ALASKA LEGISLATURE 2412

HOUSE and SENATE FINANCE COMMITTEE FILES, 2001 - 2002

907-451-2043

FY 00

INVOICE

Department OF Family and Youth Services

AUG [illegible] 2001
SPECIAL NEEDS

Tutoring Contract for [redacted] 401801432

Due in Full: $800.00
All tutoring has been completed with excellent results for this young man.
Thank you for providing this opportunity for me to have been of service.

Donna Sherrouse
Donna Sherrouse, Ed.D. Date Submitted: August 1st, 2001

ph # no longer active

Please call 972-208-9851 if there are questions. The same number may be used as a fax but you must call first.

My new address is

Dr. Donna Sherrouse
4677 Home Place
Plano, Texas 75024

I certify that this is a just and proper bill and authorize its payment.

Signature [signature] Date 9/10/01

800.00

00 -06213 063 . 7 7333 $
Year - Collocation - Expenditure - Amount

-06213 . 7 ______ $
Year - Collocation - Expenditure - Amount

003F1866
OI# 401801432

Judy Z[illegible] 1-11-02

Alaska Department of Health and Social Services
Division of Family and Youth Services

345	Barrow	003F1866
Region	Office	Request #

REQUEST FOR SPECIAL NEEDS FUNDS FOR FOSTER CARE

Special Needs funding is assessed on an as-needed basis only and pre-authorization is required.
Limitation: This form is to used only for one time or irregular special needs expenditures on behalf of children in foster care.
Receipts and supporting documentation are required.

Child's Name: [redacted] DOB: 04/02/92 Prober Case Number: 401801432

Eligibility Status: (check one) ☐ Title IV-E eligible ☒ Not IV-E eligible ☐ Eligibility pending

Proposed services are for ☒ Child or ☐ Parent(s) or ☐ Sibling(s) or ☐ Other family members

Proposed services are court-ordered ☐ (please attach court order)

I. **Describe the specific need and how the request is consistent with the case plan (case plan must be attached).**

SEE #4 OTHER

II. TITLE IV-E FOSTER CARE MAINTENANCE

1. Clothing - Initial (Refer to CPS Chapter 6.0, Section 6.2.2.8 for policy) $_____
2. Clothing – Extraordinary & Justified by Case Plan $_____
3. Food – Special Diet $_____
4. Extr[illegible]ary Laundry (Must have medical or psychological) $_____
   Describ[e]: _____
5. Personal Incidentals $_____
   Describe: _____
6. Special One-Time Items $_____
   ☐ Special cribs, beds, mattresses
   ☐ Other (must be explained and within allowable DFYS regulations)
   Describe: _____

ENTERED

7. Visitation with Family – Long Distance telephone cards for the child $_____
8. Licensed Child Care (Please provide DFYS license number_____) $_____
   Licensed Child Care for foster child:
   ☐ during foster parent's employment when the foster child is not in school
   ☐ during the foster parent's attendance at mandatory foster parent training
   ☐ during foster parents attendance at case conference, case reviews, court hearing, without foster child
   ☐ which facilitate the foster parent's attendance at Division approved activities which are beyond the scope of "ordinary parental duties"
9. Travel - Child family visitation $_____

II.A. SUB-TOTAL – IV-E FOSTER CARE MAINTENANCE	$_____

III. TITLE IV-E FOSTER CARE ADMINISTRATIVE

1. Travel $_____
   ☐ Miles over 50 per week for foster child's attendance at administrative case or judicial reviews
   ☐ Foster child pre-placement visit or placement with foster home
   ☐ Foster Parents attendance at administrative case/judicial reviews and mandatory case conferences/team meetings
   ☐ Other approved travel by foster child as part of case plan
   Describe: _____
   ☐ Escort Travel as justified by case plan (may require travel authorization)
   ☐ For Visitation

REQUEST FOR SPECIAL NEEDS FUNDS FOR FOSTER CARE

Child's Name: ____________ ______

☐ For Placement

2. Foster Parent Damages and loss — $______
Refer to CPS Adm. Chapter 6.0, section 6.2.2.7 (4) (b)
Please attach form 06-9440 and police report if applicable.

3. Shipping & Freight Costs (Child's belongings only) — $______

4. Other-Services critical for completion of the case plan — $______
- ☐ Genetic/Paternity Testing
- ☐ Advertising for Missing Parents
- ☐ Birth Certificates
- ☐ Expert Witnesses (ICWA/Non-ICWA)
- ☐ Supervised Visitation
- ☐ Court Teleconference Costs

III.A. SUB-TOTAL IV-E FOSTER CARE ADMINISTRATIVE $______

IV. NON-IV-E REIMBURSEMENT

1. Independent Living – Limited to those expenses that facilitates the transition of foster children to independent living that are not otherwise reimbursable under maintenance or administration or other resource. — $______
Describe: ______

2. Medical, Dental, Diagnostic, Therapeutic, and Assessment Services — $______
As payer of last resort (no Medicaid coverage or other third party reimbursement)
Refer to 7 AAC 53.320.
- ☐ Medical Describe: ______
- ☐ Dental Describe: ______
- ☐ Diagnostic (i.e. Psych evaluations) Describe: ______
- ☐ Therapeutic (i.e. Counseling) Describe: ______
- ☐ Assessment Services Describe: ______
- ☐ Medical equipment, furnishings, or discretionary devises for children with special needs
  Describe: ______
- ☐ Travel Describe: ______

3. Unlicensed Child Care for Foster Child — $______
- ☐ During foster parent's employment when the foster child is not in school
- ☐ During the foster parent's attendance at mandatory foster parent training
- ☐ During foster parents attendance at case conference, case reviews, court hearing, without foster child
- ☐ Which facilitate the foster parent's attendance at Division approved activities which are beyond the scope of "ordinary parental duties"

4. Other [illegible]vices critical for completion of the case plan of a child in foster care when [illegible] other resources are available — $ 800.00
Describe: [redacted], was placed in an Inupiat Immersion class for his lower grades and as a result cannot read at his grade level in English. The foster parents told me that the elementary school recommended removing David Jr. from the Inupiat Immersion class because the language wasn't being reinforced in the parental home and David was falling behind in his school work. David is now having problems in school related to his reading ability. According to the foster parent, David's younger brother who wasn't in the Inupiat Immersion class is reading better than his older brother and this is causing problems in the home. The foster parents have asked if David can receive tutoring for reading at the North Slope Montessori School. The cost is $20 per day and four days per week are re[illegible]ended for a total of 40 classes in order to improve one grade level. The cost for ten weeks is $800.

Child's Name: ______________ ______________

IV.A. SUB-TOTAL NON-IV-E REIMBURSABLE	$ 800.00

V. EXPLAIN HOW ALTERNATIVE SOURCES OF FUNDING FOR ALL ITEMS ABOVE HAVE BEEN EXHAUSTED: This is an extra cost that the foster parents can't afford. A petition to terminate the parental rights of this child has been filed.

VI. TOTAL COST: $ 800.00

VII. ☒ one time cost ☐ short term costs (date) __/__/__ to __/__/__

VIII. Payee Name ~~North Slope Montessori Academy~~ Donna Shemouse Address ~~P. O. Box 409, Barrow, AK~~

IX. SSN or Fed Tax ID# ______ Vendor # (PVN) ______ Reimbursement ☐

X. Jacqueline Poole 3180 04/03/00
Social Worker Signature PCN Date

XI. APPROVALS:

[signature] 2462 4/13/00 Susan Artes 3016 4/14/00
S.W. IV Signature PCN Date S.W. V Signature PCN Date

Karina Harm 4/5/00 ______ __/__/__
Children's Services Manager Date Family Services Program Administrator Date
Required for Requests exceeding $1,500.00 and Out-of-State Travel

XII. FISCAL INFORMATION (To be filled out by fiscal)

CATEGORY	COST	CODING
IV-E Foster Care Maintenance (II.A.)	$	
IV-E Foster Care Administrative (III.A.)	$	
Non-IV-E Reimbursable (IV.A.)	$	
TOTAL OF REQUEST:	$ ~~[illegible]~~ 400	

SB

291/292

(File 3)

SFIN

FILE

Alaska Department of Health and Social Services
Division of Family and Youth Services

341 Region | Kotzebue/MFR Office | 023F527 Request #

REQUEST FOR SPECIAL NEEDS FUNDS FOR RESIDENTIAL CARE

Special Needs funding is assessed on an as-needed basis only and pre-authorization is required.
Limitation: This form is to used only for one time or irregular special needs expenditures on behalf of children in residential care.
Receipts and supporting documentation are required.

Child's Name: [redacted] DOB: 02-28-93 Prober Case Number: 402120620

Eligibility Status: (check one) ☒ Title IV-E eligible ☐ Not IV-E eligible ☐ Eligibility pending

Proposed services are for ☒ Child or ☐ Parent(s) or ☐ Sibling(s) or ☐ Other family members

Proposed services are court-ordered ☐ (please attach court order)

I. **Describe the specific need and how the request is consistent with the case plan (case plan must be attached).**
Child entering ARC Anchorage Student Residential Living Center, while attending school for the deaf, requires funds in an account to cover extra curricular activities and school photos etc., He has been at Putyuk Children's Home since placement with his grandparent's failed. Grandparent's were not receiving any financial assistance.

II. TITLE IV-E FOSTER CARE MAINTENANCE

1. Clothing - Initial (Refer to CPS Chapter 6.0, Section 6.2.2.8 for policy) $____
2. Clothing – Extraordinary & Justified by Case Plan $____
4. Special One-Time Items $ 200.00
   - ☐ Special cribs, beds, mattresses
   - ☒ Other (must be explained and within allowable DFYS regulations)
   - Describe: Account for extra curricular activities
5. Visitation with Family – Long Distance telephone cards for the child $____
6. Travel - Child family visitation $____

II.A. SUB-TOTAL IV-E FOSTER CARE MAINTENANCE	$ 200.00

III. TITLE IV-E FOSTER CARE ADMINISTRATIVE

1. Travel $____
   - ☐ Foster child pre-placement visit or placement with foster home
   - ☐ Other approved travel by foster child as part of case plan
   - Describe: ____
   - ☐ Escort Travel as justified by case plan (may require travel authorization)
     - ☐ For Visitation
     - ☐ For Placement
2. Shipping & Freight Costs (Child's belongings only)
3. Other-Services critical for completion of the case plan $____
   - ☐ Genetic/Paternity Testing
   - ☐ Advertising for Missing Parents
   - ☐ Birth Certificates
   - ☐ Expert Witnesses (ICWA/Non-ICWA)
   - ☐ Supervised Visitation
   - ☐ Court Teleconference Costs

[stamp] I certify this is a just and proper bill and authorize its Payment.
[signature] 9/10/01
Signature Date

02 - 06213 776 - 7 7376 - $ 200.00
Year - Collocation - Expenditure - Amount

-06213 - 7 ____ $
Year - Collocation - Expenditure - Amount

ARC85780 023F527
FYN OI#

402120620

III.A. SUB-TOTAL IV-E FOSTER CARE ADMINISTRATIVE	$____

Child's Name: [redacted]

IV. NON-IV-E REIMBURSEMENT

1. Independent Living – Limited to those expenses that facilitates the transition of foster children to independent living that are not otherwise provided by the residential grant or other resources. Describe: ______ $______
2. Medical, Dental, Diagnostic, Therapeutic, and Assessment Services $______
   As payer of last resort (no Medicaid coverage or other third party reimbursement)
   Refer to 7 AAC 53.320.
   - ☐ Medical Describe: ______
   - ☐ Dental Describe: ______
   - ☐ Diagnostic (i.e. Psych evaluations) Describe: ______
   - ☐ Therapeutic (i.e. Counselling) Describe: ______
   - ☐ Assessment Services Describe: ______
   - ☐ Medical equipment, furnishings, or discretionary devises for children with special needs Describe: ______
   - ☐ Travel Describe: ______
3. Other services critical for completion of the case plan of a child in foster care when no other resources are available $______
   Describe: ______

IV.A. SUB-TOTAL NON-IV-E REIMBURSABLE $______

V. EXPLAIN HOW ALTERNATIVE SOURCES OF FUNDING FOR ALL ITEMS ABOVE HAVE BEEN EXHAUSTED: Tribe nor parent's have funds for the account required at the school.

VI. TOTAL COST: $ 200.00

VII. ☒ one time cost ☐ short term costs (date) ___/___/___ to ___/___/___

VIII. Payee Name [redacted] ARC Living Cener Address Anchorage, Alaska

IX. SSN or Fed Tax ID# [redacted] Vendor # (PVN) ______ Reimbursement ☐

X. [signature] 4MNS 08/31/01
Social Worker Signature PCN Date

XI. APPROVALS:

[signature]	3770	8/31/01	[signature]	5016	8/31/01
S.W. IV Signature	PCN	Date	S.W. V Signature	PCN	Date

______	___/___/___	______	___/___/___
Children's Services Manager	Date	Family Services Program Administrator	Date

Required for Requests exceeding $1,500.00 and Out-of-State Travel

XII. FISCAL INFORMATION (To be filled out by fiscal)

CATEGORY	COST	CODING
IV-E Foster Care Maintenence (II.A.)	$______	______
IV-E Foster Care Administrative (III.A.)	$______	______
Non-IV-E Reimbursable (IV.A.)	$______	______
TOTAL OF REQUEST:	$______	

Alaska Department of Health and Social Services
Division of Family and Youth Services

341 — Region
Kotzebue/MFR — Office
023F52 — Request #

PURCHASE AUTHORIZATION

(Vendor Copy)

402120620
Probar Case Number (9 digits)

TYPE OF SERVICES/GOODS REQUESTED: Funds for account to cover extra curricular activities

Notice: Copy of this authorization must accompany the invoice.

Notice: The State of Alaska is tax exempt. Number 92-6001185.

Within 30 days of purchase, the itemized invoice with the authorization form attached should be forwarded to the address below. The case number must be written on the invoice.

[Purchase above the amount authorized is the responsibility of the purchaser, and will not be paid by the State of Alaska.]

Division of Family and Youth Services
Northern Regional Office
751 Old Richardson Highway, Suite 300
Fairbanks, Alaska 99701-7899

Total cost of this request $ 200.00

[X] one-time cost
$200.00
[ ] short term costs
(date) / / to / /

Payee Name [redacted] ARC of Anchorage

Address 2211 Arca Dr.

Anchorage, Alaska 99508

SS or Tax ID# 574-13-5691

Vendor # (PVN)

Loretta M. Beaver
Worker Signature

4MN5
PCN

08/31/01
Date

AUTHORIZED PURCHASER

06-9710 (Rev. 12/99) ADMIN PUR
7 AAC 53.010 - 370

Distribution: Original – Regional Office
Copies – Case File & Vendor
This form filed on page 4

```
INQ-TR:  TANAB - LAPSE BALANCE                                              10/03/2001
CY: 2002  APPN: 24296 (2000) - FC SPECIAL NEED-GF


LAPSED EXPENDITURE AUTHORIZATIONS .......................          -336091.86
PLUS:  LAPSE ADJUSTMENTS ..... ..........................             8650.32
                                                               ------------------
AVAILABLE LAPSE BALANCE .................................          -327441.54
                                                               ==================

LESS:  RESTRICTED EXPENDITURE AUTHORIZATIONS .............
                                                               ------------------
UNRESTRICTED AVAILABLE LAPSE BALANCE ....................          -327441.54
                                                               ==================


Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
 CONT  QUIT                                          PFKYS                 HELP
4-©              A Sess-1     146.63.51.196          X2EP                  2/1
```

2/25 SPOKE TO ROD — WILL ~~[illegible]~~ [illegible] AND CALLBACK

Situk Leasing Compa[redacted]

SIL93160

VEHIC[redacted]

LESSOR: SITUK LEASING COMPANY
P.O. Box 230
Yakutat, AK 99689
(907) 784-3316 907-784-3232

Lessee: Name	MINIMUM RATE CHARGE — ONE DAY (24 hrs.) RATES DO NOT INCLUDE FUEL
[illegible] McClure	
Driver's License No. [illegible] State AK Expires [illegible]	Time IN
Address [illegible] Dr.	Time OUT [illegible] 12-16
City/State [illegible] AK	Vehicle Make — Body Style — Year — License #
Insurance Company [illegible]	Mileage IN
Company: Name State of Alaska [illegible]	Mileage OUT [illegible]
Address [illegible]	Mileage Driven

CHARGES

Days @ 65.00 per day	
Extra Hrs. @ 6.00 per hour	
FREE DAILY MILES	
Subtotal	
Fuel	
Misc. Charges	
Subtotal	
Total Charges	
Tax	
AMOUNT DUE	
LESS DEPOSIT (if any)	
NET DUE	

IF LESSEE RETURNS THE VEHICLE WITH LESS FUEL THAN WHEN LEASED, A FUEL SERVICE CHARGE WILL BE MADE.

In	E	1/8	1/4	3/8	1/2	5/8	3/4	7/8	F
Out	E	1/8	1/4	3/8	1/2	5/8	3/4	7/8	F

Vehicle shall NOT be operated by any person except LESSEE and the following Authorized Operators who must be validly licensed to drive and have Lessee's prior permission: persons 25 or over who are members of Lessee's immediate family and permanently reside in Lessee's household; the employer, partner, executive officer, or a regular employee of Lessee; additional authorized operator(s) approved by Lessor in writing.

THE VEHICLE IS LEASED UPON THE CONDITIONS SHOWN ON THIS PAGE AND UPON THE REVERSE HEREOF. LESSEE REPRESENTS HE OR SHE HAS READ, UNDERSTANDS AND AGREES WITH THE CONDITIONS.

[signature]

Signature of Lessee

LESSEE SHALL BE LIABLE FOR ALL DIRECT AND ACCIDENTAL LOSS OR DAMAGE TO VEHICLE.

LESSEE IS LIABLE FOR ALL PARKING AND DRIVING VIOLATIONS AND MUST REMIT PAYMENT DIRECTLY TO PROPER AUTHORITIES.

LESSEE MUST REPORT ALL ACCIDENTS TO LESSOR PROMPTLY, NOTIFY LOCAL POLICE AUTHORITIES AND COMPLETE AN ACCIDENT REPORT.

DEPOSITS: Deposit Amount	Received By	Date
$		

Prepared by Computed by

Place of delivery and redelivery:

STATE OF ALASKA

DEPT. FINANCE

TRANSPORTATION REQUEST

NO. 1105131

AGENCY	ORIGIN	DESTINATION Seinban YAKUTAT
BILLING ADDRESS	PLACE OF ISSUE Juneau	DATE OF ISSUE 8-9
CITY STATE ZIP	CARRIER Sitak Leasing	
NAME & TITLE OF TRAVELER JOHN McCLURE, SWTII	TICKET NUMBER	

FINANCIAL CODING Judy Zangri 1-16-02

VALUE $ 65.00 NO TAX PAYABLE

SY	CC	PGM	LC	ACCT	FY
06	21	3086-	77	282	

FOR AIR CHARTER | HOURS | RATE

SHADED BOX TO BE COMPLETED BY THE CARRIER.
SEE COMPLETE INSTRUCTIONS ON REVERSE.

CERTIFICATION:
The facts stated herein or on supporting documents are correct and in accordance with established travel regulations.

SIGNATURE OF TRAVELER

02 01' Rev 6/85)

TA 06C098155Z

INQ-WD: WARRANT 25553993 DETAIL INQUIRY - REFERENCE LINES 02/25/9

REF	TYPE	NUMBER	AMOUNT	DATE	COMMENTS
1	PVN	JOM90032			
2	INV	TA06CO981552		12/16/97	
3	TA	06CO981552	33.00	12/16/97	FINAL/MCCLURE-JNU/YAK-12/16
4	STR	1105131			SITUK LEASING-65.00
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17	SRD	06710		01/27/98	
18	OD	A11475030012		01/27/98	

(ENTER TO RETURN)

PF1=MAIN MENU 3=CURR BAL'S 5=BASE 6=FINANCIAL LINES 7=ADD'L REFS 8=REMIT'

```
INQ-TR:  TANAB - LAPSE BALANCE                                              01/16/2002
CY: 2002  APPN: 22546 (1998) - FC SPECIAL NEED


LAPSED EXPENDITURE AUTHORIZATIONS ........................          -77184.23
PLUS:  LAPSE ADJUSTMENTS .................................           29421.17
                                                            -----------------
AVAILABLE LAPSE BALANCE ..................................          -47763.06
                                                            =================

LESS:  RESTRICTED EXPENDITURE AUTHORIZATIONS .............          -49536.65
                                                            -----------------
UNRESTRICTED AVAILABLE LAPSE BALANCE .....................
                                                            =================


Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                                              PFKYS             HELP
4-©                A Sess-1    146.63.51.196             X2E7              2/1
```

```
INQ-CC: COLLOCATION CODE INQUIRY                                        01/16/2002

  COLLOCATION CODE 6213686         ACTIVE?  YES                  CREATING RSN 04985
          COA YEAR 2002                                            UPDATE RSN 04985
       SET-UP YEAR 1998
             TYPE: NON-PRIMARY
DESCRIPTION SHORT: FC OTH STATE ONLY FS
 DESCRIPTION LONG: FC OTHER STATE ONLY FS
                   \
                   \

REPORTS TO APPROPRIATION: 22516 - FC SPECIAL NEED
         REPORTS TO FUND: 11100 - GENERAL FUND
 REPORTS TO ORGANIZATION: 24593 - CPS FOSTER CARE
      REPORTS TO PROGRAM: 25326 - FOSTER HOMES/STATE

            POSTING?  YES          CORRESPONDING CURR YR APPN
ADD PROGRAM ALLOWED?  NO
LC OVERRIDE ALLOWED?  YES              LAPSE COLLOCATION CODE  6213663
 DEFAULT LEDGER CODE                     LAPSE CC SET-UP YEAR  1999
FOR NEXT CC ENTER==> COLLOCATION CODE ________ COA YEAR ____ SET-UP YEAR ____
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                              LCINQ LCLST        PFKYS              HELP
4-©                A Sess-1     146.63.51.196               X2E7             #§ 22/40
```

```
INQ-CC: COLLOCATION CODE INQUIRY                                         01/16/2002

  COLLOCATION CODE 6213663          ACTIVE?  YES                 CREATING RSN 04985
         COA YEAR 2002                                             UPDATE RSN 04985
     SET-UP YEAR 2000
            TYPE: NON-PRIMARY
DESCRIPTION SHORT: NRO SN STATE
 DESCRIPTION LONG: NRO SN STATE
                   /
                   /

REPORTS TO APPROPRIATION: 25408 - NRO SPECIAL NEED
         REPORTS TO FUND: 11100 - GENERAL FUND
 REPORTS TO ORGANIZATION: 24514 - FOSTER CARE HOME BAS
      REPORTS TO PROGRAM: 25336 - FC SPECL NEED STATE

          POSTING?  YES          CORRESPONDING CURR YR APPN
ADD PROGRAM ALLOWED?  NO
LC OVERRIDE ALLOWED?  YES            LAPSE COLLOCATION CODE  6213663
 DEFAULT LEDGER CODE                   LAPSE CC SET-UP YEAR  2001
FOR NEXT CC ENTER==> COLLOCATION CODE _________ COA YEAR ____ SET-UP YEAR ____
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                              LCINQ LCLST       PFKYS             HELP
4-©                A Sess-1      146.63.51.196            X2E7            #§ 22/40
```

```
INQ-CC: COLLOCATION CODE INQUIRY                                        01/16/2002

   COLLOCATION CODE 6213663         ACTIVE?  YES                  CREATING RSN 04985
           COA YEAR 2002                                            UPDATE RSN 05036
        SET-UP YEAR 2001
              TYPE: NON-PRIMARY
 DESCRIPTION SHORT: NRO SN STATE
  DESCRIPTION LONG: NRO SN STATE
                    /
                    /

 REPORTS TO APPROPRIATION: 25408 - NRO SPECIAL NEED
          REPORTS TO FUND: 11100 - GENERAL FUND
  REPORTS TO ORGANIZATION: 24514 - FOSTER CARE HOME BAS
       REPORTS TO PROGRAM: 25336 - FC SPECL NEED STATE

            POSTING?  YES          CORRESPONDING CURR YR APPN
ADD PROGRAM ALLOWED?  NO
LC OVERRIDE ALLOWED?  YES              LAPSE COLLOCATION CODE  6213663
 DEFAULT LEDGER CODE                     LAPSE CC SET-UP YEAR  2002
FOR NEXT CC ENTER==> COLLOCATION CODE ________ COA YEAR ____ SET-UP YEAR ____
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                             LCINQ LCLST      PFKYS             HELP
4-©             A Sess-1    146.63.51.196                X2E7             #S 22/40
```

INVOICE

TANANA AIR SERVICE
P.O. BOX 60713
FAIRBANKS AK 99706
(907) 474-0301

INVOICE NO

SOLD TO: DEPT. OF HEALTH & SOCIAL SVC
DIV. OF ADMIN. SVCS.-FINANCE
P.O. BOX 110650
JUNEAU, AK 99811-0650
(907) 465-3131

SHIP TO:

Page 1

ACCOUNT NO.	SALES PERSON	PURCHASE ORDER NO.	SHIP VIA	COL.	PPD	DATE SHIPPED	TERMS	INVOICE DATE
ALASS	4E	EXCESS	FAI-NIB			01/08/95	NET 30	08 03 00

QTY. ORDERED	QTY. SHIPPED	QTY. BACK ORDERED	ITEM NUMBER	DESCRIPTION	UNIT PRICE	DISC. %	EXTENDED PRICE
1	1		EXCESS	EXCESS FOR [redacted] 19 LBS @ $0.75/LB FAI-NIB CHARGE ALASS	14.25	0	14.25

SALES AMOUNT	14.25
SALES TAX	
FREIGHT	
TOTAL	14.25

INVOICE

TANANA AIR SERVICE
P. O. BOX 60713
FAIRBANKS, AK 99706
(907) 474-0301

INVOICE NO [illegible]

Vendor # [illegible]

SOLD TO: DEPT. OF HEALTH & SOCIAL SVC
DIV. OF ADMIN. SVCS. FINANCE
P.O. BOX 110650
JUNEAU, AK 99811-0650
(907) 465-3121

SHIP TO:

Page 1

ACCOUNT NO.	SALES PERSON	PURCHASE ORDER NO.	SHIP VIA	COL	PPD	DATE SHIPPED	TERMS	INVOICE DATE
AL466	4E	EXCESS	FAI-N1B			01/08/99	NET 30	09/03/00

QTY. ORDERED	QTY. SHIPPED	QTY. BACK ORDERED	ITEM NUMBER	DESCRIPTION	UNIT PRICE	DISC %	EXTENDED PRICE
1	1		EXCESS	EXCESS FOR [redacted] 19 LBS @ $0.75/LB FAI N1B CHARGE AL466	14.25	0	14.25

ATTN: DIANE

THIS IS AN AMENDED COPY OF INVOICE # 48064 WHICH WE SPOKE ABOUT. THE TICKET ($364.00) HAS BEEN CREDITED, BUT THE CHARGE FOR THE BAGS REMAINS UNPAID...

