A and R Medical Supply
Medical Bills

A&R

A&R Medical Supply
5010 Lomas NE
Albuquerque, NM 87110
(505) 256-1610

CLIENT ACCT. NO.	DOCUMENT NO.	REF. CODE	TYPE
000000020836	0000192729	JI	A

DATE: 01/16/2003 PAGE: 1

BILL TO:

DOUG COPP

PO BOX 534 27 SUMPTION RD.
SANDIA PARK NM 87047

SHIPPING DIRECTIONS

BCBS OF NM
P.O.BOX 27630
ALBUQUERQUE NM 87125-7630

ADDITIONAL INFORMATION

DATE	INVOICE#	QTY.	T/O/S	DESCRIPTION	*RENT IND	CHARGE	DED.	PATIENT PORTION	PAYMENTS
10/04/2002	0000186663	1		NEBULIZER MISTER NEB HS123	R	12.64			
10/04/2002	0000186663			WRITE OFF ALLOWABLE	0				0.70
11/01/2002	0000186663			1500 DT					
11/19/2002	0000186663			BC NM PMNT CK#40361942	0				3.48
11/30/2002	0000186663			WRITE OFF ALLOWABLE	0				7.60
11/30/2002	0000186663			INVOICED CUSTOMER					
01/16/2003	0000186663			INVOICED CUSTOMER					
11/04/2002	0000189794	1		NEBULIZER MISTER NEB HS123	R	12.64		-7.60	
11/04/2002	0000189794			WRITE OFF ALLOWABLE	0				0.70
11/11/2002	0000189794			1500					
12/10/2002	0000189794			BC NM PMNT #40380313; HOPE	0				3.48
12/10/2002	0000189794			BC WRITE OFF ALLOWABLE	0				7.60
01/16/2003	0000189794			INVOICED CUSTOMER					
12/04/2002	0000192729	1		NEBULIZER MISTER NEB HS123	R	12.64			
12/13/2002	0000192729			1500 BC9					
12/31/2002	0000192729			BC NM PMNT 40398354; HOPE	0				3.48
12/31/2002	0000192729			WRITE OFF ALLOWABLE	0				8.30
01/16/2003	0000192729			INVOICED CUSTOMER					

* NOTE: R=Rental P=Purchase O=N/A

***PATIENT AMOUNT DUE IS DAYS FROM INV DATE

PATIENT AMT DUE: -7.60***

PRIM PAYOR DUE: 26.35
SEC PAYOR DUE:
TOTAL DUE: 1.35

Thank you!

PATIENT AMT DUE IS DAYS FROM 01/16/2003

WE ACCEPT: M/C, VISA, DISCOVER, CHECK, CASH

LIFETIME AUTHORIZATION: I request that payment of authorized Medicare, Medicaid, or other private insurance benefits be made to A & R Medical Supply, for any service provided me by A & R Medical Supply. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, CHAMPUS and its agents, or any private insurance company any information needed to determine these benefits or benefits for related services. I understand that I am responsible for payment of all deductibles and co-insurance charges. In addition, I agree to be responsible for the full amount of charges if any physician or I fail to provide within 30 days information necessary to submit the claim for assigned covered benefits.

PATIENT EDUCATION: I certify that I have been instructed in the proper care and use of the above equipment. I also certify that I have read and understand the Lifetime Authorization and have received my Patient's Rights and Responsibilities.

THIS DELIVERY RECEIPT IS SUBJECT TO ALL OF THE TERMS SET FORTH ON THE REVERSE SIDE, WHICH TERMS ARE HEREBY INCORPORATED BY REFERENCE AND MADE PART OF THIS AGREEMENT BETWEEN (SELLER) AND CUSTOMER/BUYER

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ALL OF THE TER ABOVE AND ON THE REVERSE SIDE, AND I HAVE RECEIVED A COMPLETE C OF THIS RECEIPT.

PAID ON DELIVERY	DELIVERED BY
CUSTOMER PO NO.	DATE

(CUSTOMER'S SIGNATURE)

BlueCross BlueShield
of New Mexico
P. O. Box 27630
Albuquerque, NM 87125 - 7630

Explanation of Benefits (EOB). **This is not a bill.**
BLUE CHOICE PPO NS $500 DEDUCT LO
01-16-03

Customer Service: 1-800-432-0750

PAULINA E COPP
PO BOX 534
SANDIA PK/GOLDEN NM 87047-0534

Visit our website at www.bcbsnm.com

Claim Information

Member Name:	Paulina E Copp
Group No.:	**N9030**
Identification No.:	**YIE560450095**
Claim No.:	300870027630C
Patient Name:	Douglas Copp

Summary

Total Billed:	$12.64
Total Benefits Approved:	**$0.00**
Amount You May Owe Provider:	$4.34

The following shows how this claim was processed.

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
A AND R MEDICAL SUPPLY				
Provider Patient Account No.: 000000020836				
Med/Surg Supplies	01-04-03	12.64	8.30 (1)	4.34
Totals		**$12.64**	**$8.30**	**$4.34**

Coverage Information

Totals	**$12.64**	**$8.30**	**$4.34**
Deductions			
Applied to Your 2003 Health Care Plan Deductible		$4.34	
Total Deductions			**-$4.34**
Total Benefits Approved			**$0.00**
Amount You May Owe Provider			**$4.34**

1,577 NM2573

BlueCross BlueShield
of New Mexico
P. O. Box 27630
Albuquerque, NM 87125 - 7630

Explanation of Benefits (EOB). **This is not a bill.**
BLUE CHOICE PPO NS 5500 DEDUCT LO
03-20-03

Customer Service: 1-800-432-0750

PAULINA E COPP
PO BOX 534
SANDIA PK/GOLDEN NM 87047-0534

Visit our website at www.bcbsnm.com

Claim Information

Member Name:	Paulina E Copp
Group No.:	**N9030**
Identification No.:	**YIE560450095**
Claim No.:	306970098700C
Patient Name:	Douglas Copp

Summary

Total Billed:	$12.64
Total Benefits Approved:	**$0.00**
Amount You May Owe Provider:	$12.64

e following shows how this claim was processed.

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
A AND R MEDICAL SUPPLY				
Provider Patient Account No.: 20836				
Rental Med Equipment	03-04-03	12.64		12.64
Totals		$12.64	$0.00	$12.64

Coverage Information

Totals	$12.64	$0.00	$12.64
Deductions			
Applied to Your 2003 Health Care Plan Deductible		$12.64	
Total Deductions			-$12.64
Total Benefits Approved			$0.00
Amount You May Owe Provider			$12.64

of New Mexico
P. O. Box 27630
Albuquerque, NM 87125 - 7630

Explanation of Benefits (EOB). **This is not a bill.**
BLUE CHOICE PPO NS S500 DEDUCT LO
04-16-03

Customer Service: 1-800-432-0750

PAULINA E COPP
PO BOX 534
SANDIA PK/GOLDEN NM 87047-0534

Visit our website at www.bcbsnm.com

Claim Information

Member Name:	Paulina E Copp
Group No.:	**N9030**
Identification No.:	**YIE560450095**
Claim No.:	309870029860C
Patient Name:	Douglas Copp

Summary

Total Billed:	$12.64
Total Benefits Approved:	**$10.12**
Amount You May Owe Provider:	$2.52

The following shows how this claim was processed.

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
A AND R MEDICAL SUPPLY				
Provider Patient Account No.:	000000020836			
Rental Med Equipment	04-04-03	12.64		12.64
Totals		**$12.64**	**$0.00**	**$12.64**

Coverage Information

Totals	**$12.64**	**$0.00**	**$12.64**
Deductions			
Your Coinsurance Amount		$2.52	
Total Deductions			-$2.52
Total Benefits Approved			**$10.12**
Amount You May Owe Provider			$2.52

Total covered benefits approved for this claim: $10.12 to A AND R MEDICAL SUPPLY on 04-16-03.

(turn over)

1,347 NM2573

BlueCross BlueShield
of New Mexico
P. O. Box 27630
Albuquerque, NM 87125 - 7630

Explanation of Benefits (EOB). **This is not a bill.**
BLUE CHOICE PPO NS S500 DEDUCT LO
05-22-03

Customer Service: 1-800-432-0750

PAULINA E COPP
PO BOX 534
SANDIA PK/GOLDEN NM 87047-0534

Visit our website at www.bcbsnm.com

Claim Information

Member Name:	Paulina E Copp
Group No.:	N9030
Identification No.:	YIE560450095
Claim No.:	313473000460C
Patient Name:	Douglas Copp

Summary

Total Billed:	$12.64
Total Benefits Approved:	$10.12
Amount You May Owe Provider:	$2.52

The following shows how this claim was processed.

