SUZLON ROTOR 0100
WAUSAU INSURANCE
PO BO 8016
WAUSAU WI 54402

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) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 631092086

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MORALESDECORNE MARIA G

3. PATIENT'S BIRTH DATE MM DD YY: 06 11 1958 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): MORALESDECORNE MARIA G

5. PATIENT'S ADDRESS (No., Street): 811 OMAHA AVE

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 1711 SO HWY 75

CITY: WORTHINGTON STATE: MN

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: PIPSTONE STATE: MN

ZIP CODE: 56187 TELEPHONE (Include Area Code): (507) 343 9024

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 56164 TELEPHONE (Include Area Code): (507) 343 9024

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

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: SUZLON ROTOR

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.

SIGNED SIGNATURE ON FILE DATE 041008

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 PAY SUBSCRIBER

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: 01 30 08

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: RICHARD D SUDMEIER MD

17a.

17b. NPI 1194820811

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 715 . 90

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	01 30 08		11		99213		1	81 00	1		NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 460224743 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 63469861-10

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO

28. TOTAL CHARGE $ 81 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 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.)

RICHARD D SUDMEIER MD

SIGNED 041008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

AVERA WORTHINGTON SPECIALT
508 TENTH STREET
WORTHINGTON MN 56187-2343

a. 1306939806 b.

33. BILLING PROVIDER INFO & PH # (507) 372 2921

AVERA WORTHINGTON SPECIALTY CL
508 10TH STREET
WORTHINGTON MN 56187

a. 1306939806 b.

PHYSICIAN OR SUPPLIER INFORMATION

0726672WC

Avera · Worthington Specialty Clinics

Maria Morales De Carrejo — Name — Parent — 07-26-67 History No.

Date	
1/22/08	Doctor RDS Nurse MC Age 49 Ht — (A) Wt 142 B/P 110/70 (Reg.) Lg. ___ P 80 Temp — Drug Intolerance NKDA Smoke NO Pain level today 1-10 ___ Interpreter ___
	MEDS: SAME AS 1/7/08

Patient Name maria moralesdecarrejo Medical Record 072667-2
Set up appointment to see ~~Dr.~~ PVG Rehab Specialty OT
to be seen at Wgtn. on 1-23-08 (date) at 10A.m (time)
Referring Dr. Sudmeier
Insurance referral needed - Y X N ___
Release information done - Y ___ N X
Initials SRose Date 1-22-08

1/22/08 Maria Morales Decorne MR#07-26-67

S: 49-year-old with type II diabetes. She has been having a lot of pain in her arm on the right for which she has been off work. She does not feel she can go back to work yet. She has been using a sling from time to time on the arm.

O: No tenderness. Decreased range of motion of the shoulder.

Her glycosylated hemoglobin is up. Lipids are satisfactory.

A: 1. Type II diabetes mellitus. 2. Shoulder and arm pain.

P: Do some physical therapy and see again in 3 months.

Richard D. Sudmeier, M. D.

RDS:sks T:1/23/08 D:1/22/08

1/25/08	RDS: f/u fax ~~refill~~ Nexium Rx Prilosec 40mg #30 take one daily (to replace Nexium). Walgreen. M. Cwotri
1/30/08	Doctor RDS Nurse MC Age 49 Ht — (A) Wt 142 B/P 130/60 (Reg.) Lg. ___ P 68 Temp — Drug Intolerance NKDA Smoke NO Pain level today 1-10 7 Interpreter ___
	MEDS: SAME 1/7/08

1/30/08 Maria Morales Decorne MR#07-26-67

Chief Complaint: Right shoulder pain.

History of Present Illness: She has been having this pain for several weeks. She has been going to physical therapy. Still has pain with movement. Doesn't feel she can go back to work yet. She has been taking Naprosyn with only partial relief.

Plan: Advised to continue with physical therapy and see orthopedics. Off work until February 11th.

Richard D. Sudmeier, M. D.

RDS:sks T:1/31/08 D:1/30/08

SUZLON ROTOR 0100
WAUSAU INSURANCE
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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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CARRIER

PATIENT AND INSURED INFORMATION

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): 631092086

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5. PATIENT'S ADDRESS (No., Street): 811 OMAHA AVE

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 1711 SO HWY 75

CITY: WORTHINGTON STATE: MN

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: PIPSTONE STATE: MN

ZIP CODE: 56187 TELEPHONE (Include Area Code): (507) 343 9024

ZIP CODE: 56164 TELEPHONE (Include Area Code): (507) 343 9024

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:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: SUZLON ROTOR

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 041008

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. PAY SUBSCRIBER SIGNED _____

14. DATE OF CURRENT: MM DD YY 01 22 08 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: RICHARD D SUDMEIER MD

17a.

17b. NPI 1194820811

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. 729.5
2. 250.00
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER 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 22 08		11		99214		12	122 00	1		NPI	
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.: 63469851-10

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO

28. TOTAL CHARGE: $ 122 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 122 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.)
RICHARD D SUDMEIER MD
SIGNED 041008 DATE

32. SERVICE FACILITY LOCATION INFORMATION
AVERA WORTHINGTON SPECIALT
508 TENTH STREET
WORTHINGTON MN 56187-2343
a. 1306939806 b.

33. BILLING PROVIDER INFO & PH # (507) 372 2921
AVERA WORTHINGTON SPECIALTY CL
508 10TH STREET
WORTHINGTON MN 56187
a. 1306939806 b.

Avera Worthington Specialty Clinics

Name: Maria Morales De Cornejo | Parent | History No. 07-26-67

Date	
1/22/08	Doctor RDS Nurse MC Age 49 Ht — (A) Wt 142 B/P 110/70 (Reg.) Lg.___ Smoke NO Pain level today 1-10___ P 80 Temp — Drug Intolerance NKDA Interpreter —
	MEDS: SAME AS 1/7/08

Patient Name maria moraledecornejo Medical Record 072667-2
Set up appointment to see Dr. Avera Rehab Specialty OT
to be seen at Wgtn. on 1-23-08 (date) at 10A.m (time)

Referring Dr. Sudmeier
Insurance referral needed - Y X N___
Release information done - Y___ N X
Initials SRose Date 1-22-08

1/22/08 Maria Morales Decorne MR#07-26-67

S: 49-year-old with type II diabetes. She has been having a lot of pain in her arm on the right for which she has been off work. She does not feel she can go back to work yet. She has been using a sling from time to time on the arm.

O: No tenderness. Decreased range of motion of the shoulder.

Her glycosylated hemoglobin is up. Lipids are satisfactory.

A: 1. Type II diabetes mellitus. 2. Shoulder and arm pain.

P: Do some physical therapy and see again in 3 months.

Richard D. Sudmeier, M. D.

RDS:sks T:1/23/08 D:1/22/08

1/25/08	RDS: w/o fax ~~refill~~ Nexium Rx Prilosec 40mg #30 take one daily (to replace Nexium). Walgreen. M. Ewen
1/30/08	Doctor RDS Nurse MC Age 49 Ht — (A) Wt 142 B/P 130/60 (Reg.) Lg.___ Smoke NO Pain level today 1-10 7 P 68 Temp — Drug Intolerance NKDA Interpreter___
	MEDS: SAME 1/7/08

1/30/08 Maria Morales Decorne MR#07-26-67

Chief Complaint: Right shoulder pain.

History of Present Illness: She has been having this pain for several weeks. She has been going to physical therapy. Still has pain with movement. Doesn't feel she can go back to work yet. She has been taking Naprosyn with only partial relie

Plan: Advised to continue with physical therapy and see orthopedics. Off work until February 11th.

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SUZLON ROTOR 0100
WAUSAU INSURANCE
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HEALTH INSURANCE CLAIM FORM

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CITY: WORTHINGTON STATE: MN

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: PIPSTONE STATE: MN

ZIP CODE: 56187 TELEPHONE (Include Area Code): (507) 343 9024

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 56164 TELEPHONE (Include Area Code): (507) 343 9024

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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:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: SUZLON ROTOR

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.

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SIGNED _____ DATE 041008

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: RICHARD D SUDMEIER MD

17a. _____

17b. NPI 1194820811

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. 715.90
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 01 07 08		11		99213		1	81 00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 460224743

26. PATIENT'S ACCOUNT NO.: 63469841-10

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO

28. TOTAL CHARGE: $ 81 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 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.)

RICHARD D SUDMEIER MD

SIGNED 041008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

AVERA WORTHINGTON SPECIALT
508 TENTH STREET
WORTHINGTON MN 56187-2343

a. 1306939806 b.

33. BILLING PROVIDER INFO & PH # (507) 372 2921

AVERA WORTHINGTON SPECIALTY CL
508 10TH STREET
WORTHINGTON MN 56187

a. 1306939806 b.

1/2/08

Doctor RDS Nurse MC Age 49 Ht — (A) Wt 140 B/P 110/72 (Reg.) Lg.

P 64 Temp ____ Drug Intolerance MKA Smoke ND Pain level today 1-10 ____

Interpreter JESSICA - DAU.

MEDS: PROPOXYPHENE/ACET 100/650 mg T/T & 4-6° DAILY
METFORMIN 1000 mg T BID
GLIPIZIDE XL 10 mg T DAILY
LOVASTATIN 40 mg T DAILY

1/7/08 Maria Morales Decorne MR#07-26-67

S: 49-year-old who complains of pain in the left shoulder. She apparently at work on the 5th picked up something heavy and felt pain in her left posterior shoulder down into her arm. She went to the Emergency Room where she was seen and had an x-ray of the shoulder that was negative. She was given Darvocet and a sling. She still has pain with movement.

O: There is pain on movement of the shoulder with mild tenderness over the trapezius.

A: Shoulder pain – probable muscle strain.

P: Advised Naprosyn 500 b.i.d. for 10 days. No use of the right arm for a week. Return if not better.

RDS:sks T:1/9/08 D:1/8/08 Richard D. Sudmeier, M. D.