IF YOU HAVE QUESTIONS, PLEASE CALL ME.
(907) 474-0301
THANKS,

Dana Silva

SALES AMOUNT	14.25
SALES TAX	
FREIGHT	
TOTAL	14.25

(907) 474-0301 PASSENGER COUPON Ticket No. 48064

PASSENGER NAME	Not Transferable	PLACE OF ISSUE FAI	FARE 338.60	449
[redacted]		ISSUING AGENT (B)	TAX 25.40	030.47
From FAI	[redacted]	EXCESS Allowable Weight 40 / Excess 19 / Rate	EXCESS 14.25	TICKET IS TO BE CHGED TO WORLY
		DATE OF ISSUE 1/08/99	TOTAL 378.25	
To NIB	FLT 19 / DATE 1/08 / TIME	PAX WEIGHT 160	FORM OF PAYMENT P.O. #017764	
To FAI		BAG WEIGHT 59	ACCOUNT OR VOUCHER # CHG to ALASKA DFYS (NOT AN ACCT.)	FOR EXCESS ONLY / CASHIER'S STAMP

WHITE - ORIGINAL | GREEN - ACCOUNTING | YELLOW - 1ST DESTINATION | PINK - RETURN | GOLDENROD

```
INQ-TR:  TANAB - LAPSE BALANCE                                        01/16/2002
CY: 2002  APPN: 22546 (1999) - FC SPECIAL NEED


LAPSED EXPENDITURE AUTHORIZATIONS .......................        -366777.64
PLUS:  LAPSE ADJUSTMENTS .................................         26238.10
                                                           ------------------
AVAILABLE LAPSE BALANCE ..................................        -340539.54
                                                           ==================

LESS:  RESTRICTED EXPENDITURE AUTHORIZATIONS .............         -75000.00
                                                           ------------------
UNRESTRICTED AVAILABLE LAPSE BALANCE .....................        -265539.54
                                                           ==================


Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                                            PFKYS              HELP
4-©             A Sess-1   146.63.51.196                X2E7              2/1
```

```
INQ-CC: COLLOCATION CODE INQUIRY                                    01/16/2002

  COLLOCATION CODE 6213629         ACTIVE?  YES              CREATING RSN 04985
          COA YEAR 2002                                        UPDATE RSN 04985
       SET-UP YEAR 1999
             TYPE: NON-PRIMARY
DESCRIPTION SHORT: NRO FC OS STATE-FS
 DESCRIPTION LONG: NRO FC OS STATE ONLY FS
                   /
                   /

REPORTS TO APPROPRIATION: 25408 - NRO SPECIAL NEED
         REPORTS TO FUND: 11100 - GENERAL FUND
 REPORTS TO ORGANIZATION: 24514 - FOSTER CARE HOME BAS
      REPORTS TO PROGRAM: 25336 - FC SPECL NEED STATE

            POSTING?  YES          CORRESPONDING CURR YR APPN
ADD PROGRAM ALLOWED?  NO
LC OVERRIDE ALLOWED?  YES              LAPSE COLLOCATION CODE  6213629
 DEFAULT LEDGER CODE                     LAPSE CC SET-UP YEAR  2000
FOR NEXT CC ENTER==> COLLOCATION CODE ________ COA YEAR ____ SET-UP YEAR ____
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                           LCINQ LCLST       PFKYS                HELP
4-©             A Sess-1    146.63.51.196                X2E7             #S 22/40
```

```
INQ-CC: COLLOCATION CODE INQUIRY                                        01/16/2002

   COLLOCATION CODE 6213629        ACTIVE?  YES                 CREATING RSN 04985
           COA YEAR 2002                                          UPDATE RSN 04985
        SET-UP YEAR 2000
              TYPE: NON-PRIMARY
 DESCRIPTION SHORT: NRO SN OS STATE
  DESCRIPTION LONG: NRO SN OS STATE
                    /
                    /

REPORTS TO APPROPRIATION: 25408 - NRO SPECIAL NEED
         REPORTS TO FUND: 11100 - GENERAL FUND
 REPORTS TO ORGANIZATION: 24514 - FOSTER CARE HOME BAS
      REPORTS TO PROGRAM: 25336 - FC SPECL NEED STATE

            POSTING?  YES          CORRESPONDING CURR YR APPN
ADD PROGRAM ALLOWED?  NO
LC OVERRIDE ALLOWED?  YES              LAPSE COLLOCATION CODE  6213629
 DEFAULT LEDGER CODE                     LAPSE CC SET-UP YEAR  2001
FOR NEXT CC ENTER==> COLLOCATION CODE ________ COA YEAR ____ SET-UP YEAR ____
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                            LCINQ LCLST       PFKYS              HELP
4-©                A Sess-1    146.63.51.196              X2E7             #§ 22/40
```

```
INQ-CC: COLLOCATION CODE INQUIRY                                          01/16/2002

  COLLOCATIUN CODE 6213629          ACTIVE?  YES                 CREATING RSN 04985
          COA YEAR 2002                                            UPDATE RSN 04985
       SET-UP YEAR 2001
             TYPE: NON-PRIMARY
DESCRIPTION SHORT: NRO SN OS STATE
 DESCRIPTION LONG: NRO SN OS STATE
                  /
                  /

REPORTS TO APPROPRIATION: 25408 - NRO SPECIAL NEED
         REPORTS TO FUND: 11100 - GENERAL FUND
 REPORTS TO ORGANIZATION: 24514 - FOSTER CARE HOME BAS
      REPORTS TO PROGRAM: 253:.6 - FC SPECL NEED STATE

             POSTING?  YES          CORRESPONDING CURR YR APPN
ADD PROGRAM ALLOWED?  NO
LC OVERRIDE ALLOWED?  YES              LAPSE COLLOCATION CODE  6213629
 DEFAULT LEDGER CODE                     LAPSE CC SET-UP YEAR  2002
FOR NEXT CC ENTER==> COLLOCATION CODE ________ COA YEAR ____ SET-UP YEAR ____
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                            LCINQ LCLST        PFKYS              HELP
4-©               A Sess-1      146.63.51.196                X2E7          #§ 22/40
```

```
INQ-VM:  VENDOR DETAIL                                              01/15/2002

    VENDOR NUMBER: TAS94286                      DATE LAST ACTIVITY: 01/03/2002
          ACTIVE? YES
     VENDOR CLASS: MI
VENDOR DESC SHORT: TANANA AIR SERVICE
 VENDOR DESC LONG: TANANA AIR SERVICE/OWNERSHIP CHANGE IN
                   5/94/OLD PVN ATA91052/BUSINESS NOW A SUB
                   SIDIARY OF BIDZY-TA-HOT'ANNA CORPORATION

      VENDOR NAME: BIDZY-TA-HOT'ANNA CORPORATION
          ADDRESS: DBA TANANA AIR SERVICE
                   PO BOX 60713
                   FAIRBANKS                          AK     99706-0713

   VENDOR CONTACT: BETH, ACCOUNTANT
            PHONE: (907)474-0301 EXT
    TAX-ID NUMBER: EIN920068608
 1099 REPORTABLE? NO

 ENTER VENDOR NUMBER FOR NEXT DETAIL==> ________
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                                            PFKYS              HELP
4-©                A Sess-1     146.63.51.196 ·           X325             22/42
```

PENINSULA AIRWAYS, INC.
6100 BOEING AVENUE
ANCHORAGE AK 99502

*** INVOICE ***

Sold to: 003925
AK HEALTH & SOCIAL SERVICES
ADMINISTRATIVE SERVICES FISCAL
P O BOX 110650
JUNEAU AK 99811

Ship to: 003925
AK HEALTH & SOCIAL SERVICES
ADMINISTRATIVE SERVICES FISCAL
P O BOX 110650
JUNEAU AK 99811

FY99

SECOND REQUEST

Invoice #	Invoice Date	Terms	Document Number	Doc. Date
564984-00	03/11/1999		4200126729	03/11/1999

Quantity	Um	Description	Price	Amount
1.00	EA	RB SNP ANC RT 11	770.00	770.00

I certify that this document is an exact copy of the original.

Signed: Berta Barrett
Peninsula Airways, Inc.

Judy Zangus 1-16
99-06213662-772

PEN AIR
339 4200 126 729
PENINSULA AIRWA
STATION 65
ST. PAUL, AK

SNP/SNP
09 MAR 99

SNP KS 358.14
ANC 3V 358.14

From: Saint Paul — KS 450 B 09 MAR 345 PM OK BKS
To: Anchorage — KS 185 Q 10 MAR 800 AM OK QEV
To: Saint Paul

MAR 17 1999

MS 2:15P

USD 358.14

716.28 53.72

770.00

STATE P.A. #115 9918

3925

4200126729 1 0

* Eleanor Starr

TRAVEL AUTHORIZATION — **STATE OF ALASKA**

TRAVEL AUTHORIZATION NO.	DATE
1159918	3/10/99

NAME OF TRAVELER	TITLE	SOCIAL SECURITY NUMBER
Eleanore L. STARR	Social Worker	518-62-5865

WARRANT MAILING ADDRESS	CITY	STATE	ZIP CODE
P.O. Box 293	St Paul, Alaska	99660	

DEPARTMENT	DIVISION	BARGAINING UNIT	WORK STATION

PURPOSE OF TRIP

Escort suicidal patient to Anchorage for evaluation

FINANCIAL CODING	ESTIMATED COSTS	TRANSPORTATION	PER DIEM	OTHER	TOTAL
		$	$	$	$

ITINERARY	FROM	DEPARTURE DATE/TIME	TO	RETURN DATE/TIME

APPROVALS	DIVISION	DATE	DEPARTMENT	DATE	GOV. (OUT-OF-STATE ONLY)	DATE

ACTUAL COSTS

DATE	EXPLANATION	MILES X RATE	MILEAGE OR CASH FARE	PER DIEM	OTHER
3/9/99	Depart St Paul				
3/10/99	RETURN ON REEVE'S				
3/9/99	[redacted] ONE WAY ON PENAIR				

I certify that this document is an exact copy of the original.
Signed: Berta Bessi[illegible]
Peninsula Airways, Inc.

CLAIMANT'S CERTIFICATION: The facts stated herein or on supporting documents are correct and in accordance with established travel regulations, and unused ticket were returned.

CLAIMANT'S SIGNATURE: Eleanore L Starr

APPROVAL SIGNATURE: ______

SUBTOTALS THIS PAGE

PAGE 1 OF ______ PAGES

TOTAL ALL PAGES $ 1155.00

TR/FW NO.	ISSUED TO	AMOUNT	DATE

LESS TRAVEL ADVANCE $

FINAL PAYMENT $

REF	TYPE	NUMBER	AMOUNT	DATE	COMMENTS
1	PVN				
2					
3					
4					

IN	AMOUNT	SY	CC	PGM	LC	ACCT	FY

027 (6/91) 19/11/02-027.PM3

```
INQ-TR:  TANAB - LAPSE BALANCE                                        01/16/2002
CY: 2002  APPN: 22546 (1999) - FC SPECIAL NEED


LAPSED EXPENDITURE AUTHORIZATIONS .........................        -366777.64
PLUS:  LAPSE ADJUSTMENTS ..................................          26238.10
                                                              ------------------
AVAILABLE LAPSE BALANCE ...................................        -340539.54
                                                              ==================

LESS:  RESTRICTED EXPENDITURE AUTHORIZATIONS ..............         -75000.00
                                                              ------------------
UNRESTRICTED AVAILABLE LAPSE BALANCE ......................        -265539.54
                                                              ==================


Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                                                PFKYS           HELP
4-©           A Sess-1      146.63.51.196                  X2E7            2/1
```

```
INQ-CC: COLLOCATION CODE INQUIRY                                            01/16/2002

  COLLOCATION CODE 6213662         ACTIVE?  YES                   CREATING RSN 04985
          COA YEAR 2002                                             UPDATE RSN 04985
       SET-UP YEAR 1999
             TYPE: NON-PRIMARY
DESCRIPTION SHORT: SCRO FC STATE-FS
 DESCRIPTION LONG: SCRO FC STATE ONLY FS
                   /
                   /

REPORTS TO APPROPRIATION: 25407 - SCRO SPECIAL NEED
         REPORTS TO FUND: 11100 - GENERAL FUND
 REPORTS TO ORGANIZATION: 24514 - FOSTER CARE HOME BAS
      REPORTS TO PROGRAM: 25336 - FC SPECL NEED STATE

            POSTING?  YES          CORRESPONDING CURR YR APPN
ADD PROGRAM ALLOWED?  NO
LC OVERRIDE ALLOWED?  YES              LAPSE COLLOCATION CODE  6213662
 DEFAULT LEDGER CODE                     LAPSE CC SET-UP YEAR  2000
FOR NEXT CC ENTER==> COLLOCATION CODE ________ COA YEAR ____ SET-UP YEAR ____
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                            LCINQ LCLST        PFKYS               HELP
4-©               A Sess-1     146.63.51.196                X2E7             #5 22/40
```

```
INQ-CC: COLLOCATION CODE INQUIRY                                              01/16/2002

  COLLOCATION CODE 6213662        ACTIVE?  YES                  CREATING RSN 04985
          COA YEAR 2002                                           UPDATE RSN 04985
       SET-UP YEAR 2000
             TYPE: NON-PRIMARY
DESCRIPTION SHORT: SCRO SN STATE
 DESCRIPTION LONG: SCRO SN STATE
                   /
                   /

REPORTS TO APPROPRIATION: 25407 - SCRO SPECIAL NEED
         REPORTS TO FUND: 11100 - GENERAL FUND
 REPORTS TO ORGANIZATION: 24514 - FOSTER CARE HOME BAS
      REPORTS TO PROGRAM: 25336 - FC SPECL NEED STATE

            POSTING?  YES          CORRESPONDING CURR YR APPN
ADD PROGRAM ALLOWED?  NO
LC OVERRIDE ALLOWED?  YES              LAPSE COLLOCATION CODE  6213662
 DEFAULT LEDGER CODE                     LAPSE CC SET-UP YEAR  2001
FOR NEXT CC ENTER==> COLLOCATION CODE ________ COA YEAR ____ SET-UP YEAR ____
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                             LCINQ LCLST      PFKYS             HELP
4-©              A Sess-1    146.63.51.196             X2E7              #§ 22/40
```

```
INQ-CC: COLLOCATION CODE INQUIRY                                    01/16/2002

  COLLOCATION CODE 6213662          ACTIVE?  YES             CREATING RSN 04985
          COA YEAR 2002                                        UPDATE RSN 05059
       SET-UP YEAR 2001
             TYPE: NON-PRIMARY
DESCRIPTION SHORT: SCRO SN STATE
 DESCRIPTION LONG: SCRO SN STATE
                   /
                   /

REPORTS TO APPROPRIATION: 25407 - SCRO SPECIAL NEED
         REPORTS TO FUND: 11100 - GENERAL FUND
 REPORTS TO ORGANIZATION: 24514 - FOSTER CARE HOME BAS
      REPORTS TO PROGRAM: 25336 - FC SPECL NEED STATE

            POSTING?  YES          CORRESPONDING CURR YR APPN
ADD PROGRAM ALLOWED?  NO
LC OVERRIDE ALLOWED?  YES              LAPSE COLLOCATION CODE  6213662
 DEFAULT LEDGER CODE                     LAPSE CC SET-UP YEAR  2002
FOR NEXT CC ENTER==> COLLOCATION CODE ________ COA YEAR ____ SET-UP YEAR ____
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                            LCINQ LCLST       PFKYS             HELP
4-©              A Sess-1    146.63.51.196                X2I /            #§ 22/40
```

