80	
*Place of Service		12 Coordination of Other Benefits		Total Charge	144.00
DO Doctor's Office		M/Care Pd.	Other Paid	Total	
IL Independent Lab					
H Patient's Home					
IH Inpatient Hospital					
C Other Location					
Nh Nursing Home		M/Care CoIn	M/Care Ded.	Total	
ECF Extended Care Fac.					
OH Outpatient Hosp.					
				Unpaid Balance	144.00

PROVIDER CERTIFICATION

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."</p> <p>To the best of my knowledge no other resource exists.</p>	Remarks:
	*Number has been requested
Signature <i>[Signature]</i>	Date <i>3-19-74</i>
Resubmittal Indicator	Medical Review

State Subpart 18  
 Provider's Copy  
 Send white & orange copies for payment.

15 Provider Ref: *MM E*

**06** ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES **161697 A**  
 Outpatient Hospital-Practitioner-Home Health Agency Invoice

10 PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
Coupon or Authorization Number <b>Crippled Children Services</b>		Race <b>W</b>	Name of Provider <b>Alaska Treatment Center</b>	
Name of Patient <b>Evans, Margaret (Missy)</b>			3710 E 20th Avenue Anch Ak 99504	
Date of Birth <b>02 / 19 / 69</b>	Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Elig. Code <b>30P</b>	Provider ID No. <b>*</b>	Category <b>14</b>
Case No. <i>656-380</i>	Resource <b>X</b>	Payee ID No. (if different from above) <b>ATC 964</b>		

**NATURE OF ACCIDENT OR ILLNESS**

DIAGNOSES		Diagnosis Code (opt.)
List Primary Diagnosis First <b>cerebral palsy</b>		Primary <b>343</b>
		Secondary
Have all other payment sources been exhausted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Service Preauthorization No. (if applicable) <b>01897 67</b>
Comments:		Referring or Consulting Physician <b>Dr Brown</b>

**SERVICES RENDERED**

Date of Service	Place of Service*	Description of Medical or Surgical Procedure	1969 RVS Proc. Code	Charge	STATE USE ONLY
01-22-74	OL	Physical Therapy	97100	28.80	<i>1210</i>
01-24-74	OL	Physical Therapy	97100	14.40	<i>1440</i>
01-29-74	OL	Physical Therapy	97100	14.40	<i>1440</i>
01-31-74	OL	Physical Therapy	97100	28.80	<i>1210</i>
*Place of Service DO Doctor's Office IL Independent Lab H Patient's Home IH Inpatient Hospital OL Other Location NH Nursing Home ECF Extended Care Fac. OH Outpatient Hosp.			12 Coordination of Other Benefits		
			M/Care Pd.	Other Paid	Total
			Total Charge <b>86.40</b> <i>6580</i>		
			Less		
			Unpaid Balance <b>8640</b>		<i>6580</i>

**PROVIDER CERTIFICATION**

<p>"This is to certify that the foregoing is true, accurate, and complete, and is in compliance with Title VI of the Civil Rights Act of 1964 which precludes exclusion or discrimination on the ground of race, color, or national origin. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."          To the best of my knowledge no other resource exists.</p>	Remarks:  <b>*Number has been requested</b>
	Signature: <i>[Signature]</i> Date: <i>B-19-74</i>

Rec. copy on Aug. 75

Cascade

CENTRAL OFFICE

STATE OF ALASKA

15 PROVIDER REF.

06

DEPARTMENT OF HEALTH & SOCIAL SERVICES

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

10	PATIENT INFORMATION		STATE USE ONLY	PROVIDER INFORMATION	
COUPON OR AUTHORIZATION NUMBER		NAME OF PROVIDER		NAME OF PROVIDER	
66079E		NAME OF PATIENT		SPENCER P. FALCON MD	
Michael Naumoff		RACE		PROVIDER ID. NO.	
DATE OF BIRTH		ELIG. CODE		CATEGORY	
03/07/67		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		SPS-434	
CASE NO.		RESOURCE		PAYEE ID NO. (if different from above)	

NATURE OF ACCIDENT OR ILLNESS

DIAGNOSES		DIAGNOSIS CODE (OPT.)
LIST PRIMARY DIAGNOSIS FIRST		PRIMARY
Shigella		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 RV5 PROC. CODE	CHARGE	STATE USE ONLY	
2/18/73	DO	Office Care	90000	10.00	1000	1
✓	✓	Injection (Ampicillin)	90030	5.00	500	1
✓	✓	White Blood Count	85030	7.50	400	6
*PLACE OF SERVICE		12 COORDINATION OF OTHER BENEFITS		TOTAL CHARGE	22.50	
DOCTOR'S OFFICE		MEDICARE PAID	OTHER INS.	TOTAL		
INDEPENDENT LAB				LESS		
PATIENT'S HOME				UNPAID BALANCE	22.50 1900	
INPATIENT HOSPITAL						
OTHER LOCATIONS		MEDICARE CO-INS.	MEDICARE DEDUCT.	TOTAL		
NURSING HOME						
EXTENDED CARE FACILITY						
OUTPATIENT HOSPITAL						

PROVIDER CERTIFICATION

THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS 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 AND STATE LAWS.	REMARKS:
--	----------

