AIG Domestic Claims, Inc.
Workers' Compensation Division

P. O Box 1821
Alpharetta, GA 30023-1821
866-642-5246 (Toll Free)
866-958-1211 (Fax)

February 6, 2008

Suzlon Rotor Corp
1711 S. Highway 75
Pipestone, MN 56164

To whom it may concern:

We are unable to process the enclosed documentation for the following reason(s):

[x] Our records indicate that an Employer's First Report of Injury has not been received for this employee. If the report has already been sent, we would appreciate your forwarding another copy with the enclosed documentation. A new Workers' Compensation injury can also be reported by phone at **(877) 399-6442.**

[x] We have researched the attached documents but have been unable to match the patient to a claim in our Workers' Compensation data base. Please verify this is a Workers' Compensation claim and that AIG is the handling administrator of these claims.

[ ] We need additional information to process (checked):

[ ] AIG CLAIM NUMBER	[ ] AIG POLICY NUMBER	[ ] TAX ID NUMBER
[ ] CLAIMANT NAME	[ ] INSURED NAME	[ ] ITEMIZED CHARGES
[ ] SS NUMBER	[ ] DATE OF INJURY/LOSS	[ ] CPT/REV CODES
[ ] DATE OF BIRTH	[ ] DATE OF SERVICE	[ ] PROVIDER NAME PHYSICAL ADDRESS

[ ] Additionally several states require the use of standard HCFA/CMS1500 or UB92/UB04 billing form. AR, CO, CT, DC, FL, KS, LA, MA, MI, MN, MS, NC, NH, NM, NV, PA, RI, SD, TX, & VT

[ ] Other: Our records indicate that your company is the designated TPA for this policy. Please notify the sender of your correct mailing address.

Please resubmit all documentation with the information requested should additional processing be necessary. **If you have any questions on this correspondence, please contact our Customer Service Department at 866-642-5246**. Thank you for your cooperation.

AIG Domestic Claims, Inc.
Document Management Center
Linda Lafond, Manager

ENCL: Original Correspondence

AIG
PO BOX 1825
ALPHARETTA 30023

0100

RETU
ALP DP15 NOV 0 8 2007

IDE

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA ☐ PICA ☐

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	TRICARE CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (Member ID#)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☒ (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
							464733127		

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
MORA ANTONIO	01 03 1976 M ☒ F ☐	MORA ANTONIO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
314 13TH ST	Self ☐ Spouse ☐ Child ☐ Other ☒	314N 14TH ST
CITY / STATE	8. PATIENT STATUS	CITY / STATE
WORTHINGTON MN	Single ☐ Married ☐ Other ☐	WORTHINGTON MN
ZIP CODE / TELEPHONE (Include Area Code)	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (Include Area Code)
56187 (507)727 0035		56187 (507)727 0035
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. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	c. OTHER ACCIDENT? ☐ YES ☒ NO	SUZLON ROTOR CORPORATION
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME
		AIG
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.
NO OTHER COVERAGE		

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: 103007

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: 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 MM DD YY FROM TO
10 11 07		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 1G D25406 / 17b. NPI 1699738559	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
BRUCE W KOCOUREK DO		
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO / $ CHARGES
		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)		23. PRIOR AUTHORIZATION NUMBER
1. 692.9 2. 3. 4.		

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID #
1 10 26 07	11		99213		1	81 00	1		NPI	1699738559
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
411831345 ☒	73911561	☒ YES ☐ NO	$ 81 00	$ 0 00	$ 81 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (507) 825 5700
D25406 BRUCE W KOCOUREK DO	PIPESTONE MEDICAL GROUP 920 4TH AVE SW PIPESTONE MN 56164-1455	PIPESTONE MEDICAL GROUP 920 4TH AVENUE SW PIPESTONE MN 56164
SIGNED 103007 DATE	a. 1073576906 b.	a. 1699738559 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

790-0116 (08-05) (OCR) 1PT.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

WC151593

Pipestone Medical Group
Avera

Medications	Diagnosis
✓	

Antonio Mora
Patient's Name

DOB 1-3-76 Page ____

(M) F Allergies NKA

Date 10-26-07 wt 327 BP 120/76 P ____ T ____ DOE 10-17-07

Rash arms, legs & back. See form. Allegra

COPY

SKIN

Circle or √ = Present or Yes, ☐ Absent or No, ut = Not Done

Date: 10 / 26 / 07 Time: ☐ AM PM

Name: Antonia Mora (M) F

Birth Date: 01 / 03 / 76 Race: C B L A O

VITAL SIGNS

Age 31 Wt 327 HT. ____ TEMP ____ O2 Sat ____

BP(L) 132/76 (R) ____ PULSE ____ RR ____

HPI - SUBJECTIVE 4

Chief Complaint: ☒ rash ☐ sore (s) ☐ wound ☐ skin lesion ☐ infection ☒ itching

Other: ____

Symptoms began: # 2 D (W) M Ago ☐ chronic condition

Started on: ☐ face ☐ scalp ☐ neck ☐ trunk ☒ arms ☐ hands ☐ groin ☐ legs ☐ feet ☐ nails

Other: ____

☒ itches ☐ tender ☐ oozing ☐ crusts ☐ rough

☒ spreading ☐ recurring ☐ seasonal ☐ painful ☐ blisters

☐ fever ☐ joint pain ☐ URI or "Cold" Sx

Contact with: ☐ plants ☒ chemicals ☐ animals

☐ treatment tried so far: Works @ Suzkn. Rash from work.

response: ____

seen elsewhere: ____

*Constant itching arms, legs + lower back.