Please Remit To:

PO Box 99001
Anchorage, AK 99509
(907) 777-6921

Invoice

Bill To:

State of Alaska
Dept of Health & Social Svcs/DFVS
350 Main St, Room 410
Juneau, AK 99801

Invoice # 92035

Invoice Date 1/22/99

Purchase Order No.	Sales Representative	Terms
02-60-0171-99	Peter Bost 1(907)777-6662	Net 30

1	99-0102	3512 DSU/CSU	$503.00	$503.00
1		V.35 to DB25, 6' Cable	$45.00	$45.00

99- 6213458-75791
Judy Zangri 1-16-02

Comments

Subtotal: $548.00

Invoice Total: $548.00

○ White—Original ● Yellow—File

GCI - SALES ORDER

COPY

SALES ORDER # 99-0102 REQUIRED DATE: 01/08/99

TODAYS DATE: 1/5/99
SALES REP: peter host

CUSTOMER'S NAME:	State of Alaska
CONTACT NAME:	Guy Crockroft
PHONE NUMBER:	907-465-5758
P.O. NUMBER:	02-60-0171-99

BILL FREIGHT:	y
DROP SHIP:	n
BURN-IN:	n
CONFIGURE:	n
INSTALL:	n
DEMO:	
DEMO FROM:	
DEMO TO:	

PURCHASING DEPT. ONLY:

REQ. REC. DATE	1/5/99
ORDERED DATE	1/5/99
VEN. SHIP DATE	
ORDER REF #	
DATE RECEIVED	[illegible]
REC REPORT #	[illegible]
CUST DEL DATE	[illegible]
DELIVERY TKT #	[illegible]
SENT TO BILLING	[illegible]

BILL TO ADDRESS (CUSTOMER)
State of Alaska Dept. of Health & Social Svcs/DFVS
350 Main Street, Room 410
Juneau, Ak 99801

SHIP TO ADDRESS
DOA/Division of Info. Svcs NSSADC
3300 Fairbanks Street
Anchorage, Ak 99503

COMMENT

PART #	DESCRIPTION	QTY	SALE PRICE	TOTAL
48388	3512 DSU/CSU	1	503.00	503.00
48323	V.35 to DB25, 6ft. Cable	1	45.00	45.00
				0.00
				0.00
				0.00
			SALE TOTAL	548.00

Also see 99-0102
0103
0104
0105

FAX

Date : 12/06/01

Total number of pages : 3

To : FrankMiyasato

Company :

Department :

Fax number : 19074653184

From : Colette Brooke

Subject: Purchase Order 02-60-0171-99

```
INQ-CC: COLLOCATION CODE INQUIRY                                  01/16/2002

  COLLOCATION CODE 6213458        ACTIVE?  YES             CREATING RSN 04985
          COA YEAR 2002                                      UPDATE RSN 04985
       SET-UP YEAR 2000
              TYPE: NON-PRIMARY
 DESCRIPTION SHORT: CO GENERAL ADMIN
  DESCRIPTION LONG: CO GENERAL ADMIN
                    /
                    ________________________06010301*

 REPORTS TO APPROPRIATION: 25426 - FAM & YOUTH SVCS MGN
          REPORTS TO FUND: 11100 - GENERAL FUND
  REPORTS TO ORGANIZATION: 24503 - ADMINISTRATION
       REPORTS TO PROGRAM: 22640 - FYS ADMINISTRATION

              POSTING?  YES           CORRESPONDING CURR YR APPN
 ADD PROGRAM ALLOWED?  NO
 LC OVERRIDE ALLOWED?  YES               LAPSE COLLOCATION CODE  6213458
  DEFAULT LEDGER CODE                      LAPSE CC SET-UP YEAR  2001
 FOR NEXT CC ENTER==> COLLOCATION CODE ________ COA YEAR ____ SET-UP YEAR ____
 Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
 CONT  QUIT                              LCINQ LCLST      PFKYS             HELP
4-©              A Sess-1     146.63.51.196             X2E7            #§ 22/40
```

```
INQ-CC: COLLOCATION CODE INQUIRY                                          01/16/2002

  COLLOCATION CODE 6213458          ACTIVE?  YES             CREATING RSN 04985
          COA YEAR 2002                                         UPDATE RSN 05036
       SET-UP YEAR 2001
             TYPE: NON-PRIMARY
DESCRIPTION SHORT: CO GENERAL ADMIN
 DESCRIPTION LONG: CO GENERAL ADMIN
                   /
                   ________________________________06010301*

REPORTS TO APPROPRIATION: 22550 - FMLY & YTH SVCS MGMT
         REPORTS TO FUND: 11100 - GENERAL FUND
 REPORTS TO ORGANIZATION: 24503 - ADMINISTRATION
      REPORTS TO PROGRAM: 22640 - FYS ADMINISTRATION

             POSTING?  YES          CORRESPONDING CURR YR APPN
ADD PROGRAM ALLOWED?   NO
LC OVERRIDE ALLOWED?   YES              LAPSE COLLOCATION CODE  6213458
 DEFAULT LEDGER CODE                      LAPSE CC SET-UP YEAR  2002
FOR NEXT CC ENTER==> COLLOCATION CODE ________ COA YEAR ____ SET-UP YEAR ____
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                                LCINQ LCLST        PFKYS              HELP
4-©              A Sess-1     146.63.51.196                 X2E7               #§ 22/40
```

```
INQ-CC: COLLOCATION CODE INQUIRY                                   01/16/2002

  COLLOCATION CODE 6213458        ACTIVE?  YES            CREATING RSN 04709
          COA YEAR 2001                                     UPDATE RSN 04709
       SET-UP YEAR 1999
             TYPE: NON-PRIMARY
DESCRIPTION SHORT: CO GENERAL ADMIN
 DESCRIPTION LONG: CO GENERAL ADMIN
                   /
                   /______________________________06010301*

REPORTS TO APPROPRIATION: 22550 - FMLY & YTH SVCS MGMT
         REPORTS TO FUND: 11100 - GENERAL FUND
 REPORTS TO ORGANIZATION: 24503 - ADMINISTRATION
      REPORTS TO PROGRAM: 22640 - FYS ADMINISTRATION

            POSTING?  YES          CORRESPONDING CURR YR APPN
ADD PROGRAM ALLOWED?  NO
LC OVERRIDE ALLOWED?  YES              LAPSE COLLOCATION CODE  6213458
 DEFAULT LEDGER CODE                     LAPSE CC SET-UP YEAR  2000
FOR NEXT CC ENTER==> COLLOCATION CODE ________ COA YEAR ____ SET-UP YEAR ____
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                            LCINQ LCLST       PFKYS              HELP
4-©               A Sess-1    146.63.51.196               X2E7            #§ 22/40
```

```
INQ-TR:  TANAB - LAPSE BALANCE                                          01/16/2002
CY: 2002  APPN: 22550 (2000) - FMLY & YTH SVCS MGMT


LAPSED EXPENDITURE AUTHORIZATIONS .......................          -139144.27
PLUS:  LAPSE ADJUSTMENTS ................................            10959.07
                                                                ----------------
AVAILABLE LAPSE BALANCE .................................          -128185.20
                                                                ================

LESS:  RESTRICTED EXPENDITURE AUTHORIZATIONS ............           -56800.00
                                                                ----------------
UNRESTRICTED AVAILABLE LAPSE BALANCE ....................           -71385.20
                                                                ================


Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
CONT  QUIT                                            PFKYS                HELP
4-©               A Sess-1    146.63.51.196             X27R                 2/1
```

269-7815 Melissa acct Clerk

CONTINUOUS PRINTING

2603 ARCTIC BLVD., ANCHORAGE, ALASKA 99503
OFFICE (907) 277-0446 ALASKA (800) 478-0446
FAX (907) 277-2126

FAX TRANSMITTAL SHEET

DATE: 11-20-00

TO: CECELIA

ATTENTION:

FAX NUMBER: 269-6532

PAGES TO FOLLOW: 1

4-9-01
WILL CK WITH AMY +
CALL ME BACK

HERE IS A CERTIFIED TRUE COPY OF THE INVOICE IN QUESTION.

4-9-01
CALLED
LEFT MESSAGE

THANK YOU FOR YOUR HELP.

PEGGY

3-13-01
LEFT MESSAGE

3-20-01 - WILL SUBMIT TO AMY FOR PAYMENT - CALL AGAIN NEXT WEEK

CECELIA PREZIOSE
269-6459

accounts payable
Robert Jackson
269-6430
FAX 269-6329

1-31-01 -
ROBERT JACKSON
STILL WAITING

3-7-01
LEFT MESSAGE

09/13/2001 02:17 9072772126 CONTINUOUS PRINTING PAGE 02

01/11/2001 08:43 9072772126 CONTINUOUS PRINTING PAGE 01

CONTINUOUS PRINTING OF ALASKA, INC.
(907) 277-0446
2503 Arctic Blvd
Anchorage, Alaska 99503

INVOICE

SOLD TO:

H&SS Public Assistance
400 Gambell
Suite 200
Anchorage, AK 99501

CPA 87278

INVOICE NO.: W-4282
INVOICE DATE: 3/22/99
CUSTOMER P.O.#: DR 077
DUE DATE: 4/21/99
CUSTOMER NUMBER 272

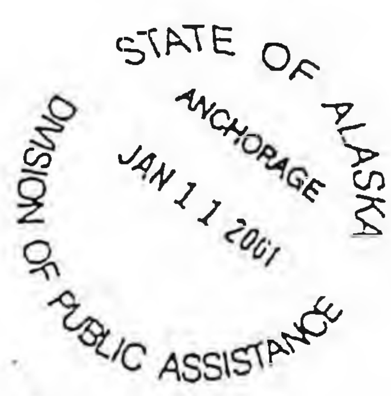
QUANTITY	DESCRIPTION	AMOUNT
40000	H4EALTH CARE PROVIDER INSTRUCTIONS	788.00

this is a certified + true copy
Peggy Colegrove
277-0446

SIGNATURE: ____________________

TERMS: 1 1/2% INTEREST ON ACCOUNTS 30 DAYS PAST DUE

SUB-TOTAL	788.00
TAX	
TOTAL	788.00
PLEASE PAY LAST AMOUNT	



I certify that this is a just and proper bill and hereby authorize the Department Certifying Officer to effect payment of same.
Signature: [signature] Date: 4-?-01
06216310 73560
8-Digit Account Code 3-Digit Object Code

$ 788.00
FY99

4/12 - ✓ AKSAS not
4/15 - ✓ paid
Tony Williams

STATE OF ALASKA
HEALTH AND SOCIAL SERVICES

TONY KNOWLES, GOVERNOR

Division of Administrative Services/Fiscal
P.O. Box 240249
Anchorage, AK 99524-0249

(907) 269-7818

April 20, 2001

Continuous Printing of AK
2503 Arctic Blvd
Anchorage, AK 99503

RE: Invoice # W4282 Acct# 273

To whom it may concern:

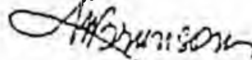
We received your fax regarding a past due invoice dated 3-22-99. Research indicates that the invoice will need to be submitted for a supplemental appropriation through the legislature.

Our Juneau fiscal office has the documents and will research for possible previous payment and then submit the invoices through the legislature for supplemental approval. Usually any supplemental requests are approved by the legislature in May of each year therefore; we are unable to pay the bill at this time.

I apologize for the delay. You may wish to suspense the invoice and contact our office in June to check the status. You can contact me directly at 269-7815.

If I can clarify the process or you need further assistance, please let me know.

Sincerely,



Marissa Brunson
Accounting Clerk II

Cc: Bobbie Fuller, Public Health
Luz Malacas, Juneau Fiscal

6-29 MESSAGE
6-29 - WILL CK W/ JUNEAU + CALL BACK
07-03 LEFT MESSAGE
07-12 - WORKING ON IT - NEED TO WAIT ON JUNEAU
TINA - SUPERVISOR

6-19 Marissa
State will pay
supervisor will authorize today
she is back from vacation

Williams, Tina

From: Williams, Tina
Sent: Tuesday, July 03, 2001 2:08 PM
To: Moskito, Orlando R.
Cc: Malacas, Luzviminda
Subject: supplemental invoices

Importance: High

Orlando,
I went through the entire supplemental file we have here and have found the following do not appear on the supplemental appropriations sheet:

1. Xerox Corporation - March 6, 2001 notified, $984.00 due for services rendered 4/20/99
2. Continuous Printing of AK - April 20, 2001 notified, $788.00 due for services rendered 3/22/99
3. The New Printer Workshop NPW, Inc. - May 8, 2001 notified, $7.50 due for services rendered 9-22-98

Continuous Printing continues to call and ask the status--what can I say to her? Is there a possibility that I do not have the complete list?
Please advise.

Thanks,

Tina Williams
Accounting Supervisor
(907) 269-7818 work
(907) 561-1308 fax

CONTINUOUS PRINTING
OF ALASKA, INC.
(907) 277-0446
2503 Arctic Blvd.
Anchorage, Alaska 99503

INVOICE

SOLD TO:

INVOICE NO. 2001

INVOICE DATE 7/30/01

CUSTOMER P.O.#

DUE DATE ~~8/29/01~~ 9-22-01

HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE
400 GAMBELL STREET - SUITE 200
ANCHORAGE, AK 99501

CUSTOMER NUMBER 273

QUANTITY	DESCRIPTION	AMOUNT
	ATTENTION: TINA WILL AMS - REFERENCE INVOICE #W-4282 - YOUR P.O. #CR077 DATED 3-22-99 LATE CHARGES FOR PAST DUE INVOICE AT 1-1/2% PER MONTH, CALCULATED TO SEPTEMBER, 2001 9/22/01	429.00

JUL 3 0 2001

SIGNATURE:______________________

TERMS: 1 1/2% INTEREST ON ACCOUNTS 30 DAYS PAST DUE.

SUBTOTAL	429.00
TAX	
TOTAL	429.00
PLEASE PAY LAST AMOUNT	

7/27/01

talked w/ Phil Healy - Continuous Printing
277-0446

He has been trying to collect on the o/s Invoice (# W-4282) for years now.

He has repeatedly contacted the program and just wants to be paid. He is going to bill for Late Charges and submit a current bill & wanted it paid.

I told him that I would need to check with the Finance Officer when he returns.

8/13/01 called Phil Healy - Continuous Printing
Requested copies of earliest correspondence on o/s Bill

Relayed the Late Charges would be considered if the supplemental and

FAX COVER SHEET

STATE OF ALASKA
DEPT. OF HEALTH & SOCIAL SERVICES
DIVISION OF ADMINISTRATIVE SERVICES
FISCAL SECTION
3601 C STREET, SUITE 578
ANCHORAGE AK 99503

DATE: 8/14/01 TIME: 10:10 am

TO: Catherine Hill for Orlando PHONE #: 465-3131

FAX #: 465-3184

NUMBER OF PAGES TO FOLLOW: 8 - including cover page

MESSAGE:

Orlando,

Per our conversation yesterday enclosed is the information received from Continuous Printing & Rate Change notice.

FROM: [illegible]

PHONE #: 269-7818 FAX #: [illegible] 1308

STATE OF ALASKA
HEALTH AND SOCIAL SERVICES

TONY KNOWLES, GOVERNOR

Division of Administrative Services/Fiscal
P.O. Box 240249
Anchorage, AK 99524-0249

(907) 269-7818

April 20, 2001

Continuous Printing of AK
2503 Arctic Blvd
Anchorage, AK 99503

RE: Invoice # W4282 Acct# 273

To whom it may concern:

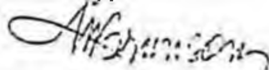
We received your fax regarding a past due invoice dated 3-22-99. Research indicates that the invoice will need to be submitted for a supplemental appropriation through the legislature.

Our Juneau fiscal office has the documents and will research for possible previous payment and then submit the invoices through the legislature for supplemental approval. Usually any supplemental requests are approved by the legislature in May of each year therefore; we are unable to pay the bill at this time.

I apologize for the delay. You may wish to suspense the invoice and contact our office in June to check the status. You can contact me directly at 269-7815.

If I can clarify the process or you need further assistance, please let me know.

Sincerely,



Marissa Brunson

Accounting Clerk II

Cc: Bobbie Fuller, Public Health
Luz Malacas, Juneau Fiscal

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE MM DD YY: 08041946 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): 521 N. KLEVIN ST. APT. 2

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 521 N. KLEVIN ST. APT. 2

CITY: ANCHORAGE STATE: AK

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: ANCHORAGE STATE: AK

ZIP CODE: 99508 TELEPHONE (Include Area Code): (907)-562-4775

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 99508 TELEPHONE (INCLUDE AREA CODE): (907)-562-4775

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 08 04 46 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State) [ ] YES [X] NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: AK-BCCEDP

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 06/13/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): ** ** **

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM ** ** ** TO ** ** **

19. RESERVED FOR LOCAL USE: 70280

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V72.3 GYNECOLOGICAL E
2. 401.9 HYPERTENSION, ES
3.
4.

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
06 09 99	06 09 99	50	1	99214	1	~~93 00~~ 66.03	1				92-0047965

Ok to pay ANN 84583

$ 66.03 01-0631144 1 06602301 73230

[signature] 07-11-01

RECEIVED JUL 11 2001 SECTION OF MATERNAL, CHILD & FAMILY HEALTH ANCHORAGE OFFICE

66.03 66.03

25. FEDERAL TAX I.D. NUMBER: 92-0047965 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 040075-01

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ ~~93 00~~

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ ~~93 00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PAM ENGLE PA-C

SIGNED DATE 06/13/01 FDA Mam Cert# 183533

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Anchorage Neighborhood Hlth Ctr
P.O. Box 201849
ANCHORAGE AK 99520-1849

PIN# 92-0047965 GRP# 92-0047965

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB 0938-0008

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE MM DD YY: 08041946 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): 521 N. KLEVIN ST. APT. 2
CITY: ANCHORAGE STATE: AK
ZIP CODE: 99508 TELEPHONE (Include Area Code): (907)-562-4775

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

7. INSURED'S ADDRESS (No., Street): 521 N. KLEVIN ST. APT. 2
CITY: ANCHORAGE STATE: AK
ZIP CODE: 99508 TELEPHONE (INCLUDE AREA CODE): (907)-562-4775

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):
a. OTHER INSURED'S POLICY OR GROUP NUMBER:
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
c. EMPLOYER'S NAME OR SCHOOL NAME:
d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO
b. AUTO ACCIDENT? PLACE (State) [ ] YES [X] NO
c. OTHER ACCIDENT? [ ] YES [X] NO
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER:
a. INSURED'S DATE OF BIRTH MM DD YY: 08 04 46 SEX M [ ] F [X]
b. EMPLOYER'S NAME OR SCHOOL NAME:
c. INSURANCE PLAN NAME OR PROGRAM NAME: AK-BCCEDP
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes, return to and complete item 9 a-d*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 06/13/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): ** ** **
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 92-0047965
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM ** ** ** TO ** ** **
19. RESERVED FOR LOCAL USE: 70290
20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V72.3 GYNECOLOGICAL E
2. 401.9 HYPERTENSION, ES
3.
4.

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
06 09 99	06 09 99	50	5	88164	1	~~20 00~~ 7.15	1				92-0047965
~~06 09 99~~	~~06 09 99~~	~~50~~	~~5~~	~~87210~~	1	~~20 00~~	1				

Ok to pay
$7.15 01-0631441 06602301 73230
[signature] 07-11-01

RECEIVED
JUL 1? 2001
SECTION OF MATERNAL, CHILD & FAMILY HEALTH
ANCHORAGE OFFICE

7.15 7.15

25. FEDERAL TAX I.D. NUMBER: 92-0047965 SSN [ ] EIN [X]
26. PATIENT'S ACCOUNT NO.: 040075-01
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE: $ ~~40 00~~
29. AMOUNT PAID: $ 0 00
30. BALANCE DUE: $ ~~40 00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
HM ENGLE PA-C
SIGNED DATE: 06/13/01 FDA Mam Cert# 183533

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Anchorage Neighborhood Hlth Ctr
P.O. Box 201849
ANCHORAGE AK 99520-1849
PIN# 92-0047965 GRP# 92-0047965

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB 0938-0008

AK-BCCEDP
3601 C STREET STE. #534
PO BOX 240249
ANCHORAGE AK 99524-0249

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID): X OTHER

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE: 08 04 1946 SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): 521 N. KLEVIN ST. APT. 2
CITY: ANCHORAGE STATE: AK
ZIP CODE: 99508 TELEPHONE (Include Area Code): (907)-562-4775

6. PATIENT RELATIONSHIP TO INSURED: Self X / Spouse / Child / Other

7. INSURED'S ADDRESS (No., Street): 521 N. KLEVIN ST. APT. 2
CITY: ANCHORAGE STATE: AK
ZIP CODE: 99508 TELEPHONE (INCLUDE AREA CODE): (907)-562-4775

8. PATIENT STATUS: Single X / Married / Other; Employed / Full-Time Student / Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):
a. OTHER INSURED'S POLICY OR GROUP NUMBER:
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
c. EMPLOYER'S NAME OR SCHOOL NAME:
d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / X NO
b. AUTO ACCIDENT? YES / X NO PLACE (State)
c. OTHER ACCIDENT? YES / X NO
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER:
a. INSURED'S DATE OF BIRTH: 08 04 46 SEX: F X
b. EMPLOYER'S NAME OR SCHOOL NAME:
c. INSURANCE PLAN NAME OR PROGRAM NAME: AK-BCCEDP
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / X NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 06/13/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): ** ** **

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM ** ** ** TO ** ** **

19. RESERVED FOR LOCAL USE: 70280

20. OUTSIDE LAB? YES / X NO $ CHARGES: 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
V76.12 MAMMOGRAM, BREAS
1. ___ 2. ___ 3. ___ 4. ___

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.

A From MM DD YY	A To MM DD YY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies CPT/HCPCS Modifier	E Diagnosis Code	F $ Charges	G Days or Units	H EPSDT Family Plan	I EMG	J COB	K Reserved for Local Use
06 08 99	06 08 99	50	4	76092	1	~~100 00~~ 69.23	1				92-0047965

Ok to pay
$69.23 01-06311441 06602301 73230
[signature] 07-11-01

JUL 10 2001

SECTION OF MATERNAL, CHILD & FAMILY HEALTH
ANCHORAGE OFFICE

69.23 69.23

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 92-0047965 SSN EIN: X EIN

26. PATIENT'S ACCOUNT NO.: 040075-01

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES / NO

28. TOTAL CHARGE: $ ~~100 00~~

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ ~~100 00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
PAM ENGLE PA-C
SIGNED DATE 06/13/01

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
FDA Mam Cert# 183533

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Anchorage Neighborhood Hlth Ctr
P.O. Box 201849
ANCHORAGE AK 99520-1849
PIN# 92-0047965 GRP# 92-0047965

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB 0938-0008

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE: 07 12 1979 — SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): 2141 WASHNGTON AVE

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): 2141 WASHNGTON AVE

CITY: ANCHORAGE | STATE: AK

8. PATIENT STATUS: Single | Married X | Other; Employed | Full-Time Student | Part-Time Student

CITY: ANCHORAGE | STATE: AK

ZIP CODE: 99515 | TELEPHONE (Include Area Code): (907)-277-7492

ZIP CODE: 99515 | TELEPHONE (INCLUDE AREA CODE): (907)-277-7492

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) — YES | X NO

a. INSURED'S DATE OF BIRTH: 07 12 79 — SEX: M | F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M | F

b. AUTO ACCIDENT? — YES | X NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? — YES | X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: AK-BCCEDP

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE — DATE: 06/13/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 03 02 00

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: SALVADORI, GABRIEL V

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM ** ** ** TO ** ** **

19. RESERVED FOR LOCAL USE: 97817-FPC

20. OUTSIDE LAB? YES | X NO — $ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 564.1 COLON, IRRITABLE
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.

From MM DD YY	To MM DD YY	Place of Service	Type of Service	CPT/HCPCS Modifier	Diagnosis Code	$ Charges	Days or Units	EPSDT Family Plan	EMG	COB	Reserved for Local Use
03 02 00	03 02 00	50	1	99213	1	~~81 00~~ 52.97	1				92-0047965
03 02 00	03 02 00	50	2	57452	1	~~222 00~~ 91.12	1				

RECEIVED
[date illegible] 2001
SECTION OF MATERNAL, CHILD & FAMILY HEALTH
ANCHORAGE OFFICE

Ok to pay
$ 144.09 ANN 84523
00 0631 1441 73230
[signature] 09-6-01

144.09

25. FEDERAL TAX I.D. NUMBER: 92-0047965 — SSN EIN X

26. PATIENT'S ACCOUNT NO.: 062053-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES | NO

28. TOTAL CHARGE: $ ~~303 00~~

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ ~~303 00~~ 144.09

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

JOAN F HOFFMAN MD

SIGNED — DATE: 06/13/01 FDA Mam Cert# 183533

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Anchorage Neighborhood Hlth Ctr
P.O. Box 201849
ANCHORAGE AK 99520-1849

PIN# 92-0047965 | GRP# 92-0047965

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88 — PLEASE PRINT OR TYPE — FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
02 14 00					14.60					

RECEIVED

SEP 05 2001

SECTION OF MATERNAL CHILD & FAMILY HEALTH ANCHORAGE OFFICE

Ok to pay

$14.60 00-06311441 73230

09-6-01

14.60

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB 0938-0008

AF-MCH-FOO
3601 C STREET STE. 934
PO BOX 240249
ANCHORAGE AK 99524-0249

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY 05 14 71 SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 1315 CORDOVA ST #309

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street) 1315 CORDOVA ST #309

CITY ANCHORAGE STATE AK

8. PATIENT STATUS Single [X] Married Other

CITY ANCHORAGE STATE AK

ZIP CODE 99501 TELEPHONE (Include Area Code) (907)276-7280

Employed Full-Time Student Part-Time Student

ZIP CODE 99501 TELEPHONE (INCLUDE AREA CODE) (907)276-7280

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY 05 14 71 SEX M F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME AF-BCCEDP

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 04/12/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 03 31 00

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE SALVADORI, GABRIEL V

17a. I.D. NUMBER OF REFERRING PHYSICIAN 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE 88771-FBC

20. OUTSIDE LAB? YES [X] NO $ CHARGES 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V76.1 SCREENING, BREAS
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 31 00	03 31 00	50	1	99212 GC	1	~~[illegible] 00~~ 38.82	1				92-0047965

Ok to pay

$ 38.82 00-06311441 73230

[signature] 09-6-01

RECEIVED

SEP 06 2001

SECTION OF MATERNAL, CHILD & FAMILY HEALTH, ANCHORAGE OFFICE

38.82

25. FEDERAL TAX I.D. NUMBER SSN EIN 92-0047965

26. PATIENT'S ACCOUNT NO 0501 / 5-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE $ [illegible] 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ [illegible] 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED [illegible] MD DATE 04 12 01 FOR MAR [illegible]

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Anchorage Neighborhood Hlth Ctr
P.O. Box 201344
ANCHORAGE AK 99520-1344
PIN# 92-0047965 GRP# 92-0047965

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)

PLEASE DO NOT STAPLE IN THIS AREA

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

6\11

HEALTH INSURANCE CLAIM FORM

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE: 05061956 SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): 1147 LATOUCHE

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 1147 LATOUCHE

CITY: ANCHORAGE STATE: AK

8. PATIENT STATUS: Single Married X Other; Employed Full-Time Student Part-Time Student

CITY: ANCHORAGE STATE: AK

ZIP CODE: 99501 TELEPHONE (Include Area Code): (907-278-5829

ZIP CODE: 99501 TELEPHONE (INCLUDE AREA CODE): (907-278-5829

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

RECEIVED JUL 25 2001 SECTION OF MATERNAL CHILD & FAMILY HEALTH ANCHORAGE OFFICE

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES X NO
b. AUTO ACCIDENT? YES X NO PLACE (State)
c. OTHER ACCIDENT? YES X NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH: [redacted] SEX: M F X

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: AK-BCCEDP

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 06/20/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): ** ** **

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM ** ** ** TO ** ** **

19. RESERVED FOR LOCAL USE: 8.38995

20. OUTSIDE LAB? YES X NO $ CHARGES: 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): V76.12 MAMMOGRAM, BREAST

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
12 15 99	12 15 99	50	4	76092	1	~~100 00~~ 66.22	1				92-0047965

RECEIVED 2001 SECTION OF MATERNAL CHILD & FAMILY HEALTH ANCHORAGE OFFICE

Ok to pay
$66.22 06-06311441 73230
[signature] 9.6.01

66.22 66.22

25. FEDERAL TAX I.D. NUMBER: 92-0047965 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 045374-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ ~~100 00~~

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ ~~100 00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

TECHNICIAN XRAY XRAY

SIGNED DATE 06/20/01 FDA Mam Cert# 183533

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Anchorage Neighborhood Hlth Ctr
P.O. Box 201849
ANCHORAGE AK 99520-1849
PIN# 92-0047965 GRP# 92-0047965

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90)

Patient Tracking Fees - Quarter 4

Provider: ANHC

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			5/8/2001	99396	$145.00	$30.00
			4/26/2001	99396	$145.00	$30.00
			6/11/2001	99386	$145.00	$30.00
			3/30/2001	88164	$31.00	$30.00
			4/13/2000	99214	$117.00	$30.00
			3/27/2001	99214	$117.00	$30.00
			5/22/2001	88164	$31.00	$30.00
			3/15/2001	99203	$119.00	$30.00
			5/3/2001	99396	$145.00	$30.00
			6/1/2001	88164	$31.00	$30.00
			4/18/2001	99214	$117.00	$30.00
			1/19/2001	88164	$31.00	$30.00
			6/1/2001	99214	$117.00	$30.00
			4/12/2001	99204	$170.00	$30.00
			6/27/2001	99396	$145.00	$30.00
			5/15/2001	99396	$145.00	$30.00
			5/11/2001	99396	$145.00	$30.00
			5/11/2001	99214	$117.00	$30.00
			6/6/2001	88164	$31.00	$30.00
			7/13/2001	99397	$165.00	$30.00
			2/20/2001	99386	$175.00	$30.00
			2/12/2001	99213	$145.00	$30.00
			5/31/2001	99213	$81.00	$30.00
			6/14/2001	88164	$31.00	$30.00

Patient Tracking Fees - Quarter 4

Provider: ANHC

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			6/15/2001	99204	$170.00	$30.00
			5/2/2001	88164	$31.00	$30.00
			7/11/2001	99396	$145.00	$30.00
			4/30/2001	99214	$117.00	$30.00
			5/2/2001	88164	$31.00	$30.00
			5/11/2001	88164	$31.00	$30.00
			3/14/2001	99214	$117.00	$30.00
			5/3/2001	99396	$145.00	$30.00
			5/10/2001	88164	$31.00	$30.00
			5/16/2001	88164	$31.00	$30.00
			4/16/2001	99215	$187.00	$30.00
			6/7/2001	99396	$145.00	$30.00
			5/9/2001	99213	$81.00	$30.00
			6/9/1999	99214	$93.00	$29.00
			4/5/2001	99213	$81.00	$30.00
			5/15/2001	88164	$31.00	$30.00
			7/13/2001	99213	$81.00	$30.00
			2/26/2001	99213	$81.00	$30.00
			5/31/2001	88164	$31.00	$30.00
			6/8/2001	99396	$145.00	$30.00
			5/11/2001	99214	$117.00	$30.00
			6/18/2001	88164	$31.00	$30.00
			4/18/2001	99214	$117.00	$30.00
			6/15/2001	99396	$145.00	$30.00

Patient Tracking Fees - Quarter 4

Provider: ANHC

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			6/1/2001	99386	$175.00	$30.00
			3/22/2001	88164	$31.00	$30.00
			4/27/2001	88164	$31.00	$30.00

Total Patient Tracking Fees: $5,849.00

Ok to pay ANN 84583

$ 90.00 01-06311441 06602300 ~~73230~~

02-2-01 73270

Ok to pay

$ 59.00 00-06311441 06602300 ~~73230~~

02-2-01 73270

Ok to pay

$ 5490.00 01-06311441 06602301 ~~73230~~

02-2-01 73270

Ok to pay

$ 210.00 02-06311441 06602301 ~~73230~~

02-2-01 73270

ANCHORAGE

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
P.O. BOX

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)
P.O. BOX

CITY
ANCHORAGE
STATE
AK

8. PATIENT STATUS
Single Married Other
Employed Full Time Student Part-Time Student

CITY
ANCHORAGE
STATE
AK

ZIP CODE
TELEPHONE (Include Area Code)
( )

ZIP CODE
TELEPHONE (INCLUDE AREA CODE)
( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. AUTO ACCIDENT? YES NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME
AK-BCBSDA

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE
SIGNED
DATE 01/25/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE
SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN
92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE
93038

20. OUTSIDE LAB? NO — $ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1. V72.3 GYNECOLOGICAL E
2. V25.09 FAMILY PLANNING

Ok to pay — ANN 84583
$ 96.16 00 0631144173230
(signature) 09-26-01

22. MEDICAID RESUBMISSION — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]					[illegible]
03 29 00	03 29 00	50	5	[illegible]		[illegible]					
03 29 00	03 29 00	50	5	88164		14.46		3			
[illegible] 29 00	03 29 00	[illegible]									
[illegible]											
						96.16					

RECEIVED
JAN 29 2001
SECTION OF MATERNAL, FAMILY HEALTH
ANCHORAGE OFFICE
96.16

25. FEDERAL TAX I.D. NUMBER — SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE 01/25/01

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
ANCHORAGE
PIN# — GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

3601 C STREET
PO BOX 240249
ANCHORAGE AK

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) P.O. BOX 230124

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street) P.O. BOX 230124

CITY ANCHORAGE STATE AK

8. PATIENT STATUS Single Married Other; Employed Full-Time Student Part-Time Student

CITY ANCHORAGE STATE AK

ZIP CODE 99523 TELEPHONE (Include Area Code) (907) 345-4764

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

FY 06

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 01/25/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN 92-0047565

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE 93038

20. OUTSIDE LAB? YES NO $ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V72.3 GYNECOLOGICAL E
2. V25.09 FAMILY PLANNING
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 29 00	03 29 00	50	1	99214	1 2		1				92-0047565
					1						

RECEIVED

JAN 29 2001

SECTION OF MATERNAL, CHILD & FAMILY HEALTH ANCHORAGE OFFICE

25. FEDERAL TAX I.D. NUMBER 92-0047565 SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ANCHORAGE

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION — PATIENT AND INSURED INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB 0938-0008

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE MM DD YY: 06251976 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): 9725 INDEPENDENCE DR. #A204
CITY: ANCHORAGE STATE: AK
ZIP CODE: 99507 TELEPHONE (Include Area Code): (907)-677-8874

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 9725 INDEPENDENCE DR. #A204
CITY: ANCHORAGE STATE: AK
ZIP CODE: 99507 TELEPHONE (INCLUDE AREA CODE): (907)-677-8874

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OT
b. OT MI
c. EI
d. II

F4 99

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO
b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. OTHER ACCIDENT? [ ] YES [X] NO
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH MM DD YY: 06 25 76 SEX: M [ ] F [X]
b. EMPLOYER'S NAME OR SCHOOL NAME: DENNIS MILLHOUSE
c. INSURANCE PLAN NAME OR PROGRAM NAME: AK-BCCEDP
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes, return to and complete item 9 a-c.*

...RE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of ... medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 09/04/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: ** ** **

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM ** ** ** TO ** ** **

19. RESERVED FOR LOCAL USE: 98759

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 ...
1. 616.10 VAGINITIS AND VD
2. V72.3 GYNECOLOGICAL E

Ok to pay $ 67.57 99 AAM 94583 -06311441 73230
[signature] 09-26-01

22. ...ISSION ORIGINAL REF. NO.
23. ...TION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
02 03 00	02 03 00	50	1	99213	1 2	~~52 00~~ 52.97	1				92-0047965
~~02 03 00~~	~~02 03 00~~	~~50~~	~~5~~	~~[illegible]~~	1	0 00	1				
02 03 00	02 03 00	50	5	87490	1	0 00	1				
02 03 00	02 03 00	50	5	88164	1	~~20 00~~ 14.60	1				
~~02 03 00~~	~~02 03 00~~	~~50~~	~~5~~	~~87210~~	1	~~20 00~~					
						67.57					

SECTION OF MATERNAL, CHILD & FAMILY HEALTH ANCHORAGE OFFICE

25. FEDERAL TAX I.D. NUMBER: 92-0047965 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 063205-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ ~~102 00~~

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ ~~102 00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SORAYA ARAGUNDI MD
SIGNED DATE: 09/04/01 FDA Mam Cert# 183533

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

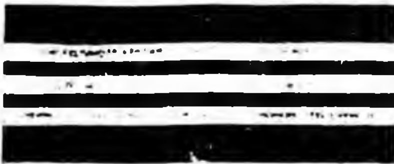
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Anchorage Neighborhood Hlth Ctr
P.O. Box 201949
ANCHORAGE AK 99520-1949
PIN# 92-0047965 GRP# 92-0047965

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

CARRIER | PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION



PLEASE DO NOT STAPLE IN THIS AREA

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY 11 19 1964 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 317 STATE ST. #B

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street) 317 STATE ST. #B

CITY ANCHORAGE STATE AK

8. PATIENT STATUS Single [ ] Married [ ] Other [X] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY ANCHORAGE STATE AK

ZIP CODE 99504 TELEPHONE (Include Area Code) (907)-522-1490

ZIP CODE 99504 TELEPHONE (INCLUDE AREA CODE) (907)-522-1490

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY 11 19 64 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME TRIPLE AAA SERV

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME AK-BCCEDP

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06/13/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) ** ** **

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM ** ** ** TO ** ** **

19. RESERVED FOR LOCAL USE 105154 MT

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V72.3 GYNECOLOGICAL E
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
04 18 00	04 18 00	50	1	99201	1	~~72.00~~ 46.12	1				92-0047965
~~04 18 00~~	~~04 18 00~~	~~50~~	~~5~~	~~87252~~	1	87.00	1				
AAN 84583											
				00-0631141 0060 2300		13230					46.12
						46.12					

RECEIVED

SECTION OF MATERNAL CHILD & FAMILY HEALTH ANCHORAGE OFFICE

25. FEDERAL TAX I.D. NUMBER 92-0047965 SSN EIN [X]

26. PATIENT'S ACCOUNT NO. 073257-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE $ ~~160.00~~

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ ~~160.00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

CORINNE BARCLAY PA-C

SIGNED DATE 06/13/01 FDA Mam Cert# 183533

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Anchorage Neighborhood Hlth Ctr
P.O. Box 201849
ANCHORAGE AK 99520-1849
PIN# 92-0047965 GRP# 92-0047965

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY 12171960 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) PO BOX 111446

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street) PO BOX 111446

CITY ANCHORAGE STATE AK

8. PATIENT STATUS Single [X] Married [ ] Other [ ]

CITY ANCHORAGE STATE AK

ZIP CODE 99511-1446 TELEPHONE (Include Area Code) (907) 229-3224

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE 99511-1446 TELEPHONE (INCLUDE AREA CODE) (907) 229-3224

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY 12 17 60 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME SELF EMPLOYED

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME AK-BCCEDP

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 03/29/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ** ** ** ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM ** ** ** TO ** ** **

19. RESERVED FOR LOCAL USE 31321

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V72.3 GYNECOLOGICAL E

2.

3.

4.

00-063 144 06602300

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. ~~1330~~ 1757

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 27 00	03 27 00	50	1	99213	1	~~61 00~~ 52.97	1				92-0047965
~~03 27 00~~	~~03 27 00~~	~~50~~	~~5~~	~~36701~~	~~1~~	~~8 00~~	1				
03 27 00	03 27 00	50	5	~~87420~~	1	~~20 00~~	1				
03 27 00	03 27 00	50	5	88164	1	~~20 00~~ 14.60	1				
~~03 27 00~~	~~03 27 00~~	~~50~~	~~5~~	87210	1	20 00	1				
03 27 00	~~03 27 00~~	~~50~~	~~5~~	~~84703~~	1	~~15 00~~	1				

RECEIVED DEC 04 2001 SECTION OF MATERNAL CHILD & FAMILY HEALTH ANCHORAGE OFFICE

25. FEDERAL TAX I.D. NUMBER 92-0047965 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO. 015167-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE $ ~~157 00~~ 67.57

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ ~~157 00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHYLLIS DUNCKEL MD

SIGNED DATE 03/29/01 FDA Mam Cert# 183533

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Anchorage Neighborhood Hlth Ctr
P.O. Box 201849
ANCHORAGE AK 99520-1849

PIN# 92-0047965 GRP# 92-0047965

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90)

CARRIER / PATIENT AND INSURED INFORMATION / PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

Screen

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE: 01 19 1969 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): 212 TAYLOR ST #1
CITY: ANCHORAGE STATE: AK
ZIP CODE: 99508 TELEPHONE (Include Area Code): (907)278-0199

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 212 TAYLOR ST #1
CITY: ANCHORAGE STATE: AK
ZIP CODE: 99508 TELEPHONE (INCLUDE AREA CODE): (907)278-0199

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):
a. OTHER INSURED'S POLICY OR GROUP NUMBER:
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
c. EMPLOYER'S NAME OR SCHOOL NAME:
d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO
b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. OTHER ACCIDENT? [ ] YES [X] NO
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER:
a. INSURED'S DATE OF BIRTH: 01 19 69 SEX M [ ] F [X]
b. EMPLOYER'S NAME OR SCHOOL NAME:
c. INSURANCE PLAN NAME OR PROGRAM NAME: AK-BCCEDP
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 07/06/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): ** ** **

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM ... TO ...

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM ** ** ** TO ** ** **

19. RESERVED FOR LOCAL USE: 104410 MT

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V72.3 GYNECOLOGICAL F
2. 626.4 MENSTRUATION, IR
3. 616.10 VAGINITIY
4.

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 03 00	03 03 00	50	1	99201	1	~~61 00~~ 46.12	1				92-0047965

RECEIVED

DEC 03 2001

SECTION OF MATERNAL, CHILD & FAMILY HEALTH ANCHORAGE OFFICE

$46.12

00C631441.0602300-73230

46.12

25. FEDERAL TAX I.D. NUMBER: 92-0047965 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 048668-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ ~~61 00~~

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ ~~61 00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
CORINNE BARCLAY PA-C
SIGNED DATE 07/06/01 FDA Mam Cert# 183533

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Anchorage Neighborhood Hlth Ctr
P.O. Box 201849
ANCHORAGE AK 99520-1849
PIN# 92-0047965 GRP# 92-0047965

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

screen

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [ ] CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (VA File #) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE MM DD YY: 04101950 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): 701 HOYT APT. #4

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 701 HOYT APT. #4

CITY: ANCHORAGE STATE: AK

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: ANCHORAGE STATE: AK

ZIP CODE: 99505 TELEPHONE (Include Area Code): (907)-277-8087

ZIP CODE: 99508 TELEPHONE (INCLUDE AREA CODE): (907)-277-8087

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 04 10 50 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: AK-BCCEDP

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE 05/18/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ** ** ** ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM ** ** ** TO ** ** **

19. RESERVED FOR LOCAL USE: 105751

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 311 DEPRESSIVE DISOR
2. V76.12 MAMMOGRAM, BREAS
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
~~05 24 00~~	~~05 24 00~~	~~50~~	~~1~~	~~992x2~~	~~1~~	~~62.00~~	1 N/A				92-0047965
05 24 00	05 24 00	50	4	76092	2	~~102.00~~ 67.81	1				

RECEIVED
DEC 04 2001
SECTION OF MATERNAL CHILD & FAMILY HEALTH OFFICE ANCHORAGE

#67.81

00-0631144106602500-73230

67.81
67.81

25. FEDERAL TAX I.D. NUMBER: 92-0047965 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 073536-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO

28. TOTAL CHARGE: $ ~~165.00~~

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ ~~165.00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JULIAN GONZALEZ MD
SIGNED DATE 05/18/01 FDA Mam Cert# 165583

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Anchorage Neighborhood Hlth Ct
P.O. Box 201849
ANCHORAGE AK 99520-1849
PIN# 92-0047965 GRP# 92-0047965

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

AK-BCCEDP
3601 C STREET STE. #934
PO. BOX 240249
ANCHORAGE AK 99524-0249

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE MM DD YY: 04 01 1950 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): 701 HOYT APT. #4

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 701 HOYT APT. #4

CITY: ANCHORAGE STATE: AK

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: ANCHORAGE STATE: AK

ZIP CODE: 99508 TELEPHONE (Include Area Code): (907)-277-8087

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 99508 TELEPHONE (INCLUDE AREA CODE): (907)-277-8087

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 04 10 50 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: AK-BCCEDP

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO ... If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE 05/18/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

14. DATE OF CURRENT: MM DD YY ** ** ** ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM ** ** ** TO ** ** **

19. RESERVED FOR LOCAL USE: 105751

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V76.2 PAP SMEAR; CERVI
2. ___
3. ___
4. ___

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.

A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
05 05 00	05 05 00	50	1	99204	1	~~170 00~~ 143.88	1				92-0047965

RECEIVED

$143.88 DEC 04 2001

00-0631441-06602300 13230

[signature] 12-4

143.88

SECTION OF MATERNAL, CHILD & FAMILY HEALTH ANCHORAGE OFFICE

25. FEDERAL TAX I.D. NUMBER: 92-0047965 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 07-36.36-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO

28. TOTAL CHARGE: $ ~~170 00~~

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ ~~170 00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

JULIAN GONZALEZ MD

SIGNED DATE 05/18/01 FDA Mam Cert# 183533

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Anchorage Neighborhood Hlth Ctr
P.O. Box 201849
ANCHORAGE AK 99520-1849

PIN# 92-0047965 GRP# 92-0047965

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PATIENT AND INSURED INFORMATION / PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE (MM DD YY): 04101950 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): 701 HOYT APT. #4
CITY: ANCHORAGE STATE: AK
ZIP CODE: 99508 TELEPHONE (Include Area Code): (907)-277-8087

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 701 HOYT APT. #4
CITY: ANCHORAGE STATE: AK
ZIP CODE: 99508 TELEPHONE (INCLUDE AREA CODE): (907)-277-8087

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
c. EMPLOYER'S NAME OR SCHOOL NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO
b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. OTHER ACCIDENT? [ ] YES [X] NO
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH MM DD YY: 04 10 50 SEX M [ ] F [X]
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME: AK-BCCEDP
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED ______ DATE 05/18/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED ______

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: ** ** **

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM ** ** ** TO ** ** **

19. RESERVED FOR LOCAL USE: 105751

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V76.2 PAP SMEAR; CERVI
2. ~~V20.2 ROUTINE INFANT O~~
3. ___
4. ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies CPT/HCPCS Modifier	E Diagnosis Code	F $ Charges	G Days or Units	H EPSDT Family Plan	I EMG	J COB	K Reserved for Local Use
~~05 05 00~~	~~05 05 00~~	~~50~~	~~5~~	~~87797~~		~~0 00~~	1				92-0047965
05 05 00	05 05 00	50	5	88164	1	~~31 00~~ 14.60	1				
~~05 05 00~~	~~05 05 00~~	~~50~~	~~5~~	~~87210~~		~~21 00~~	1				

00-0631441-0660230 73230 #14.60
12-4-01 14.60

RECEIVED DEC 04 2001
SECTION OF MATERNAL CHILD & FAMILY HEALTH ANCHORAGE OFFICE

25. FEDERAL TAX I.D. NUMBER: 92-0047965 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 073536-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO

28. TOTAL CHARGE: $ ~~52 00~~
29. AMOUNT PAID: $ 0 00
30. BALANCE DUE: $ ~~52 00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JULIAN GONZALEZ MD
SIGNED DATE 05/18/01 FDA Mam Cert# 183533

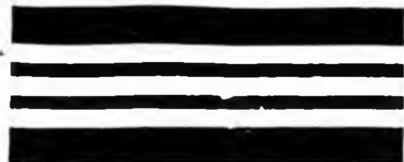
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Anchorage Neighborhood Hlth Ct
P.O. Box 201849
ANCHORAGE AK 99520-1849
PIN# 92-0047965 GRP# 92-0047965

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PLEASE
DO NOT
STAPLE
IN THIS
AREA



SCREEN

PICA

HEALTH INSURANCE CLAIM FORM

MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) PO BOX 280521

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No. Street)

CITY ANCHORAGE STATE AK

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE ON FILE

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNATURE ON FILE

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
02 19 00 02 19 00	50	1	99213		53.97					
02 19 00 02 19 00	50	5			14.60					

Ok to pay

$ 67.57 00-06311441 73230

12-7-01

67.57

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

CHILD ... ANCHORAGE

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $ 67.57

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED DATE

PLEASE PRINT OR TYPE

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

AK-BCCEDP
3601 C STREET STE. #33-
PO BOX 240249
ANCHORAGE AK 99524-0249

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE MM DD YY: 11 23 1974 SEX M F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): 3236 EAST 43RD AVE

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 3236 EAST 43RD AVE

CITY: ANCHORAGE STATE: AK

8. PATIENT STATUS: Single Married [X] Other; Employed Full-Time Student Part-Time Student

CITY: ANCHORAGE STATE: AK

ZIP CODE: 99508 TELEPHONE (Include Area Code): (206) 561-1802

ZIP CODE: 99508 TELEPHONE (INCLUDE AREA CODE): (206) 561-1802

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 11 23 74 SEX M F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: AK-BCCEDP

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO *If yes,* return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 10/05/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE: 90384

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V72.3 GYNECOLOGICAL E
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
03 10 00	03 10 00	11	5	99164	1	~~00~~ 14.60	1				92-0047965

RECEIVED

DEC 21 2001

SECTION OF MATERNAL, CHILD & FAMILY HEALTH ANCHORAGE OFFICE

Ok to pay

$14.60 00-06311441 73230

[signature] 12-26-01

1460

1460

25. FEDERAL TAX I.D. NUMBER: 92-0047965

26. PATIENT'S ACCOUNT NO.: 006025-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE $ ~~00~~

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ ~~00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SUSAN E. [illegible] MD

SIGNED DATE: 3 05 01

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

[illegible]
P.O. BOX [illegible]
ANCHORAGE [illegible]

PIN# [illegible] GRP# [illegible]

PLEASE DO NOT STAPLE IN THIS AREA

STATE OF ALASKA-BCCEDP
PO BOX 240249
ANCHORAGE AK 995240249

(PRI)JP(LINE)J
OP: LJ

PICA APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted], [redacted]

3. PATIENT'S BIRTH DATE MM DD YY 1937 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted], [redacted]

5. PATIENT'S ADDRESS (No., Street) PO BOX 570059

6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street) SAME AS PATIENT

CITY CHUGIAK STATE AK

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE 99567 TELEPHONE (Include Area Code) (907) 696-3400

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY 1937 SEX M F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO X PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME STATE OF ALASKA-BCCEDP

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X *If yes, return to and complete item 9 a-d*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE DOUGLAS M. SAVIKKO, DO

17a. I.D. NUMBER OF REFERRING PHYSICIAN E55135

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V76.12
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 05 00	01 05 00	11	4	76092-26	1	~~[illegible]~~ 21.69	1				1757

Ok to pay FLR3467

$21.69 00-06311441 73230

[signature] 09-10-01

RECEIVED SEP 06 2001

21.69 SECTION OF MATERNAL, CHILD [illegible] HEALTH 21.69 ANCHORAGE OFFICE

25. FEDERAL TAX I.D. NUMBER 92-0037443 SSN EIN

26. PATIENT'S ACCOUNT NO. 01 114672

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 34.00

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ ~~34.00~~

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) DAVID MUELLER, MD 08 29 01

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) PIC MOBILE 3340 PROVIDENCE DR ANCHORAGE AK 99508

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # AK RADIOLOGY ASSOCIATES 4001 DALE ST, #105 ANCHORAGE AK 99508 PIN# 7-55-1571 GRP#

COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2)(12-90)

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

Patient's birth date: 07 09 [illegible]

Insured's name: Same as Patient

Patient's address: PO BOX 772472

City: Eagle River State: AK

Zip code: 99577 Telephone: 338 8715

Ok to pay

$608.01 00-06311412 06602100 77610

P. Kinnunen 3/9/01

SECTION OF MATERNAL, CHILD & FAMILY HEALTH ANCHORAGE OFFICE

Signed: Signature on file

Signed: Signature on file

Ok to pay

$9.51 01-06311412 06602101 77610

Diagnosis: V26.52 P. Kinnunen 3/9/01

V25.9

Date of service	Place	Procedure	Diagnosis code	Charges
05 10 00	50	99202	2	91 00
06 14 00	50	55250	1	~~609 00~~ $517.01
11 06 00	50	89300	1	~~57 00~~ $9.51

2001

SECTION OF MATERNAL CHILD & FAMILY HEALTH ANCHORAGE OFFICE $617.52

Total charge: 757 00 ~~757~~

AUG - 3 2001

Patient Tracking Fees - Quarter 4

Provider: Aurora Clinic 69

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			5/29/2001	99215	$100.00	$30.00
			3/6/2000	99215	$121.35	$30.00
			5/15/2001	99215	$100.00	$30.00
			3/24/2001	99215	$100.00	$30.00
			4/28/2001	99213	$60.00	$30.00
			6/8/2001	99215	$100.00	$30.00
			6/20/2001	99215	$100.00	$30.00
			6/9/2001	99215	$100.00	$30.00
			1/9/2001	99215	$20.00	$30.00
			5/19/2001	99205	$110.00	$30.00
			6/22/2001	99215	$100.00	$30.00
			5/1/2001	99205	$110.00	$30.00
			5/19/2001	99215	$100.00	$30.00
			5/11/2001	99204	$75.00	$30.00
			6/6/2001	99215	$100.00	$30.00
			6/9/2001	99215	$100.00	$30.00
			4/13/2001	99215	$100.00	$30.00
			5/22/2001	99205	$110.00	$30.00
			6/16/2001	99205	$110.00	$30.00
			5/19/2001	99205	$110.00	$30.00
			6/19/2001	99205	$110.00	$30.00
			5/11/2001	99215	$100.00	$30.00
			5/19/2001	99215	$100.00	$30.00
			5/19/2001	99215	$100.00	$30.00

Patient Tracking Fees - Quarter 4

Provider: Aurora Clinic 69

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			6/9/2001	99215	$100.00	$30.00
			5/8/2001	99215	$100.00	$30.00
			4/20/2001	99205	$110.00	$30.00
			7/7/2001	99205	$110.00	$30.00
			7/7/2001	99215	$100.00	$30.00
			5/15/2001	99215	$100.00	$30.00
			Total Patient Tracking Fees:			$900.00

Ok to pay

$60.00 02-06311441 06602301 73250

[signature] 02-2-01

Bill Review

V | Done | QuickNotes | Claim Hist | ?

Visit Dt	Bill Typ	FeeNum	Off	Dr.	Plan	Charge	Payment	Adjmnt
01/19/00	207990 Bll	409162	ol	jg		95.00	0.00	0.00

Operator ATP
First Form Printed For On **/**/** For 0.00 E? n
Last Form Printed For On **/**/** For 0.00 E? n
Last Tracer Printed For On **/**/** Susp? n Suprs Stm? n

Notes For: [redacted]
07097000 Pint Paid 0.00
07097000 Plan Paid 0.00
Balance 95.00

Visit Dt	Procedure	Dr.	Diagnosis	S	POS	Charge	Credit
01/19/00	Ov - New Patient - L	jg	Throat Pain		50	75.00	
06/06/01	Pd 06/06/01 A D		Adj:B/D Agency Placeme				-75.00
01/19/00	Streptococcus, Group	jg	Throat Pain		50	20.00	
06/06/01	Pd 06/06/01 A D		Adj:B/D Agency Placeme				-20.00
06/27/01	Adj:B/D Agency Place	jg	Throat Pain			0.00	
06/27/01	Pd 06/27/01 RRW		Adj:B/D Agency Placeme				95.00

Enter Function Key:

Jun. 27. 2001 4:36PM

No. 2012 P. 1

4060347 18

REQUEST # 002AF2226
CODE EN#0603438-26 LN#9
PVN # FAC00349
AMOUNT $95.00
AUTHORIZATION [illegible]
6-25-01

deleted
~~4559770-26~~

Fairview Health Center
1217 E. 10th Avenue
Anchorage, AK 99501
(907) 257-4600 Phone

- (907) 257-4625 Fax
  Dr. Madeleine Grant
  John Riley, PA-C

- (907) 257-4620 Fax
  Dr. Bruce Chandler
  Dr. Brad Gessner
  Dr. Tom Hunt
  Jill Johnson, PA-C

- (907) 257-4692 Fax
  Dr. Sharon Smith
  Dr. Soraya Aragundi
  Pam Engle, PA-C
  Charlotte Gardner, PA-C

- (907) 257-4644 Fax
  Medical Records

- (907) 257-4654 Fax
  Special Programs

- (907) 257-4691 Phone
- (907) 257-4687 Fax
  ANHC Pharmacy

- (907) 257-4661 Phone
- (907) 257-4654 Fax
  ANHC Dental Clinic

MIS – 257-4665

Mt. View Health Center
3521 Mt. View Drive
Anchorage, AK 99508
(907) 792-2300 Phone
- (907) 792-2399 Fax
  Dr. Phyllis Dunckel
  Corinne Barclay, PA-C

Administrative Office
903 W. N. Lights Blvd. #218
Anchorage, AK 99503
(907) 792-6534 Phone
(907) 792-6520 Ex. Fax
(907) 792-6544 Bus. Fax
(907) 792-6524 Billing Mgr.

