Avera
Dell Rapids Medical Clinic

We're Caring for Life

111 - 10th Street East
PO Box 8
Dell Rapids, SD 57022-0008
(605) 428-5446
Fax (605) 428-2333

Confidential Facsimile Cover Sheet

Date: 3-3-08

Time: 11:20. ☒ a.m. ☐ p.m. CMG

Number of pages (including cover sheet): 3.

TO: Tom – Suzlon Rotor Co.
(authorized receiver's name and/or department)

(authorized receiver's facility name)

(authorized receiver's facility address)

Telephone: 507-562-6700 FAX: 507-562-6800.
(authorized receiver's number) (authorized receiver's fax number)

FROM: Linda N.
(sender's name and department)
Avera Dell Rapids Medical Clinic
111 - 10th Street East
P.O. Box 8
Dell Rapids, SD 57022-0008

Telephone: **(605) 428-5446** FAX: **(605) 428-2333**
(sender's number) (sender's fax number)

REMARKS: Sorry this is so old!

AIG CLAIM SERVICES 0100
PO BOX 1822
ALPHARETTA GA 30023

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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 [X] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 503743367
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MADTSON BRIAN A	3. PATIENT'S BIRTH DATE MM DD YY: 07 22 1957 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): MADTSON BRIAN A	
5. PATIENT'S ADDRESS (No., Street): 135 ZELIFF	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 135 ZELIFF	
CITY: SHERMAN STATE: SD	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY: SHERMAN STATE: SD	
ZIP CODE: 57030 TELEPHONE (Include Area Code): (605) 594 2142	
ZIP CODE: 57030 TELEPHONE (Include Area Code): (605) 594 2142	
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: AIG CLAIM SERVICES	
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? [ ] YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: WORKERS COMPENSATION	
d. INSURANCE PLAN NAME OR PROGRAM NAME: NO OTHER COVERAGE	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. SIGNATURE ON FILE SIGNED _____ 103107 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 MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SHAWN CULEY MD	17a. 1G F72988
17b. NPI 1063480390	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
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): 1. 692.4 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. 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 05 11 07	81		80101	90	1	160 00	8		NPI	1063480390
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 460224743 [ ] [X]	26. PATIENT'S ACCOUNT NO.: 52753821-2	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.) SHAWN CULEY MD SIGNED 103107 DATE	32. SERVICE FACILITY LOCATION INFORMATION: MCKENNAN REGIONAL LAB 800 E 21ST STREET SIOUX FALLS SD 57105-1016 a. 1891718136 b.		33. BILLING PROVIDER INFO & PH # (605) 428 5446: AVERA DELL RAPIDS MEDICAL CLIN 111 E 10TH STREET DELL RAPIDS SD 57022-0008 a. 1063480390 b.		

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org
WC12230

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

AIG CLAIM SERVICES 0100
PO BOX 1822
ALPHARETTA GA 30023

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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 [X] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 503743367
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4. INSURED'S NAME (Last Name, First Name, Middle Initial): MADTSON BRIAN A	
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7. INSURED'S ADDRESS (No., Street): 135 ZELIFF	
CITY: SHERMAN STATE: SD	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
CITY: SHERMAN STATE: SD	
ZIP CODE: 57030 TELEPHONE (Include Area Code): (605) 594 2142	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE: 57030 TELEPHONE (Include Area Code): (605) 594 2142	
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: AIG CLAIM SERVICES	
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? [ ] YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: WORKERS COMPENSATION	
d. INSURANCE PLAN NAME OR PROGRAM NAME: NO OTHER COVERAGE	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. SIGNATURE ON FILE SIGNED ____ DATE 061307

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 MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SHAWN CULEY MD	17a. 1G 672988
17b. NPI 1063480390	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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): 1. 692.4 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. 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 05 11 07	11		99213		1	79 00	1		NPI	1063480390
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 460224743 [ ] [X]	26. PATIENT'S ACCOUNT NO.: 52623101-2	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE: $ 79 00	29. AMOUNT PAID: $ 0 00	30. BALANCE DUE: $ 79 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.)
SHAWN CULEY MD
SIGNED 061307 DATE

32. SERVICE FACILITY LOCATION INFORMATION
AVERA SPLIT ROCK CLINIC
980 4TH STREET
GARRETSON SD 57030-9999
a. b.

33. BILLING PROVIDER INFO & PH # (605) 428 5446
AVERA DELL RAPIDS MEDICAL CLIN
111 E 10TH STREET
DELL RAPIDS SD 57022-0008
a. 1063480390 b.

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