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
A AND R MEDICAL SUPPLY				
Provider Patient Account No.:	000000020836			
Rental Med Equipment	05-04-03	12.64		12.64
Totals		$12.64	$0.00	$12.64

Coverage Information

Totals	$12.64	$0.00	$12.64
Deductions			
Your Coinsurance Amount		$2.52	
Total Deductions			-$2.52
Total Benefits Approved			$10.12
Amount You May Owe Provider			$2.52

Total covered benefits approved for this claim: $10.12 to A AND R MEDICAL SUPPLY on 05-22-03.

Turn over

NM257E

Albuquerque Regional Medical Center
Medical Bills

BlueCross BlueShield
of New Mexico
P. O. Box 27630
Albuquerque, NM 87125 - 7630

Explanation of Benefits (EOB). **This is not a bill.**
BLUE CHOICE PPO NS $500 DEDUCT LO
10-21-02 *EIA*

Customer Service: 1-800-432-0750

PAULINA E COPP
PO BOX 534
SANDIA PK/GOLDEN NM 87047-0534

Visit our website at www.bcbsnm.com

Claim Information

Member Name:	Paulina E Copp
Group No.:	N9030
Identification No.:	YIE560450095
Claim No.:	229151010130X
Patient Name:	Douglas Copp

Summary

Total Billed:	$2230.68
Total Benefits Approved:	**$1070.74**
Amount You May Owe Provider:	$267.67

The following shows how this claim was processed.

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
ALB REGIONAL MEDICAL CTR				
Provider Patient Account No.: 33755701				
X-Ray Services	10-04-02	850.44	340.17 (1)	510.27
X-Ray Services	10-04-02	1380.24	552.10 (1)	828.14
Totals		$2230.68	$892.27	$1338.41

Coverage Information

Totals	$2230.68	$892.27	$1338.41
Deductions			
Your Coinsurance Amount		$267.67	
Total Deductions			-$267.67
Total Benefits Approved			$1070.74
Amount You May Owe Provider			$267.67

Total covered benefits approved for this claim: $1,070.74 to ALB REGIONAL MEDICAL CTR on 10-21-02

Anesthesia Associates of New Mexico
Medical Bills

ANESTHESIA ASSOCIATES OF NM
PO BOX 98 PH#505-260-4343
ALBUQUERQUE, NM 87103
(505) 260-4300

Statement Date Page: 01
08/01/03
Federal Tax Id:
850210604

Due From:

DOUGLAS F COPP
PO BOX 534
SANDIA PARK, NM 87047

Insurance: 0.00
Patient : 507.94
Total Due: 507.94
PatientId: 808744*1

Date	Code	Procedure Description	Amount
Physician: ERVIN HINDS M.D.		Site: PRESBYTERIAN KASEMAN HOSPITA	
Diagnosis: 719.47		ANKLE/FOOT PAIN	
08/01/02	SPP	SELF PAY PMT	-20.00
07/29/02	99203	NEWPT./OUTPT OFFICE LIMITED (30 MIN	260.00
06/27/03	TRCB	TRCB	-240.00
06/27/03	TRCB	TRCB	240.00
Visit # 1 Chgs: 260.00 Pmts: -20.00 Adjs: 0.00 Bal:			240.00
Physician: ERVIN HINDS M.D.		Site: PRESBYTERIAN KASEMAN HOSPITA	
Diagnosis: 722.52		DEGENERATION OF LUMBAR OR LUMBOSACR	
08/13/02	99214	INTERMEDIATE (25 MIN)	195.00
08/21/02	SPP	SELF PAY PMT	-20.00
10/17/02	BSP	BLUE CROSS PMT	-69.77
10/17/02	BSCA	BLUE CROSS CREDIT	-105.23
Visit # 2 Chgs: 195.00 Pmts: -89.77 Adjs: -105.23 Bal:			0.00
Physician: ERVIN HINDS M.D.		Site: PRESBYTERIAN KASEMAN HOSPITA	
Diagnosis: 722.52		DEGENERATION OF LUMBAR OR LUMBOSACR	
08/28/02	99499	COPYING MEDICAL RECORDS	10.00
08/29/02	NIP	NO INS PMT	-10.00
Visit # 3 Chgs: 10.00 Pmts: -10.00 Adjs: 0.00 Bal:			0.00
Physician: ERVIN HINDS M.D.		Site: PRESBYTERIAN KASEMAN HOSPITA	
Diagnosis: 722.73		HNP WITH MYELOPATHY NTERVERTEBRAL D	
09/03/02	62311	EPIDURAL,LUMBAR OR CAUDAL	520.00
09/03/02	64483	TRANSFORAMINAL,LUMBAR OR SACRAL	520.00
11/19/02	BSP	BLUE CROSS PMT	-339.20
11/19/02	BSCA	BLUE CROSS CREDIT	-404.00
12/10/02	BSP	BLUE CROSS PMT	-169.60
04/23/03	TRCB	TRCB	-127.20
04/23/03	TRCB	TRCB	127.20
Visit # 4 Chgs: 1,040.00 Pmts: -508.80 Adjs: -404.00 Bal:			127.20
Physician: ERVIN HINDS M.D.		Site: PRESBYTERIAN KASEMAN HOSPITA	
Diagnosis: 722.73		HNP WITH MYELOPATHY NTERVERTEBRAL D	
09/10/02	99213	LIMITED	130.00
10/01/02	SPP	SELF PAY PMT	-44.72
10/10/02	BSCA	BLUE CROSS CREDIT	-74.10
09/25/02	SPP	SELF PAY PMT	-8.82
04/23/03	TRCB	TRCB	-2.36
04/23/03	TRCB	TRCB	2.36

ANESTHESIA ASSOCIATES OF NM
PO BOX 98 PH#505-260-4343
ALBUQUERQUE, NM 87103
(505) 260-4300

Statement Date
08/01/03
Federal Tax Id:
850210604

Due From:

DOUGLAS F COPP
PO BOX 534
SANDIA PARK, NM 87047

Insurance: 0.00
Patient : 507.94
Total Due: 507.94
PatientId: 808744*1

Date	Code	Procedure Description	Amount
Physician: ERVIN HINDS M.D.		Site: PRESBYTERIAN KASEMAN HOSPITA	
Diagnosis: 722.73		HNP WITH MYELOPATHY NTERVERTEBRAL D	
09/17/02	99213	LIMITED	130.00
10/03/02	BSP	BLUE CROSS PMT	-44.72
10/03/02	BSCA	BLUE CROSS CREDIT	-74.10
09/25/02	SPP	SELF PAY PMT	-11.18
Visit # 6	Chgs: 130.00	Pmts: -55.90 Adjs: -74.10 Bal:	0.00
Physician: ERVIN HINDS M.D.		Site: PRESBYTERIAN KASEMAN HOSPITA	
Diagnosis: 722.73		HNP WITH MYELOPATHY NTERVERTEBRAL D	
10/07/02	62311	EPIDURAL,LUMBAR OR CAUDAL	520.00
10/07/02	64483	TRANSFORAMINAL,LUMBAR OR SACRAL	520.00
11/06/02	BSP	BLUE CROSS PMT	-339.20
11/29/02	BSP	BLUE CROSS PMT	-169.60
11/29/02	BSCA	BLUE CROSS CREDIT	-404.00
04/23/03	TRCB	TRCB	-127.20
04/23/03	TRCB	TRCB	127.20
Visit # 7	Chgs: 1,040.00	Pmts: -508.80 Adjs: -404.00 Bal:	127.20
Physician: ERVIN HINDS M.D.		Site: PRESBYTERIAN KASEMAN HOSPITA	
Diagnosis: 722.73		HNP WITH MYELOPATHY NTERVERTEBRAL D	
11/11/02	99213	LIMITED	130.00
11/29/02	BSP	BLUE CROSS PMT	-44.72
11/29/02	BSCA	BLUE CROSS CREDIT	-74.10
04/23/03	TRCB	TRCB	-11.18
04/23/03	TRCB	TRCB	11.18
Visit # 8	Chgs: 130.00	Pmts: -44.72 Adjs: -74.10 Bal:	11.18
Physician: ERVIN HINDS M.D.		Site: PRESBYTERIAN KASEMAN HOSPITA	
Diagnosis: 722.73		HNP WITH MYELOPATHY NTERVERTEBRAL D	
06/27/03	99499	COPYING MEDICAL RECORDS	10.40
07/01/03	NIP	NO INS PMT	-10.40
Visit # 9	Chgs: 10.40	Pmts: -10.40 Adjs: 0.00 Bal:	0.00
Totals >>>	Chgs: 2,945.40	Pmts: -1,301.93 Adjs: -1,135.53 Bal:	507.94

