1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SUZLON ROTOR 0100
WAUSAU INSURANCE
PO BO 8016
WAUSAU WI 54402

CARRIER

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 [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 582915474

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REYESRIVERA YELISSA

3. PATIENT'S BIRTH DATE MM DD YY: 10 21 1982 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REYESRIVERA YELISSA

5. PATIENT'S ADDRESS (No., Street): 1114 7TH AVE

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

7. INSURED'S ADDRESS (No., Street): PO BOX 8016

CITY: WORTHINGTON STATE: MN

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

CITY: WAUSAU STATE: WI

ZIP CODE: 56187 TELEPHONE (Include Area Code): (507) 370 7341

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

ZIP CODE: 54402 TELEPHONE (Include Area Code): (507) 370 7341

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 042508

SIGNED _____ 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: 04 21 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. 715.90 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. #
1 04 21 08		11		99213		1	81 00	1		NPI	
2 04 21 08		11		99199		1	37 00	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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

26. PATIENT'S ACCOUNT NO.: 63512161-10

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

28. TOTAL CHARGE: $ 118 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 118 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 042508 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.

NUCC Instruction Manual available at: www.nucc.org

0814112WC

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

Avera
Worthington Specialty Clinics

Date

MR # 08-14-11(2) WC

Name Yelissa Reyes Rivera M W S D Sex: ☐ Male ☒ Female DOB 10-21-82

Address 1114 7th Ave Wgtn MN 56187 Home Phone (507) 370-7341

Work Phone

Responsible Party Occ/Empr

In Emergency Contact: Occ/Empr (spouse)

SS# 582-91-5474

Immunizations	Dates							
Td								
Tet. Tox.								
M M R								
Pneumovax								
Hepatitis A								
Hepatitis B								
Varicella								
Influenza								
Tuberculin Test								

Allergic to Medications:

Date	
1-3-08	PFT #1 maneuvers performed L Brandt, CPT
1/4/08	Doctor RDS Nurse MC Age 25 Ht 59" (A) Wt 148 B/P 124/70 (Reg) Lg. P 96 Temp — Drug Intolerance NKDA Smoke NO Pain level today 1-10 Interpreter MARIA
	PREEMPLOY: SUZLON
4/4/08	Doctor RDS Nurse LEM Age 25 Ht — (A) Wt 142 B/P 90/64 Reg. ✓ Lg. P 78 Temp — Drug Intolerance NKDA Smoke NO Pain level today 1-10 both hands R side more Interpreter Linda
	Meds: None

Name Yelissa Reyes Rivera MR # 08-14-11 (2) WC

Date

Patient Name Yelissa Reyesrivera Medical Record 081411
Set up appointment to see ~~Dr.~~ Courtney Linton Specialty ~~ortho~~
to be seen at ILO - Wgtn on 4-23-08 at 11:20
(date) (time)
Referring Dr. Sudmeier
Insurance referral needed - Y_____ N X
Release information done - Y_____ N X
Initials S.Rose Date 4-24-08

4/21/08 Yelissa Reyes-Rivera MR#08-14-11

CHIEF COMPLAINT: Wrist pain.

S: 24-year-old with pain in both wrists for the last few weeks. She has been working at a job where she does a lot of heavy use of her hands. She has noticed swelling over the left wrist first and now the right wrist is starting to swell. She has never had problems like this before. She is not taking any medication.

O: Her wrists are both tender. There is a lot of swelling, probably a ganglion over the left wrist and a smaller one on the right.

A: 1) Wrist pain.

P: Limit use of the hands for a week and have her see orthopedics. Try Motrin 800 tid in the meantime.

DD: 4/21/08 DT: 4/22/08 rap Richard D. Sudmeier, M.D.

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WAUSAU INSURANCE
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PATIENT AND INSURED INFORMATION

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

7. INSURED'S ADDRESS (No., Street): PO BOX 8016

CITY: WORTHINGTON STATE: MN

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

CITY: WAUSAU STATE: WI

ZIP CODE: 56187 TELEPHONE (Include Area Code): (507) 370 7341

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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 050608

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 05 01 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: JAMES M DONAHUE

17a.

17b. NPI 1598729550

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. 715 90 3. 2. 4.

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1 05 01 08		11		99242		1	157 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.: 63544421-10

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

28. TOTAL CHARGE: $ 157 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 157 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 050608 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
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WORTHINGTON MN 56187
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0814112WC

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

SGT 5/1

Admission History & Physical

FILE

ALL BLANKS MUST BE FILLED IN

Referring Doctor: DR. DONAHUE 5/8 WRH
Patient Name: YEZISSA REYESRIVERA
Date of Birth/Age: 10/21/82 25yo.

Reason of present illness: WRIST PAIN

Current/active medical conditions: Ø

Current medications: MOTRIN 800mg TID

Allergies: NKDA

Past medical history: NON-SIGNIFICANT. ~~CONTRIBUT~~
- Past illnesses:
- Accidents:
- Bleeding tendencies: NONE
- Previous hospitalizations:
- Previous surgeries: NONE
- Previous anesthesia problems:

Family history: NON-SIGNIFICANT

Social history/habits: SINGLE; FIVE CHILDREN; EMPLOYED.
- Smoking: NO
- Alcohol: NO
- Non-prescription drugs: NONE

Pediatric Patients: Developmental age: Immunization status:

Review of systems: (required on inpatients only)
- General:
- Skin:
- HEENT:
- Cardiovascular/Respiratory: NEGATIVE
- Gastrointestinal:
- Genitourinary:
- Neuromuscular:
- Psychological status: