

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

XXX PICA										PICA <input checked="" type="checkbox"/>													
1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)	FECA BLK LUNG <input type="checkbox"/> (SSN)	OTHER <input checked="" type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	504747431															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MOHR LARRY G				3. PATIENT'S BIRTH DATE MM DD YY 03 24 1968		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME																
5. PATIENT'S ADDRESS (No., Street) 513 SO PRAIRIE AVE APT 2				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) SAME																	
CITY SIOUX FALLS		STATE SD		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE														
ZIP CODE 57104		TELEPHONE (Include Area Code) (605) 413 7078				Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		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) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY 03 24 1963																
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME																
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME WORKMEN COMPENSATION																
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																
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 05 28 2008												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 05 24 2008				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 PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____											
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 372.00 2. 372.30 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 28 08		11	99202	1			100.00	1		1G G37195	NPI 1255391801												
2 05 29 08		11	99212	2			70.00	1		1G G37195	NPI 1255391801												
3										NPI													
4										NPI													
5										NPI													
6										NPI													
25. FEDERAL TAX I.D. NUMBER 460311856		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 916957		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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 are true and are not made for the purpose of obtaining payment for services) GREGORY D OSWALDSON M.D. 06 06 2008				32. SERVICE FACILITY LOCATION INFORMATION OPHTHALMOLOGY LTD 6601 S MINNESOTA STE 200 SIOUX FALLS SD 57108 2564				33. BILLING PROVIDER INFO & PH # (605) 336 6294 OPHTHALMOLOGY LTD 6601 S MINNESOTA AVE STE 200 SIOUX FALLS SD 57108-2564															
a. 1871589531				b. EI460311856																			

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

MOHR, LARRY G.
513 S. Prairie Avenue, Apt. 2
Sioux Falls SD 57104

45 (M)
DOB: 03-24-63

140030

MAY 28, 2008

HOME: 605-413-7078
CELL: 605-413-7078
WORK: 507-367-6700

Larry Mohr states for four days he has had an irritated left eye. He is not sure if he got anything in it but he does work around a lot of dust and fiberglass.

MEDICAL HISTORY
FAMILY HISTORY
MEDICATIONS
ALLERGIES

Negative ocular history.
Positive for father with cataracts and diabetes.
None listed.
No known drug allergies.

VISUAL ACUITY

With correction
RE 20/25
LE 20/30 + 1

EXTERNAL
EXAMINATION

Lids and lashes show a swollen left upper and lower eyelid with a little bit of edema. I see no excoriation, no vesicles. The conjunctiva shows injection with some what appears to be marginal infiltrates at the inferior temporal and superior temporal aspect. The central cornea is clear. The anterior chamber is deep and quiet. No cell or flare.

IMPRESSION

Staph marginal keratitis, left eye.

DISPOSITION

I think I am going to have him use TobraDex q.i.d. and Vigamox q.i.d. and some warm compresses. I am going to see him tomorrow afternoon and we will see how he is getting along. I could not see any foreign body although he is a little hard to evaluate because of all of the swelling but it doesn't look like it. It is just a localized area.

Greg Osmundson, M.D./les

cc: Health Care Clinic
1513 E. 10th Street
Sioux Falls SD 57103

Mohr, Larry G.
513 S. Prairie Ave., #2
Sioux Falls SD 57104

DOB: 03-24-63

140030

MAY 29, 2008

Larry Mohr is in for a recheck of his Staph marginal keratitis in the left eye. He feels like the eye is improved.

MEDICATIONS
ALLERGIES

TobraDex LE t.i.d. and Vigamox LE t.i.d.
No known drug allergies.

VISUAL ACUITY

With correction
RE 20/25
LE 20/40 + 1 PH 20/30

EXTERNAL
EXAMINATION

Lids and lashes show a little swelling and redness in the left with some scaliness as well. It has definitely improved from yesterday.

SLIT LAMP
EXAMINATION

The conjunctiva shows 1+ injection. The marginal infiltrate inferiorly is slightly better. Inferiorly it is pretty much gone. The central cornea is clear. The anterior chamber is deep and quiet.

IMPRESSION

Staph marginal keratitis, left eye.

DISPOSITION

I am going to have her continue the current drops and the warm compresses. I will see him back next week if he were to notice any continuation but this should clear up over the next day or two.

Greg Osmundson, M.D./les

cc: Health Care Clinic
1513 E. 10th Street
Sioux Falls SD 57103

1500

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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1 06 05 08		11	92012	1		115 00	1	1G E25416	NPI 1043271174		
2									NPI		
3									NPI		
4									NPI		
5									NPI		
6									NPI		
25. FEDERAL TAX I.D. NUMBER 460311856		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 916957		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 115 00	29. AMOUNT PAID \$ 0 00	30. BALANCE DUE \$ 115 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and any services rendered hereof.) DAVID R WEST MD 06 06 2008				32. SERVICE FACILITY LOCATION INFORMATION OPHTHALMOLOGY LTD 6601 S MINNESOTA STE 200 SIOUX FALLS SD 57108 2564 a. 1871589531		33. BILLING PROVIDER INFO & PH # (605) 336 6294 OPHTHALMOLOGY LTD 6601 S MINNESOTA AVE STE 200 SIOUX FALLS SD 57108-2564 a. 1871589531 b. EI460311856					

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PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Mohr, Larry G
513 S Prairie Ave Apt 2
Sioux Falls, SD 57104

DOB: 03-24-63

140030

JUN 5, 2008

Larry comes in today noticing some increased swelling and redness of his eye over the past couple of days. He wonders if he got some resin in there at work again. He reacts to this and has quite a skin reaction on his hands to the resin. His right eye is a little bit sore also. He says his vision is a little bit blurry and it is hard to open his eye.

MEDICATIONS

Cromolyn sodium.

ALLERGIES

No known medication allergies.

VISUAL ACUITY

With correction

LE 20/60 +2

**EXTERNAL & SLIT
LAMP EXAMINATION**

There is swelling of the upper and lids with some erythema but no obvious cellulitis. Pupils are reactive to light, no afferent pupillary defect. Motility shows full range of motion, left eye. The conjunctiva are clear. Corneas are clear. Anterior chambers are deep and quiet. There is 3+ conjunctival injection, left eye, with some peripheral corneal infiltrates. A couple of particles of resin were removed from the upper conjunctiva. The lid was everted and shows 3+ papillary reaction but no foreign body. Anterior chamber is deep and quiet. Lens is clear.

I.O.T.

LE 18 mmHg

IMPRESSION

1. Allergic versus infective blepharoconjunctivitis, left eye.
2. Possible early preseptal cellulitis, left eye.

DISPOSITION

The patient was placed on Keflex 500 mg p.o. t.i.d. orally and was given four doses of Zymar and Pred Forte as a loading dose today to help the swelling and infection. He will continue the Pred Forte and Zymar q.i.d. and return to clinic tomorrow to see Dr. Osmundson to make sure things are doing better prior to the weekend. He will use warm compresses over the left eye as needed. If the right eye starts getting a little mattery, he will use the Zymar there.

David R. West, M.D./ajt

cc:

Health Care Clinic
1513 E 10th Street
Sioux Falls, SD 57103

CC: JUN 05 2008