AIG

AIG Domestic Claims, Inc.
Workers' Compensation Division

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

Feb. 8, 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.**

[ ] 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 HARGES
[ ] 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:

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
R31
ENCL: Original Correspondence

AIG
PO BOX 1825
ALPHARETTA GA 30023

ALP DP37 FEB 04 2008

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

ALP R31 FEB 08 2008

PICA

CARRIER

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) — [X] OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	072820970	
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)
PETERS PAMELA D	02 05 1967 M [ ] F [X]	PETERS PAMELA D
5 PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1711 US HWY--75	Self [ ] Spouse [ ] Child [ ] Other [X]	1711 US HWY 75
CITY / STATE	8. PATIENT STATUS	CITY / STATE
PIPESTONE MN	Single [ ] Married [ ] Other [ ]	PIPESTONE MN
ZIP CODE / TELEPHONE (Include Area Code)	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE / TELEPHONE (Include Area Code)
56164 (507)562 6700		56164 (507)562 6700
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) [X] 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 [X] NO PLACE (State)	b EMPLOYER'S NAME OR SCHOOL NAME
		CMG SUZLON ROTOR
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO	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 [X] 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 011008

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 MM DD YY FROM TO
07 02 07		
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a 1G 080008 / 17b NPI 1730179870	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
GREG A COOPER MD		
19 RESERVED FOR LOCAL USE		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)		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF NO
1. 692.9 3.		23. PRIOR AUTHORIZATION NUMBER
2. 4.		

PATIENT AND INSURED INFORMATION

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 01 04 08	11		99213		1	81 00	1		NPI	1689722027
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
411392082 [ ] [X]	74009001	[X] 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
075758 HEIDI M THORESON PA	PIPESTONE FAMILY CLINIC 920 4TH AVE SW PIPESTONE MN 56164-1890	PIPESTONE FAMILY CLINIC 920 4TH AVENUE SW PIPESTONE MN 56164
SIGNED 011008 DATE	a. 1073576906 b.	a. 1689722027 b.

790-0118 (08-05) (OCR) 1PT

NUCC Instruction Manual available at: www.nucc.org

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

WC151201

Report of Work Ability

See Instructions on Reverse Side

RWO1

Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

This form must be provided to the employee.
(Minn. Rules 5221.0410, subp. 6)

ALP DP34 FEB 0 4 2008

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

SOCIAL SECURITY NUMBER	DATE OF INJURY
	7-2-08
EMPLOYEE Pamela Peters	Date of Birth 2-5-67
EMPLOYER Suzlon Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office 1-4-08 (date)

Select the appropriate option(s) below and fill in the applicable dates.

1. [X] Employee is able to work without restrictions as of 1-4-08 (date)

2. [ ] Employee is able to work with restrictions, from (date) to (date)

The restrictions are:

3. [ ] Employee is unable to work at all, from (date) to (date)

The next scheduled visit is: [X] as needed OR (date)

NAME (Ty'	SIGNATURE Heidi Thoresen	DEGREE PA-C
ADDRESS HEIDI M. THORESON, PA PIPESTONE MEDICAL GROUP 920 4TH AVE SW, PIPESTONE, MN 56164 507-825-5700 FAX 507-825-5895 DEA- MT1547833 MN LISC-10239 UPIN Q75758 NPI - 1689722027	STATE	LICENSE #/REGISTRATION #
CITY	AREA CODE / TELEPHONE #	DATE SIGNED 1-4-08

MN RW01 (7/01)