Itches @ hs.

REVIEW OF SYSTEMS 9/2

GENERAL CONSTITUTION

☒ sleep ☒ appetite ☐ fatigued ☐ malaise ☐ active ☐ exposure to illness WNL

☐ shingles HX

GI

☐ indigestion ☐ abd pain ☐ N / V

Stools: ☐ normal ☐ loose ☐ BRB ☐ melena ☐ change

RESPIRATORY

☐ asthma ☐ smoker ☐ bronchitis ☐ pneumonia ☐ TB ☐ cough ☐ SOB ☐ wheeze

MUSCULOSKELETAL

Cold: ☐ painful ☐ ext

Joint: ☐ swelling ☐ redness ☐ pain ☐ single ☐ multiple

ENT

☐ hayfever ☐ seasonal allergies ☐ HOH ☐ tinnitis ☑ freq URI's

PAST HISTORY 1

☐ eczema ☐ psoriasis ☐ bronchitis ☐ shingles ☐ seborrhea ☐ acne

Family Hx

Physician Signature

☐ Face Sheet Reviewed

Allergies ☐
Problem List ☐
Medications ☐
PMFH ☐
Lab Results ☐

Management Flow Sheet

Pipestone Medical Group
Avera
920 4th Ave. SW, Pipestone, MN 56164
507-825-5700 / 800-322-1155
Bruce W. Kocourek, DO

OBJECTIVE

Appearance ☒ alert ☐ tired ☐ NAD ☒ heat ☐ anxious ☐ ill
Distress ☐ mild ☐ mod ☐ severe
Build ☒ obese ☐ average ☐ slender

HEENT:

Head ☐ pain on percussion over sinuses
Eyes L R conj sclera red
L R exudate
Ears L R loss of landmarks
L R redness
L R serous changes
Nose ☐ rhinorrhea
Mouth/gums ☐ paleness ☐ ulcerations
Post. pharynx ☐ pharyngeal erythema ☐ tonsil exudate

NECK: ☐ tenderness ☐ mass ☐ adenopathy

CHEST: ☐ rales ☐ rhonchi ☐ wheezes ☐ insp ☐ exp — lungs - clear

HEART: ☒ WNL ☐ irregular ☐ murmur ☐ PMI abnl

ABD: ☐ WNL ☐ tender ☐ organomegaly ☐ mass

LYMPH: ☐ supra-clav nodes ☐ inguinal nodes ☐ axillary nodes

SKIN: ☒ rash ☐ lesions ☐ rash w/ lesions

Limited to: ☐ trunk ☐ face ☒ arms ☐ legs ☐ scalp ☐ groin

ASSESSMENT 3

☐ Viral Exanthem	057.9	☐ Dermatofibroma	216.*
☐ URI with Exanthem	057.9	☐ Seborrheic Keratosis	702.1*
☐ Herpes Zoster	053.*	☐ Actinic Keratosis	702.0
☐ Rhinophyma / Rosacea	695.3	☐ Basal Cell Ca	173.*
☐ Acne Vulgaris	706.1	☐ Tinea Versicolor	111.0
☐ Poison Ivy Dermatitis	692.6	☐ Tinea Pedis(4) Cruris(3)	110.*
☐ Urticaria	708.*	☐ Tinea Corporis	110.5
☐ Impetigo	684	☐ Eczema, atopic	691.8
☐ Cellulitis	682.*	☐ Seborrhea	690.10
☐ Benign Nevus	216.*	☐ Psoriasis	696.1
☐ Wart	078.1*	☒ Contact Dermatitis	692.*
☒ Allergic Dermatitis	692.9	☐ Sebaceous Cyst	706.2
☐ ____	____	☐ ____	____

PLAN

Labs, Imaging & Treatments Ordered: ☐ UA ☐ culture ☐ chem panel ☐ CBC ☐ arthritis profile

Instructions: COPY

Handouts: ____

MEDICATIONS 1

Over the Counter: ____

Prescriptions:

Zyrtec 10mg #15 1 po qd x 2 ref.
Prednisone 10mg #42 po qd x 6d #18

FOLLOW UP

F / U or call if not better / well in ____ / ____ D W M

☐ Add dictation to note