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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*Return this document  
to Fairclough (Encl. 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

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

<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			

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>
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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	" " "
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ATZ Travel	STR 339313	08-27-75 <sup>73</sup>	40.64	10-27-75	06-33-6-180-215	" " "
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TOTAL Medical Bills (detail attached)			<u>4,805.25</u>			
TOTAL Department of Health & Social Svcs.			<u><u>5,638.24</u></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>
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Fairbanks Med-Surg	96717	03/01/73	12.00	11/28/74	06-33-6-150-380	" "
Fairbanks Med-Surg	96683	11/21/72	30.85	11/28/74	06-33-6-550-380	" "
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	" "
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Ketchikan Med Clinic	-	09/14/71	<u>171.00</u>	11/14/75	06-66-4-112-380	Invoice not rcvd.

(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>						
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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

2/8/90  
Date

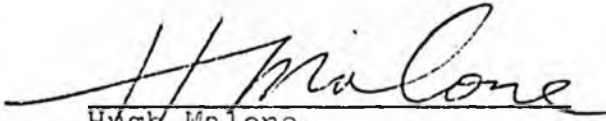
SB 531

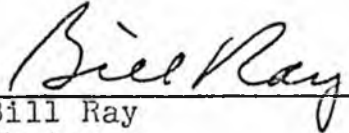
FY 76

Joint Finance Committee  
Intent  
for  
Sponsor Substitute for Senate Bill No. 606  
and  
Senate Bill No. 531

It is the Intent of the House and Senate Finance Committees that the Department of Health and Social Services transfer \$358,200 to Contract Institutions in the Division of Mental Health from general funds available in the Medicaid, General Relief Medical, or Assistance Payments appropriations notwithstanding prior Legislative Intent against transferring such funds.

\$53,200 of such funds are to be granted to the Association of Retarded Citizens of Anchorage in lieu of passage of Sponsor Substitute for Senate Bill No. 606. \$305,000 of such funds are to cover costs at the Atascadero State Hospital, the Fairbanks Rehabilitation Center, and the Association of Retarded Citizens of Anchorage in lieu of passage of Senate Bill No. 531.

  
Hugh Malone  
Chairman  
House Finance Committee

  
Bill Ray  
Chairman  
Senate Finance Committee

FISCAL NOTE

First Session - Ninth Legislature

I. REQUEST  
 Bill No. N/A -- Information requested on Pressure Vessel Section  
 Title: Pressure Vessel Trainee  
 Requested by: Representative McKinnon Date: \_\_\_\_\_  
 Return Date Requested: \_\_\_\_\_  
 Agency: LABOR Program: PRESSURE VESSEL

II. FISCAL DETAIL  
 Budget Request Unit(s) Affected: \_\_\_\_\_  
 A. EXPENDITURES: (Thousands of dollars)

OBJECT	FY 75	FY 76	FY 77	FY 78	FY 79	FY 80
100 PERSONAL SERVICES	0	19.0	1/ 21.3	3/ 22.9		
200 TRAVEL	0	2.3	2/ 2.4	4/ 4.7		
300 CONTRACTUAL	0	0.0	0.0	5/ 0.5		
400 COMMODITIES	0	0.0	0.0	0.0		
500 EQUIPMENT	0	0.3	0.0	0.0		
600 LAND & STRUCTURES	0	0.0	0.0	0.0		
700 GRANTS, CLAIMS, ETC.						
<b>TOTAL</b> <u>6/</u>	<b>0</b>	<b>21.6</b>	<b>23.7</b>	<b>28.1</b>		

B. FUNDING: (Thousands of dollars)

GENERAL FUND	0	21.6	23.7	28.1		
FEDERAL FUNDS						
OTHER						

C. POSITIONS:

PERMANENT/TEMPORARY	0 / 0	1 / 0	1 / 0	1 / 0	/	/
MAN. MONTHS (P./T.)	0 / 0	12 / 0	12 / 0	12 / 0	/	/

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

- NOTES:
1. No C.O.L. increase included, range 17, Step B
  2. 5.5% inflation factor included, in-state travel
  3. No C.O.L. increase included, range 18, Step B
  4. 5.5% inflation factor included, in-state travel plus two month training at ASME, Chicago

- IV. ATTACHMENTS <sup>5</sup> Two month ASME certification course tuition
1. Summary, Pressure Vessel Section Operations
  2. P.V. Inspector Qualifications, from 3.1 to 3.1.4

V. DATE: March 23, 1975 PREPARED BY: Tom Hair

Original: Legislative Finance  
 cc: Budget and Management  
 Prime Sponsor (First Legislator Named)

6/ NOTES, (II: FISCAL DETAIL)

B. Program Summary: Pressure Vessel Section Summary Attached

1. Fiscal Note details cost projections for establishing one new position to be classified as Pressure Vessel Inspector Trainee. Position will be flexibly staffed from Range 16-18.
2. Equipment expenditures, FY'76, are for desk and chair. Travel is for intrastate, FY'76, '77 and intrastate plus two month ASME certification, FY'78, at Chicago, Ill.

shop, the installer or other parties involved in ASME Code related requirements.