JUN. 27. 2001 4:35PM

Facsimile transmittal

To: ANNA | Fax: 261-3702
From: Robin | Date: 6/27/01
Re: [redacted] | Pages: 2
CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Anna -

I took acct out of Collections
Please call me and let me
know if you are resp. for
Bill

792-6511

The information contained in this transmission is privileged and confidential. It is intended only for the use of the individual or entity named above. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT YOU ARE NOT AUTHORIZED TO REVIEW THE FOLLOWING PAGES AND THAT ANY DISSEMINATION, DISTRIBUTION OR COPY OF THIS COMMUNICATION IS STRICTLY PROHIBITED. If you have received this communication in error, please notify us immediately by telephone (collect) and destroy the original message. Thank you.

Alaska Department of Health and Social Services
Division of Family and Youth Services

Region: 271 Office: Anchorage Request #: 002AF2226

REQUEST FOR SPECIAL NEEDS FUNDS FOR FOSTER CARE

Special Needs funding is assessed on an as-needed basis only and pre-authorization is required.
Limitation: This form is to used only for one time or irregular special needs expenditures on behalf of children in foster care.
Receipts and supporting documentation are required.

Child's Name: [redacted] DOB: 04-11-87 Probe Case Number: 406034718

Eligibility Status: (check one) ☐ Title IV-E eligible ☐ Not IV-E eligible ☒ Eligibility pending

Proposed services are for ☒ Child or ☐ Parent(s)/legal guardian/Indian custodian or ☐ Sibling(s) or ☐ Other family members

Proposed services are court-ordered ☐ (please attach court order)

I. Describe the specific need and how the request is consistent with the case plan (case plan must be attached): Child was in foster care and needed medical attention.

II. TITLE IV-E FOSTER CARE MAINTENANCE

1. Clothing - Initial (Refer to CPS Chapter 6.0, Section 6.2.2.8 for policy) =$
2. Clothing – Extraordinary & Justified by Case Plan =$
3. Food – Special Diet =$
4. Extraordinary Laundry (Must have medical or psychological) =$
   Describe:
5. Personal Incidentals =$
   Describe:
6. Special One-Time Items =$
   ☐ Special cribs, beds, mattresses
   ☐ Other (must be explained and within allowable DFYS regulations)
   Describe:
7. Visitation with Family – Long Distance telephone cards for the child =$
8. Licensed Child Care (Please provide DFYS license number:) =$
   Licensed Child Care for foster child:
   ☐ during foster parent's employment when the foster child is not in school
   ☐ during the foster parent's attendance at mandatory foster parent training
   ☐ during foster parents attendance at case conference, case reviews, court hearing, without foster child
   ☐ which facilitate the foster parent's attendance at Division approved activities which are beyond the scope of "ordinary parental duties"
9. Travel - Child family visitation =$

II.A SUB TOTAL IV-E FOSTER CARE MAINTENANCE	=$

III. TITLE IV E FOSTER CARE ADMINISTRATIVE

1. Travel =$

- ☐ Miles over 50 per week for foster child's attendance at administrative case or judicial reviews
- ☐ Foster child pre-placement visit or placement with foster home
- ☐ Foster Parents attendance at administrative case/judicial reviews and mandatory case conferences/team meetings
- ☐ Other approved travel by foster child as part of case plan
  Describe:
- ☐ Escort Travel as justified by case plan (may require travel authorization)
  - ☐ For visitation
  - ☐ For placement

2. Foster Parent Damages and loss =$
Refer to CPS Adm. Chapter 6.0, section 6.2.2.7 (4) (b)
Please attach form 06-9440 and police report if applicable.

3. Shipping & Freight Costs (Child's belongings only) =$

4. Other-Services critical for completion of the case plan =$

- ☐ Genetic/Paternity Testing
- ☐ Advertising for Missing Parents
- ☐ Birth Certificates
- ☐ Expert Witnesses (ICWA/Non-ICWA)
- ☐ Supervised Visitation
- ☐ Court Teleconference Costs

III. A SUB-TOTAL IV-E FC ADMINISTRATIVE	=$

IV. NON IV-E REIMBURSEMENT

1. Independent Living – limited to those expenses that facilitates the transition of foster children to independent living that are not otherwise reimbursable under maintenance or administration or other resource. =$
Describe:

2. Medical, Dental, Diagnostic, Therapeutic, and Assessment Services =$95.00
As payer of last resort (no Medicaid coverage or other third party reimbursement)
Refer to 7 AAC 53.320.

- ☒ Medical Describe: Dr. Visit
- ☐ Dental Describe:
- ☐ Diagnostic (i.e. Psych evaluations) Describe:
- ☐ Therapeutic (i.e. Counseling) Describe:
- ☐ Assessment Services Describe:
- ☐ Medical equipment, furnishings, or discretionary devises for children with special needs
  Describe:
- ☐ Travel Describe:

3. Unlicensed Child Care for Foster Child =$

- ☐ during foster parent's employment when the foster child is not in school
- ☐ during the foster parent's attendance at mandatory foster parent training
- ☐ during foster parents attendance at case conference, case reviews, court hearing, without foster child
- ☐ which facilitate the foster parent's attendance at Division approved activities which are beyond the scope of "ordinary parental duties"

4. Other services critical for completion of the case plan of a child in foster care when no other resources are available =$
Describe:

IV.A. SUBTOTAL NON-IV-E REIMBURSABLE	=$95.00

V. EXPLAIN HOW ALTERNATIVE SOURCES OF FUNDING FOR ALL ITEMS ABOVEHAVE BEEN EXHAUSTED: Medicaid did not cover.

VI. TOTAL COST: $95.00

VII. ☒ one time cost ☐ short term costs (date) to

VIII. Payee Name: Fairview Health Center Address: 1217 E. 10th Ave. Anchorage, AK 99501

IX. SSN or Fed Tax ID#: Vendor # (PVN): Reimbursement☐

X. [signature] for Jarrin Munoz 6/27/01
Social Worker Signature PCN Date

XI. APPROVALS:
[signature] 3125 6/27/01
S.W. IV Signature PCN Date

___ / / ___
S.W. V Signature PCN Date

___ / / ___
Children's Service Manager Date

___ / / ___
Family Services Program Administrator Date
Required For Requests exceeding $1,500.00 and all Out-of-State Travel

FISCAL INFORMATION (To be filled out by fiscal)

XII.	CATEGORY	COST	CODING
	IV-E Foster Care Maintenance (II. A)	$	
	IV-E Foster Care Administrative (III. A)	$	
	Non IV-E Reimbursable (IV)	$	
	TOTAL OF REQUEST:	$	

This form must be completed in full

7 AAC 53.070, 100-110 and 300-370

Patient Tracking Fees - Quarter 4

Provider: INHC

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			5/8/2001	99396	$143.00	$30.00
			4/17/2001	99396	$143.00	$30.00
			3/20/2001	99396	$143.00	$30.00
			4/10/2001	99396	$143.00	$30.00
			5/25/2001	88164	$22.90	$30.00
			5/21/2001	99386	$190.00	$30.00
			5/25/2001	88164	$22.90	$30.00
			4/26/2001	99202	$97.00	$30.00
			4/24/2001	99396	$143.00	$30.00
			12/5/2000	99214	$137.00	$30.00
			5/9/2001	88164	$22.90	$30.00
			5/2/2001	99396	$143.00	$30.00
			5/18/2001	99212	$65.00	$30.00
			5/9/2001	99386	$190.00	$30.00
			5/15/2001	99396	$143.00	$30.00
			4/6/2001	88164	$22.90	$30.00
			4/10/2001	88164	$22.90	$30.00
			4/27/2001	88164	$22.90	$30.00
			4/17/2001	99212	$65.00	$30.00
			4/26/2001	99396	$143.00	$30.00
			5/29/2001	88164	$22.90	$30.00
			[illegible]	99213	$83.00	$30.00
			4/9/2001	99214	$130.00	$30.00
			4/24/2001	99396	$143.00	$30.00

Patient Tracking Fees - Quarter 4

Provider: INHC

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			4/6/2001	99386	$190.00	$30.00
			5/7/2001	99396	$143.00	$30.00
			4/30/2001	99212	$65.00	$30.00
			4/6/2001	99396	$143.00	$30.00
			4/6/2001	99386	$190.00	$30.00
			12/18/2000	99213	$83.00	$30.00
			5/7/2001	99396	$80.90	$30.00
			5/23/2001	99214	$130.00	$30.00
			4/26/2001	99386	$190.00	$30.00
			5/9/2001	99202	$97.00	$30.00
			4/10/2001	99213	$83.00	$30.00
			4/30/2001	88164	$22.90	$30.00
			5/8/2001	99386	$190.00	$30.00
			4/3/2001	99396	$143.00	$30.00
			4/4/2001	88164	$22.90	$30.00
			4/10/2001	99214	$130.00	$30.00
					Total Patient Tracking Fees:	$1,920.00

Ok to pay INH 95180

$30.00 00-06311441 06602300 73230 70

[signature] 08-2-01

Ok to pay

$1890.00 01-06311441 06602301 73230 70

[signature] 08-2-01

Patient Tracking Fees - Quarter 4

Provider: NTN 9

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
NEIGHBOR TO NEIGHBOR			4/23/2001	99214	$88.10	$30.00
			5/15/2001	99214	$88.10	$30.00
			5/16/2001	99205	$186.20	$30.00
			4/26/2001	99204	$148.04	$30.00
			5/31/2001	99215	$130.38	$30.00
			3/22/2001	99214	$88.10	$30.00
			6/8/2001	99212	$40.43	$30.00
			5/21/2001	99214	$88.10	$30.00
			6/22/2001	99214	$88.10	$30.00
			5/17/2001	99203	$102.21	$30.00
			6/22/2001	99215	$130.38	$30.00
			[illegible]	99204	$148.04	$30.00
			[illegible]15/2000	99204	$143.88	$30.00
			4/13/2001	99214	$88.10	$30.00
			4/30/2001	99214	$88.10	$30.00
			6/14/2001	99215	$1[illegible]0.38	$30.00
			3/30/2001	99214	$88.10	$30.00
			7/11/2001	99214	$88.10	$30.00
			6/22/2001	99215	$130.38	$30.00
			4/24/2001	99213	$56.63	$30.00
			3/21/2001	99204	$148.04	$30.00
			6/8/2001	99205	$186.20	$30.0[illegible]
			3/27/2001	99202	$69.36	$30.00
			4/2/2001	99204	$148.04	$30.00

Patient Tracking Fees - Quarter 4

Provider: [illegible]

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			3/28/2001	99214	S88.10	S30.00
			5/18/2001	99215	S130.38	S30.00
			3/26/2001	99204	S148.04	S30.00
			3/30/2001	99202	S69.36	S30.00
			5/9/2001	99214	S88.10	S30.00
			6/27/2001	99203	S102.21	S30.00
			6/20/2001	99203	S102.21	S30.00
			6/15/2001	99204	S148.04	S30.00
			5/23/2001	99204	S148.04	S30.00
			5/23/2001	99204	S148.04	S30.00
			4/2/2001	99204	S148.04	S30.00

Number of Patients 107

Total Patient Tracking Fees: S3,210.00

Ok to pay NTNC1182

$ 30.00 01-06311441 06602300 73230

[signature] 08-2-01

Ok to pay

$ 30.00 01 06311441 06602300 73230

[signature] 08-2-01

Ok to pay

$ 2970.00 01-06311441 06602301 73230

[signature] 08-2-01

Ok to pay

$ 150.00 02-06311441 06602301 73230

[signature] 08-2-01

Network Business Systems, Inc.
1577 C Street
Suite 205
Anchorage AK 99501

Invoice 34597
Date 11/29/99
Page: 1
P.O. No. 99-465

Bill To: Health
SOAHSS Div Public ~~Assistance~~
3601 C Street Suite 434
PO Box 240249
Anchorage AK 99524-0249

Ship To:
SOAHSS Div Public Assistance
3601 C Street Suite 434
PO Box 240249
Anchorage AK 99524-0249

269-7935
Dora
269-7855
269-7830

FAX 562-7802 Heather

Customer ID	Salesperson ID	Shipping Method	Payment Terms	Req Ship Date	Master No.
XHSS8000	JAB100		Net 30	11/30/99	2,112

Ord'd	Shp'd	Item Number	Description	Unit Price	Disc.	Ext. Price
1	1	*NVL555	INTRANETWARE: INTEGRATING WINDOWS NT Larry Bowles Course Kit Only Did Not go to Training - Books Only!	$375.00		$375.00

7/13/01

This invoice is a certified copy of the original

Veleta A Anderson
Dir of Administration
Network Business Systems

Heather Bogan 7/13/01
Date
02 06 311 140 74222 $ 375.00

10/8/01 -

NBS does not guarantee or warrant in any way expressed or implied YR 2000 compliance of any products or services provided on this invoice.

Subtotal	$375.00
Misc	$0.00
Freight	$0.00
Trade Discount	$0.00
Total	$375.00
Pymnt Rec'd	$0.00
Balance Due	$375.00