

DR. WILLIAM H. OLSON
P.O. Box 709
101 2nd St. SE
Pipestone, MN. 56164
ph. # (507)825-5403
Fax # (507)825-6413

"Tom"

TO: Safety Manager

FROM Mavis..Office of Dr. Olson

FAX 562-6800

PAGES 4

PHONE 507-825-5403

DATE 06-23-08

CC Emmanuel Gonzales Colon

CC

URGENT

FOR REVIEW

PLEASE COMMENT

PLEASE REPLY

PLEASE RECYCLE

*COMMENTS:



S.R.C. - Pipestone, MN U.S.A.



Referral for Medical Treatment Report to Employer

Employee Name: Emmanuel A. Colon Date of Injury: 3/24/08

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Health Care Provider who completes this form to release any information to The Suzlon Rotor Corporation which substantiates, clarifies, or elaborates on my fitness for duty.

Employee Signature: Emmanuel A. Colon Date: 3-31-08

Dental Medical Provider: Dr. Wm. Olson Date / Time of Appt: 3-31-08 at 1:35 pm

ALL WORKERS' COMPENSATION MEDICAL EXPENSES must include the patient name, date of service, and Medical Provider's "Progress Notes" for treatment. Social Security Number is recommended. Mail all claims for payment directly to:

Wausau Insurance
 PO Box 8016
 Wausau, WI 54402
 1-877-870-1542

Incomplete billings or those mailed directly to Suzlon Rotor Corporation may result in slow payment processes.

Diagnosis: Broken maxillary central incisors Non-work related
where previous restorations had been present - fillings were knocked loose by the Undetermined
 Treatment Plan: Restoration of both teeth with composite restorations Work related
with a crown

RETURN TO WORK: With No Limitations Date: 3-31-08
 (Suzlon rotor Corp. has an active return-to-work program. Most temporary restrictions can be accommodated. Please call 507-562-6700 if you have any questions regarding light duty jobs.)

TOTALLY DISABLED: (Dates) From: _____ To: _____

RESTRICTED WORK: Duration of Limitations: _____ Days/Weeks

Restricted Work Hours: May Work _____ hours per day _____ hours per week.
 Restricted Lifting: Maximum lift: _____ 10lbs _____ 20lbs _____ 30lbs _____ 40lbs _____ 50lbs
 Weight limit for repetitive lifting or carrying: (more frequent than 2 times per hour)
 _____ 0-5lbs _____ 5-10lbs _____ 10-20lbs _____ 20-30lbs _____ 30-40
 Restricted bending: (Limit in degrees) _____ Bending frequency (# of times per hour): _____
 Restricted use of hand: _____ Right _____ Left _____ No Use or _____ Limited repetitive grasping, gripping
 Standing/Sitting: Standing (hours per day) _____ Sitting (hours per day) _____
 Other: _____

Next Appt. Date / Time: 4-1-08 Provider's Comments: patient can go back to work fulltime with no restrictions

Medical Provider Signature: Wm. Olson, D.D.S. Date: 4-1-08

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
 Statement of Actual Services - OR - Request for Predetermination/Preauthorization
 EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code
 Wausau Insurance
 P.O. Box 8016
 Wausau, WI 54402

OTHER COVERAGE

4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender M F 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number 10. Relationship to Primary Subscriber (Check applicable box)
 Self Spouse Dependent Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
 Colon, Emmanuel Gonzales
 1218 Fourth Ave.
 Worthington, MN 56187

13. Date of Birth (MM/DD/CCYY) 14. Gender M F 15. Subscriber Identifier (SSN or ID#)
 10 / 17 / 1983 SSN:581-95-8526

16. Plan/Group Number 17. Employer Name
 worker's compensatio Suzlon

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box)
 Self Spouse Dependent Child Other

19. Student Status FTS PTS

20. Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code
 Colon, Emmanuel Gonzales
 1218 Fourth Ave.
 Worthington, MN 56187

21. Date of Birth (MM/DD/CCYY) 22. Gender M F 23. Patient ID/Account # (Assigned by Dentist)
 10 / 17 / 1983

RECORD OF SERVICES PROVIDED

| 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 30. Description | 31. Fee |
|---------------------------------|-------------------------|------------------|----------------------------------|-------------------|--------------------|----------------------------------------|---------|
| 04/01/2008 | | JP | 9 | | D2751 | CROWN-PORCELAIN FUSED TO PREDOM. METAL | 776.00 |
| 04/01/2008 | | JP | 9 | | D2950 | CORE BUILDUP, INCLUDING ANY PINS | 177.00 |
| 04/01/2008 | | JP | 9 | | D3310 | ANTERIOR (EX. Final Restoration) | 366.00 |
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MISSING TEETH INFORMATION

| 34. (Place an 'X' on each missing tooth) | Permanent | | | | | | | | | | | | | | | | Primary | | | | | | | | | | 32. Other Fee(s) | 33. Total Fee |
|------------------------------------------|-----------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---------|---|---|---|---|---|---|---|---|---|------------------|---------------|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | A | B | C | D | E | F | G | H | I | J | | |
| | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | T | S | R | Q | P | O | N | M | L | K | | 1,319.00 |

35. Remarks: *None are non-negotiable*

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Emmanuel Gonzales Colon Signature on File 04/01/2008
 Patient/Guardian signature Date

37. I hereby authorize payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Emmanuel Gonzales Colon Signature on File 04/01/2008
 Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box)
 Provider's Office Hospital ECF Other

39. Number of Enclosures (00 to 99)
 Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics?
 No (Skip 41-42) Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining 43. Replacement of Prosthesis?
 No Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box)
 Occupational illness/injury Auto accident Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
 Dr. William Olson
 P.O. Box 709, 101 2nd. Street S.E.
 Pipestone, MN 56164

49. NPI 1144399981 50. License Number 6796 51. SSN or TIN
 TIN: 411227667
 SSN: 476-48-7544

52. Phone Number (507) 825-5403 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X William Olson, D.D.S. 04/01/2008
 Signed (Treating Dentist) Date

54. NPI 1144399981 55. License Number 6796

56. Address, City, State, Zip Code 56A. Provider Specialty Code 1223G0001X
 P.O. Box 709, 101 2nd. Street S.E.
 Pipestone, MN 56164

57. Phone Number (507) 825-5403 58. Additional Provider ID

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6. Date of Birth (MM/DD/CCYY) 7. Gender M F 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number 10. Relationship to Primary Subscriber (Check applicable box)
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|---------------------------------|-------------------------|------------------|----------------------------------|-------------------|--------------------|------------------------------------------|---------|
| 03/31/2008 | | JP | | | D0140 | LIMITED ORAL EVALUATION-PROBLEM FOCUSED | 49.00 |
| 03/31/2008 | | JP | 9 | | D0220 | INTRAORAL-PERIAPICAL FIRST FILM | 20.00 |
| 03/31/2008 | | JP | 10 | | D0230 | INTRAORAL-PERIAPICAL-EACH ADDITIONAL FIL | 16.00 |
| 03/31/2008 | | JP | | | D0460 | PULP VITALITY TESTS | 37.00 |
| 03/31/2008 | | JP | 8 | MIFL | D2335 | RESIN-FOUR OR MORE SURFACES, ANTERIOR | 193.00 |
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| | | | | | | | | | | | | | | | | | T | S | R | Q | P | O | N | M | L | K | | 315.00 |

35. Remarks: *None are non-negotiable*

AUTHORIZATIONS

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Emmanuel Gonzales Colon Signature on File 03/31/2008
 Patient/Guardian signature Date

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 Pipestone, MN 56164

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