### 3. AUTHORIZED SHOP INSPECTORS

#### 3.1 QUALIFICATIONS

All inspectors<sup>1</sup> shall comply with the National Board By-Laws, Articles III and IV, and hold a valid Certificate of Competency issued by a State of the United States or a Province of Canada (where required) and a valid National Board Commission.

An applicant for designation as an Authorized Inspector shall be at least 25 years of age and shall have education and experience equal to at least one of the following:

3.1.1 A degree in Mechanical Engineering plus one year of experience in design, construction, operation or inspection of high pressure boilers and pressure vessels.

3.1.2 A degree in a branch of Engineering other than Mechanical Engineering plus two years of experience in

<sup>1</sup> Shop Inspectors where the ASME Code Symbol Stamps are applied to the boiler, pressure vessel or piping.

design, construction, operation or inspection of high pressure boilers and pressure vessels.

3.1.3 The equivalent of a high school education plus three years of experience:

- (1) in high pressure boiler and pressure vessel construction or repair, or
- (2) as an operating engineer in charge of high pressure boiler operation, or
- (3) as an inspector of high pressure boilers and pressure vessels.

#### 3.2 PRACTICAL EXPERIENCE

In addition to the qualifications of (3.1), before an inspector is permitted to conduct shop inspections, except under direct personal supervision of a qualified Authorized Inspector, he shall:

3.2.1 Have a minimum of one year of diversified field and shop inspection experience in the construction of Section I and/or Section VIII, Pressure Vessels, or one year of

diversified experience as an inspector trainee of items under the direct supervision of an Authorized Inspector or Authorized Inspector Supervisor.

3.2.2 Through performance, have demonstrated his ability to perform shop and assembly (on-site) inspections to the satisfaction of the Authorized Inspection Agency employing him.

3.2.3 Have satisfactory experience and background for the inspection of ASME Code items according to the complexity of the assignment.

3.2.4 Have knowledge of applicable Sections of the ASME Codes, Addenda and Case Interpretations.

3.2.5 Have knowledge of Quality Control Systems, Programs and shop procedures.

3.2.6 Have knowledge and ability to evaluate and monitor shop procedures.

3.2.7 Have knowledge of the requirements for maintenance and retention of in-

transit and permanent records.

#### 3.3 RECOMMENDED TRAINING COURSE

In addition, it is recommended that he attend a training course equivalent to that given by the National Board on Welding and Methods of Nondestructive Examination.

#### 3.4 DUTIES

The Inspector's duties are covered in the applicable ASME Codes and include, but are not limited to, the following:

3.4.1 He shall verify that the manufacturer or installer has the required Certificate of Authorization to fabricate the items to be constructed. It is necessary to check the Certificate to make certain it has not expired and to determine the scope of construction permitted under the terms of the Certificate. THE FACT THAT THE MANUFACTURER OR INSTALLER HAS THE REQUIRED CODE SYMBOL STAMP IS NOT SUFFICIENT EVIDENCE TO

## PRESSURE VESSEL SECTION

Russell D. Molt, Chief Pressure Vessel Engineer

The Pressure Vessel Section has the responsibility to protect the general public from inferior and often hazardous boilers and unfired pressure vessels. This is undertaken by a staff of nationally licensed pressure vessel engineers located in Anchorage, Fairbanks, Juneau, and Ketchikan. This program consists of two completely different areas.

In order for a manufacturer to fabricate a pressure vessel in the State of Alaska, he must first obtain a certificate of authorization to apply the code symbol stamp from the American Society of Mechanical Engineers (ASME). Prior to the issuance of the certificate, the society will request approval of the fabricator's facilities from this section and ascertain that the manufacturer has obtained an inspection contract and is utilizing state engineers. Fees for this service are set by regulation. The shop in question is visited several times during the construction of each pressure vessel to assure that the unit is being built according to the code. After successful completion of the hydrostatic test, the engineer will approve the application of the code symbol stamp and sign the data sheet indication to a prospective purchaser the unit was built under State supervision to the construction standards of the ASME code.

In addition to these duties, section engineers are required to evaluate the condition of all operational boilers and pressure vessels. Boilers with steam pressure in excess of 15 psig require two inspections per year. One is given while the unit is in operation to check the function of controls, safety valves and operator expertise. A thorough examination of all internal surfaces is done during an outage that is convenient to the company. Low pressure boilers and unfired pressure vessels such as air receivers, hot water storage tanks and refinery components are examined externally on a biennial basis or internally where construction permits. Upon completion of each object inspection, a comprehensive written report is sent to the Juneau office indicating whether or not the unit is suitable for certification.

There are approximately 30,000 operational units in Alaska. Of these, approximately 30 percent are insured and inspected by licensed pressure vessel engineers employed by an insurance company. These reports are sent to the Juneau office for processing in the same manner as the state reports. There are approximately 50 insurance field engineers licensed by the section to do business in this State. These licenses are renewable annually.

Certificates of inspection are required in every work place; in every place of public assembly, and in apartment houses containing six or more units. The workload of the section is directly related to business growth within the State. The Pressure Vessel Section is currently acquiring approximately 1,000 new operational objects per year. At the current rate of business and population growth, an additional engineer is required every 1.75 years to maintain the current level of activity.

With the pipeline and related functions not taken into consideration, the pipeline function in late 1974 brought a marked increase in the number of new object inspections for every area except Southeast. Preliminary surveys indicate 1975 will triple the work load in new Pressure Vessels alone, for example; Air Receivers on drilling rigs, Heating Boilers in construction camps, Power Boilers and related refinery components on the various topping plants on the slope. A new refinery is planned for Fairbanks and a LNG plant in Kenai, not to mention the pipeline Pumping Stations.

The national average work load for a field engineer is 1600 object inspections per year in a travel area of 100 sq. miles. There are presently two Pressure Vessel Inspectors based in Anchorage. The static work load is in excess of 3,000 objects per year, per man. There is one position in Fairbanks with a static load of 3,500 objects. These three positions are required to cover the entire State from Yakutat - Northward, an area and object count far in excess of the National average. The static load does not take into consideration new objects since 1970. New objects alone would exceed 4,000.

In addition to State business, the section furnishes inspection service to various departments within the federal establishment that do not employ licensed engineers, e.g. the U. S. Department of Interior, U. S. Army, U. S. Post Office, U. S. Forest Service, Federal Aviation Agency, General Services Administration, U. S. Department of Health, Education and Welfare, U. S. Public Health Service, and Atomic Energy Commission. Fees for this service are set by regulation to compensate the State for time spent on federal property.

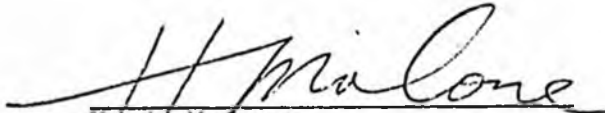
This expanding activity not only requires additions to the engineering staff but clerical staff as well. The Pressure Vessel Technician position is needed in the Juneau office to correlate incoming reports from the State as well as the participating insurance companies.

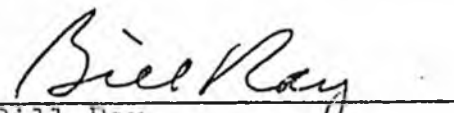
The preceding statistics may be verified by records in the Pressure Vessel Section.

Joint Finance Committee  
Intent  
for  
Sponsor Substitute for Senate Bill No. 606  
and  
Senate Bill No. 531

It is the Intent of the House and Senate Finance Committees that the Department of Health and Social Services transfer \$358,200 to Contract Institutions in the Division of Mental Health from general funds available in the Medicaid, General Relief Medical, or Assistance Payments appropriations notwithstanding prior Legislative Intent against transferring such funds.

\$53,200 of such funds are to be granted to the Association of Retarded Citizens of Anchorage in lieu of passage of Sponsor Substitute for Senate Bill No. 606. \$305,000 of such funds are to cover costs at the Atascadero State Hospital, the Fairbanks Rehabilitation Center, and the Association of Retarded Citizens of Anchorage in lieu of passage of Senate Bill No. 531.

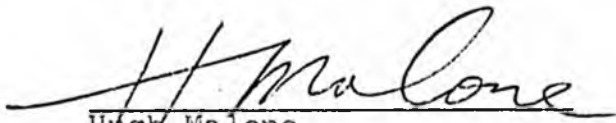
  
Hugh Malone  
Chairman  
House Finance Committee

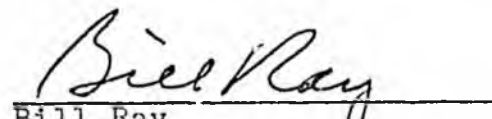
  
Bill Ray  
Chairman  
Senate Finance Committee

Joint Finance Committee  
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Hugh Malone  
Chairman  
House Finance Committee

  
Bill Ray  
Chairman  
Senate Finance Committee

COMMITTEE REPORT

1/29/76

SENATE

Mr. President:

Date \_\_\_\_\_

The Committee on FINANCE has had SB 531 supplemental appropriation for mental health contract institutions 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:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Members NOT concurring in the Majority report:

\_\_\_\_\_ recommends:  
 \_\_\_\_\_ recommends:  
 \_\_\_\_\_ recommends:  
 \_\_\_\_\_ recommends:  
 \_\_\_\_\_ recommends:

\_\_\_\_\_ Chairman

COMMITTEE REPORT

\*\*FINANCE\*\*

SENATE

1/19/76

Mr. President:

Date 1-28-76

The Committee on HEALTH, EDUCATION AND SOCIAL SERVICES has had SB 531 supplemental appropriation for mental health contract institutions 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:

*Ferguson* \_\_\_\_\_

*Genie Chance* \_\_\_\_\_

*Brad Bradley* \_\_\_\_\_

\_\_\_\_\_

Members NOT concurring in the Majority report:

\_\_\_\_\_ recommends:

\_\_\_\_\_ recommends:

\_\_\_\_\_ recommends:

\_\_\_\_\_ recommends:

\_\_\_\_\_ recommends:

*Ferguson* Chairman

531

Introduced: 1/19/76  
Referred: Health, Education  
and Social Services and  
Finance

BY THE RULES COMMITTEE BY  
REQUEST OF THE GOVERNOR

1 IN THE SENATE

2 SENATE BILL NO. 531

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 supplemental appropriation to the  
7 Department of Health and Social Services for mental  
8 health contract institutions; and providing for an  
9 effective date."

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

11 \* Section 1. The sum of \$305,000 is appropriated from the general fund  
12 to the Department of Health and Social Services for mental health contract  
13 institutions.

14 \* Sec. 2. This Act takes effect immediately in accordance with AS 01.-  
15 10.070(c).

SB 531

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 supplemental appropriation to the Department of Health and Social Services for mental health contract institutions. This amount will fully fund the cost of care for persons in Atascadero State Hospital in California and in state institutions for care of the mentally retarded.

Sincerely,

Jay S. Hammond  
Governor

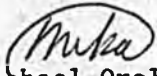
STATE  
of ALASKA

## MEMORANDUM

SB 531

TO:  FILE

DATE : January 6, 1976

FROM:   
Michael Orelove, Budget Analyst  
Division of Budget and Management  
Department of AdministrationSUBJECT: Department of Health and Social  
Services, FY 76 Supplemental Request  
of \$305.0 for Contract InstitutionsMental Retardation Program

\$65.0

The legislature funded this BRU as requested at the Governor's original level. By legislative intent, they funded two programs not approved, but they did not add the funding stating that "the remaining funds (will be) allocated at the Department's discretion". At the present time, there are no funds available within the Department. These facilities meet full cost of care and intent is expressed as: "The . . . two identified programs are to be fully funded - at \$20,000 (for Fairbanks Rehabilitation Program) and \$45,000 (ARCA)".

Atascadero State Hospital

\$240.0

The number and severity of mentally disordered offenders has exceeded the budgeted amount in this BRU. The Division was budgeted for 9 patients for 3 months. At the present time, 14 patients have been committed to this program and several more are expected before the end of this fiscal year. 75% of these cases have committed murder and require long periods of treatment.

The construction of the psychiatric security unit at API has been delayed because of the unavailability of certain supplies. Completion of the unit is now expected by April 1, 1976. This small unit will not be able to provide care for all the mentally disordered offenders referred by the courts.

MO/lw

# MEMORANDUM

TO: Francis S. L. Williamson  
Commissioner  
Department of Health and Social Services

Thru: Catherine Lloyd  
Deputy Commissioner  
Administrative Management

From: Jerry L. Schrader, M.D.  
Director  
Division of Mental Health

DATE : November 26, 1975

SUBJECT: Supplemental Request:  
Division of Mental Health

The Division of Mental Health is facing budgetary short-falls in three areas as a result of a) legislative intent without funding; b) continued care of several more mentally disordered offenders for a longer period of time than expected during FY 1976 budget preparations at Atascadero State Hospital; c) increase in inter-agency charges at Harborview Memorial Hospital from the Department of Highways for heat and rent, effective July 1, 1975, without advance notice for budgetary preparation.

The Budget Request Units (BRU) and the amounts involved are summarized below:

A. Contract BRU

1. Mental Retardation Program:

The Legislature funded this BRU as requested at the Governor's original level. By legislative intent, they funded two programs not approved, but they did not add the funding stating that "the remaining funds (will be) allocated at the Department's discretion". At the present time, there are no funds available within the Department. These facilities meet full cost of care and intent is expressed as: "The . . . two identified programs are to be fully funded - at \$20,000 (for Fairbanks Rehabilitation Program) and \$45,000 (ARCA)".

\$65,000

2. Atascadero State Hospital

The number and severity of mentally disordered offenders has exceeded the budgeted amount in this BRU. The Division was budgeted for 9 patients for 3 months. At the present time, 14 patients have been committed to this program and several more are expected before the end of this fiscal year. 75% of these cases have committed murder and require long periods of treatment.

The construction of the psychiatric security unit at API has been delayed because of the unavailability of certain supplies. Completion of the unit is now expected by April 1, 1976. This small unit will not be able to provide care for all the mentally disordered offenders referred by the courts.

The referrals just for pre-trial psychiatric evaluation have increased from 8/month to 12/month and must be given priority for the beds in this unit. The Division plans to provide long term treatment on this unit for approximately 5 to 7 mentally disordered offenders. This will require a continuation of treatment services purchased at the Atascadero State Hospital in the foreseeable future.

In addition to the large increase in clients in this program, the Atascadero State Hospital increased its charges 10% as of July 1, 1975. Based on our past experience with them, the Division expects another 10% increase in January 1976. The Atascadero cost allocation system is complex and these increases are reflected in a variety of specific charges. For example, the current room charge for patients on a regular ward was increased in July from \$33.20 to \$38.75. Similar increases have occurred in laboratory, physician, clinic, dental, radiology, and other services.

Assumptions and computations in determining Atascadero short-fall:

Budget authorization was for three months at \$900/pt/mo. average for 9 patients. As of September 30, 1975 we had 14 patients at an average cost of 1,272.43 for that month for estimated total of \$47,581.15.

We anticipate:

1. Due to delays in construction and equipping, we do not now expect the Security Unit at API to be available before April 1, 1976.
2. A 10% increase in cost of care effective January 1, 1976.
3. Continued patient census increase at Atascadero: November Add 1, December Add 2, January-April Add 1 each month.
4. Patient load should stabilize in February at 18. Patient returns will depend upon patient condition and when the security unit actually becomes physically operational, and our actual capacity to absorb the existing patients at Atascadero.

Budget Appropriation	\$24,300
Existing Appropriation:	
14 patients, end of September 1975	
Total expenditure	<u>47,521</u>
Existing shortage 9/30	<u>23,281</u>
October 1975 = at 14 patients	17,919.02
November 1975 = at 15 patients	19,086.45
December 1975 = at 17 patients	<u>21,631.31</u>
Sub Total	<u>58,536.78</u>
Total estimated short-fall, 6 mo.	<u>81,818.</u>

If 18 patients are hospitalized at Atascadero for the remaining 6 months, short-fall can be estimated at 10% increase per patient per month \$1,399.67.

Estimated total short-fall for Atascadero FY 76.	<u>\$151,164.36</u>
	<u>232,982.36</u>

B. Harborview Memorial Hospital

Interagency charges by Department of Highways for heat, steam and rent of space.

In July 1975, we were informed by the Department of Highways that the cost to Harborview for utilities and space rental in the boiler plant building was going to be immediately increased. A review of their accounts indicated:

November 26, 1975

Page 3

Steam & Heat*	\$281,400
Space rental	<u>22,000</u>
Total	<u>303,400</u>
Appropriated	<u>214,000</u>
Short-fall Payable to Dept. of Highways	<u>89,400</u>
Total Supplemental Request:	<u>89,400</u>

\*(Using average consumption of 3,310,830 gals. of steam condensate return  
@ .085¢ per gal.)

JLS:CL:prv

STATE OF ALASKA  
 Dept. of Administration  
 Budget & Management Div.

REVISED PROGRAM  
 COST ANALYSIS SUMMARY  
 by BUDGET COMPONENT

SUPPLEMENTAL

AGENCY Health and Social Services DIVISION Mental Health	CATEGORY PROGRAM SUB-PROGRAM ELEMENT SUB-ELEMENT	code 03 32 02	Health Mental Health Contract Inst.
---	--	------------------------	---

CODE	EXPENDITURE BY OBJECT	PRESENT AUTHORIZATION	REVISION INCREASE, (DECREASE)	AMENDED AUTHORIZATION
100	PERSONAL SERVICES			
200	TRAVEL	6.5	7.0	13.5
300	CONTRACTUAL SERVICES	1409.2	298.0	1707.2
400	COMMODITIES			
500	EQUIPMENT			
600	LANDS, BUILDINGS, NON-STRUCTURAL IMPROVEMENTS			
700	GRANTS, CLAIMS, SHARED REVENUE			
800	MISCELLANEOUS			
	INTER-AGENCY TRANSFERS (INCLUDED ABOVE)			
<b>NEW CODE</b>	<b>TOTAL</b>	1415.7	305.0	1720.7
	FEDERAL RECEIPTS			
	REQUIRED GENERAL FUND MATCHING			
	OTHER GENERAL FUND	1415.7	305.0	1720.7
	INTER-AGENCY TRANSFERS			
	OTHER:			
	<b>TOTAL</b>	1415.7	305.0	1720.7
	PERMANENT FULL-TIME POSITIONS	---	---	---
	PERMANENT PART-TIME POSITIONS			
	TEMPORARY (FULL-TIME EQUIVALENTS)			
	NUMBER OF MAN MONTHS	---	---	---

(CURRENT FY)

	FY ____	FY ____	FY ____	FY ____	FY ____	FY ____
EXPENDITURES - TOTAL						
SOURCE OF FUNDS						
FEDERAL						
REQ. G.F. MATCH						
OTHER G. F.						
OTHER (SPECIFY)						

ALASKA STATE LEGISLATURE

NINTH Legislature SECOND Session

SENATE BILL NO531

By THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

"An Act making a supplemental appropriation to the Department of Health and Social Services for mental health contract institutions; and providing for an effective date."

supp. approp. for mental health contract institutions  
Introduced in the Senate 1/19, 1976

HISTORY IN THE SENATE

1976

1 19

Read first time and referred to Committee on

Health, Education and Social Services and Finance

Reported back with recommendation that *Hess: no rec to Finance*

Read second time and

Read third time and

PASS	Effective Date
Yeas	Yeas
Nays	Nays
Absent	Absent
Excused	Excused

Reconsideration

PASS	Effective Date
Yeas	Yeas
Nays	Nays
Absent	Absent
Excused	Excused

Reported correctly engrossed  
Signed by President  
Sent to House

SECRETARY OF THE SENATE

HISTORY IN THE HOUSE

19

Read first time and referred to Committee on

Reported back with recommendation that

Read second time and

Read third time and

PASS	Effective Date
Yeas	Yeas
Nays	Nays
Absent	Absent
Excused	Excused

Reconsideration

PASS	Effective Date
Yeas	Yeas
Nays	Nays
Absent	Absent
Excused	Excused

Reported correctly engrossed  
Signed by Speaker  
Returned to Senate

CHIEF CLERK OF THE HOUSE

HISTORY IN THE SENATE

19

Received from House

Reported correctly enrolled

Sent to Governor

..... By Governor

Filed with Lt. Governor

Chapter No. ....

Introduced: 1/19/76  
Referred: Health, Education  
and Social Services and  
Finance

1 IN THE SENATE

BY THE RULES COMMITTEE BY  
REQUEST OF THE GOVERNOR

2 SENATE BILL NO. 531

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 supplemental appropriation to the  
7 Department of Health and Social Services for mental  
8 health contract institutions; and providing for an  
9 effective date."

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

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14 \* Sec. 2. This Act takes effect immediately in accordance with AS 01.-  
15 10.070(c).

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# STATE OF ALASKA

## THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

JUNEAU 99801

AUDIT DIVISION  
POUCH W — ALASKA OFFICE BUILDING

FINANCE DIVISION  
POUCH WF — STATE CAPITOL

### MEMORANDUM

TO: The Hon. Bill Ray  
Chairman  
Senate Finance Committee

DATE: February 10, 1976

FROM: Milt Barker  
Fiscal Analyst  
Legislative Finance

SUBJ: SB 531

As Ms. Debbie Staack pointed out, Contract Institutions received \$499,000 in Interagency Funds from Medicaid, and their General Fund appropriation was reduced by half of this amount. Arguably, under Sec. 13 of the FY 76 General Appropriations Act, Contract Institution's General Funds should have been reduced the full amount of the additional Interagency Receipts. However, RP 76-142 was approved which permits an increase of \$249,500 in Contract Institutions' total appropriation.

If the Committee now wishes the funds required under SB 531 to be transferred from Medicaid, or several other areas, they are available as indicated by the attached memo.

MBB/aef  
Attachment

# STATE OF ALASKA

## DEPT. OF HEALTH AND SOCIAL SERVICES

JAY S. HAMMOND, GOVERNOR

OFFICE OF THE COMMISSIONER

POUCH H-01 - JUNEAU 55811

January 30, 1976

Document# HFC 4

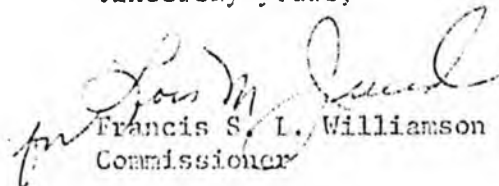
Mr. Milt Barker  
Financial Analyst  
Division of Legislative Finance

Dear Mr. Barker:

Pursuant to a verbal request by the House Finance Committee during a meeting on January 22, we have prepared the enclosed summary of projected June 30, 1976 balances for all BRU's in the Department of Health and Social Services. Because of the time lag in the State's accounting system these projected balances have been necessarily based on cost data covering only three to five months into the current fiscal year. Consequently certain factors which might occur during the remainder of the year could result in dramatic changes in the projected balances before the year is ended. Where appropriate, we have made comments concerning factors which have been the basis for our projections at this point in time.

Please contact our Administrative Services Division if you have any questions concerning this matter.

Sincerely yours,

  
Francis S. L. Williamson  
Commissioner

Enclosure

FY'76 Projected Year-End Balances  
per December 31, 1975 Forecast

<u>Budget Request Unit</u>	<u>Amount</u>	<u>GF</u>	<u>Remarks</u>
Special Education Grants	--		
ATU Nursing Grant	--		
Public Health Nursing	(35.9)	-	Supplemental request for 25.0 submitted
Community Health	(27.5)	-	Supplemental request for 18.5 submitted
Environmental Health	(2.0)	-	
Child & Family Health	36.9	22.1	Balance to be totally offset by filling Medical Director & PHN Supervisor positions and resulting clinics
Laboratories	18.9	17.3	Filling of vacant positions will reduce projected balance to zero
Health Program Support	7.6	7.6	
Certification & Licensing	14.8	-	Federal funds available only in this BRU
Public Health Administration	28.8	26.7	Filling of Director, Deputy Director and clerk position will utilize all projected lapses
Vital Statistics	4.2	4.2	
Alaska Psychiatric Institute	(73.7)		
Harborview Memorial Hospital	(55.3)		Supplemental Request for 39.4 submitted SB 532
Contract Institutions	(304.5)		Supplemental Request for 305.0 submitted SB 531
State Operated M.H. Centers	(15.8)		Supplemental Request for 23.3 submitted
Community Operated M.H. Centers	--		
M.H. Administration & Support	(30.8)		

Program Services	(268.2)		Supplemental request to be submitted
Alcatraz	10.1	2.0	
Social Services	(184.6)		plus (49.1) = (233.7)
Administration & Support	2.8	1.7	
Staff Development	(15.3)		
FIN/AFDC	271.8	27.7	Reduction in Federal funding ; probably reduce balance to zero
Adult Confinement	14.3	14.3	
Juvenile Confinement	(62.5)		Supplemental request for 42.6 submitted 118,573
Probation & Parole	(51.8)		
Admin. & Support	8.7	2.7	
Medicaid	1,023.4	50.0	Case loads have not increased as much as anticipated (50% Federal funds)
General Relief Medical	1,581.9		Represents efforts to control expenditures
Assistance Payments	(637.4)		Case loads slightly below original estimates
Eligibility Determination	27.3	27.3	
Public Assistance Administration	3.8		
BHSS--Admin & Support	(3.8)		
Quality Control/Collection			
Office on Aging	15.4	1.4	
Child Support Enforcement			

Drug Abuse	2.4	1.7
Planning & Research	(19.3)	
Violent Crimes Comp. Board	5.3	5.3
Parole Board	(10.8)	
Office of Alcoholism	(796.9)	

Due to shortfall in Federal receipts. RP and supplemental request  
in preparation

ANALYSIS OF SENATE BILL NO. 531

For an Act entitled: "An Act making a supplemental appropriation to the Department of Health and Social Services for mental health contract institutions; and providing for an effective date."

