

MED REC # CLAIM#
142791 331527

WORK COMP MISC
TO INS CLERK

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input checked="" type="checkbox"/> PICA <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (FECA BLK LUNG SSN) <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 375724242	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LANDERS WENDY G		3. PATIENT'S BIRTH DATE MM DD YY 07 28 1959 SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) 319 TYLER ST PO 55 CITY TYLER STATE MN		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME		7. INSURED'S ADDRESS (No., Street) SAME	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 11-28-07	
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 02 11 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 02 11 08		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 17a. 10/7/5424 17b. NPI	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SNOW STEVEN P MD		19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. L726.2 3. _____ 2. _____ 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. #		25. FEDERAL TAX I.D. NUMBER SSN EIN 460306092	
26. PATIENT'S ACCOUNT NO. 84557 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 269.00 29. AMOUNT PAID \$ 0.00 30. BALANCE DUE \$ 269.00	
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.) KALO JEFFREY DO SIGNED 460306092 DATE 02 20 2008		32. SERVICE FACILITY LOCATION INFORMATION HENDRICKS COMMUNITY HOSPIT 503 E LINCOLN HENDRICKS MN 56136	
33. BILLING PROVIDER INFO & PH # 605 336 2638		34. BILLY PROVIDER INFO & PH # 1033160676 EI460306092	

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION



Franklin G. Alvine, M.D.
 Gregory F. Alvine, M.D.
 Jeffrey S. Kalo, D.O.
 David Watts, M.D.
 Travis Venner, DPM

LANDERS, WENDY
 DOB: 07-28-59
 C-142791
 11 FEBRUARY 2008

HENDRICKS OUTREACH
 WORKER'S COMPENSATION

CHIEF COMPLAINT: The patient follows up today with a chief complaint of right shoulder pain. By way of history, she has worked at a local manufacturing business for about five months. About a month ago she started developing significant shoulder pain and has asked me to evaluate this shoulder problem. She had an MRI scan completed in Tyler and had a subacromial injection that helped her symptoms less than one hour. She said she did not have this problem with her previous job when she worked in a grocery store. This has been a new job that requires a fair amount of sanding, use of putty, and she describes that process to me and it sounds like a fair amount of shoulder activity. She has had no pre-existing shoulder pathology noted.

PAST MEDICAL HISTORY; PAST SURGICAL HISTORY; FAMILY HISTORY; SOCIAL HISTORY; REVIEW OF SYSTEMS:
 See intake form.

CURRENT MEDICATIONS: Please see the patient's intake record.

ALLERGIES: TUSSI.

PHYSICAL EXAMINATION: VS: BP 121/79, temp 97.4, height 5'6", weight 200 pounds. She is a pleasant female oriented to person, place, and time.

Examination today shows she has forward flexion 130 degrees, abduction 120 degrees, external rotation 90 degrees, internal rotation 60 degrees, with obviously some degree of arthrofibrosis about the shoulder. Her cuff strength is excellent at 4/5 with abduction, external rotation in a scapular and sagittal plane. Lift-off test is 5/5. Yergason-Speed signs are negative, but did describe some mild biceps pain radiating down the shoulder blade posteriorly in the medial scapular border. Spurling-compression test is negative. No distal paresthesias in the axillary, median, and ulnar nerves. Allen's test shows good collateral flow. She did have several skin changes noted across the arm and these appear to be just some dry skin over the winter season.

RADIOLOGIC EXAMINATION: Her plain films show no bony pathology. MRI scan shows mild fluid in the patient's subacromial space with mild tendonitis at most in the patient's supraspinatus tendon without any evidence of AC joint problems, labral pathology, or biceps tendonitis.

ASSESSMENT:

1. Impingement syndrome of the right shoulder secondary to overuse.

PLAN: At this point, the patient clearly does not need, in my mind, a surgical procedure. I think some work restrictions are in order. I have given those to her. She may have to consider some long-term work restrictions to avoid the work. In five months this patient developed shoulder problems and I find it unlikely that a work hardening program will make it greatly better. I have given her 10 pounds lifting on the right side, no work above chest level, and no work with the right arm in extended position. I will recheck that process in six weeks when I'm back in Tyler unless she has had interval changes. My feeling is the patient has to resolve the shoulder stiffness and then regain some semblance of strength in the shoulder before deciding on more aggressive work and it may be outside what she has done in the past.

Jeffrey S. Kalo, DO/pm
 Dictated but not read or signed by this physician.

cc Hendricks Hospital	Dr. Snow
PO Box 106	Tyler Healthcare Clinic
Hendricks, MN 56136	240 Willow St.
ATTN: Health Information	Tyler, MN 56178
	Attn: Outreach Services