Section 1 is a new section which provides for appropriation of \$305,000 from the general fund to Department of Health and Social Services for mental health contract institutions.

Section 2 is a new section which provides for the Act to be effective immediately.

POINTS OF VIEW ON BASIS OF NEED  
FOR SUPPLEMENTAL APPROPRIATION

- I. Legislative Intent to Fund Workshops at Fairbanks Rehabilitation Program and ARCA

Justification

The FY 76 Free Conference Committee Report included a statement of legislative intent which affected this Budget Request Unit.

The work activities programs of the Fairbanks Rehabilitation Association and ARCA are to be fully funded from the appropriation. At \$20,000 and \$45,000 respectively, with the remaining funds allocated at the Department's discretion.

The Department views this as a requirement to fund these programs, although they were "not approved" for inclusion in the Governor's budget request. No additional funds were included in order to implement the intent. Transfer of funds from other budget request units to provide for these services is not possible this year as there are no available funds from the Department, per Budget and Management memo of January 6, 1976.

Rebuttal

The following is an analysis of the process by which the FY 76 appropriation for the Contract Institutions Budget Request Unit was made.

<u>Program</u>	<u>Dept.'s Request</u>	<u>Gov.'s Budget</u>	<u>Legis. Intent</u>	<u>Free Conference Committee</u>
Frbks. Rehab- ilitation Ass.				
Hope Center Residential	\$ 299,380	\$ 299,380	NO MENTION	NO
Hope Indus- tries	Ø	Ø	\$20,000	REDUCTION
ARCA				FROM
Workshop Program	64,693	64,693	NO MENTION	GOVERNOR'S
Activity Center Program	45,174	Ø	45,000	REQUEST
	_____	_____	_____	_____
TOTAL FOR <u>ALL</u> CONTRAC- TUAL SERVICES (INCLUDING THE ABOVE)	\$1,114,300	\$1,049,100	\$65,000	\$1,049,100

REMAINDER FOR  
DEPARTMENT'S DISCRETION -  
\$984,000 or 93.8% OF TOTAL GOVERNOR'S REQUEST

The Legislature only channeled 6.2% or \$65,000 of the total appropriation through its intent. Legislative intent clearly stated that the \$65,000 was earmarked for ARCA and Fairbanks Rehabilitation Association and the "remaining funds allocated at the Department's discretion". The original budget request had included funds for ARCA and the Fairbanks Rehabilitation Association, and the intent appears to have been added to insure the channeling of funds to those agencies. The legislative intent was merely stating a readjustment of funding designations. Basing a supplemental request on the legislative intent appears to require additional justification.

II. Funding Shortage at Atascadero State Hospital for Mentally Disordered Offenders

Justification

The Division of Mental Health was originally budgeted for 9 patients for 3 months of care for mentally disordered offenders. The numbers and severity of these type of offenders require treatment costs beyond the FY 76 budgeted amount. Current patient loads of 14 far exceed the projected 9 patients for the fiscal year.

The Department anticipates the psychiatric security unit at API to be open on April 1, 1976, because of a delay due to unavailability of certain supplies. The unit will not be able to provide care for all the mentally disordered offenders referred by the courts so care for some of them will be contracted to other facilities.

Rebuttal

A. Availability of Funds from API Psychiatric Security Unit

The contract institutions budget request unit was funded at the level requested by the Agency. That request included 9 persons care for only 3 months or FY 76 at Atascadero, in anticipation that the Psychiatric Security Unit at API

would be opened for 10 months of FY 76. The Legislature seeing that the construction project for the Psychiatric Security Unit had not gone to bid by May 15, 1975, reduced the appropriation to that unit. It was anticipated, as stated in legislative intent that the unit would be open for only 6 months, therefore a reduction in funding for staff and other necessities seemed in order. The legislative intent also stated that a supplemental would be considered necessary if "early completion necessitates greater funding".

Therefore, the Department received the following funds for mentally disordered offenders:

<u>Institution</u>	<u>Months of Care</u>	<u>Total Appropriation</u>
Atascadero	3 months	\$ 24,300
Psychiatric Security Unit	6 months	\$218,200

The Legislature appropriated funds for 9 months of care (3 months at Atascadero and 6 months at API Psychiatric Security Unit). 3 additional months of service were required for these patients, but appear to be unfunded.

The Psychiatric Security Unit is now scheduled to be completed by April 1, 1976, due to delays caused by construction problems. Basically this unit will be able to provide maximum of 3 months of service during FY 76, instead of the 6 months as was previously anticipated. The Department makes no mention in its justification of the use of the extra funding. Projected excess of fund at Psychiatric Security Unit due to delayed opening would be approximately \$103,700 for FY 76. (See Chart A)