-- S T A T E M E N T --

Costco Pharmacy
Medical Bills

500 EUBANK BLVD SE
ALBUQUERQUE NM 87123 505-332-6602

COPP,DOUGLAS

27 SUMTION RD SANDIA PARK NM 87047 505-281-7977

RX 114850 DR.GARCIA,HENRY

ALBUTEROL INHALER UNIT (WAR) # 17

NDC:59930-1560-01

MFR: WARRICK PHARM

AUTH#21585167607999 3005

CO

06/07/2002

$12.39

500 EUBANK BLVD SE
ALBUQUERQUE NM 87123 505-332-6602

COPP,DOUGLAS

27 SUMTION RD SANDIA PARK NM 87047 505-281-7977

RX 114850 DR.GARCIA,HENRY

ALBUTEROL INHALER UNIT (WAR) # 17

NDC:59930-1560-01

MFR: WARRICK PHARM

AUTH#21585167607999 3005

CO

06/07/2002

$12.39

May be refilled 10.00 times of 17 through 6/07/2003 3005 PCS RX PLANS

COSTCO PHARMACY

DEPARTMENT

500 EUBANK BLVD SE ALBUQUERQUE NM 87123 505-332-6602

PATIENT COUNSELING INFORMATION

CONSULT YOUR PHARMACIST OR PHYSICIAN WITH A LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING IF YOU HAVE ANY QUESTIONS ABOUT ADVERSE DRUG REACTIONS.

06/07/2002

COPP,DOUGLAS
RX# 114850

ALBUTEROL INHALER UNIT (WAR)

WHY AM I USING THIS DRUG?
To treat asthma, bronchitis, other lung diseases.

HOW SHOULD I USE IT?
Follow your doctor's and/or the package instructions. Rinse mouth after each inhalation to avoid dryness. If no breathing improvement in 20 minutes, call doctor.

ARE THERE ANY SIDE EFFECTS
Very unlikely, but report: Flushing, trembling, headache, nausea, vomiting, rapid heartbeat, chest pain, weakness, signs of infection, dizziness.

HOW DO I STORE THIS?
Store at room temperature away from moisture and sunlight. Do not puncture. Do not store in the bathroom.

IF I SHOULD MISS A DOSE?
Consult your doctor about missing a dose.

WHAT ABOUT GENERICS?
Generic alternatives are available for many drugs. They are safe, effective and can save you money. Ask your pharmacist for details.

TAKE 2 PUFFS ORALLY FOUR TIMES DAILY

SHAKE WELL.
SHAKE WELL BEFORE USING. CLEAN MOUTH-PIECE AFTER EACH USE WITH WATER.

500 EUBANK BLVD SE
ALBUQUERQUE NM 87123 505-332-6602

COPP,DOUGLAS

27 SUMTION RD SANDIA PARK NM 87047 505-281-7077

RX 114849 DR.GARCIA,HENRY

PREDNISONE 20MG TAB @(SHN) # 60

NDC:00591-5443-01

MFR: DANBURY

AUTH#215851875739B9 3005

CO

06/07/2002

$9.99

500 EUBANK BLVD SE
ALBUQUERQUE NM 87123 505-332-6602

COPP,DOUGLAS

27 SUMTION RD SANDIA PARK NM 87047 505-281-7077

RX 114849 DR.GARCIA,HENRY

PREDNISONE 20MG TAB @(SHN) # 60

NDC:00591-5443-01

MFR: DANBURY

AUTH#215851875739B9 3005

CO

06/07/2002

$9.99

May be refilled 1.00 times of 60 through 8/07/2003 3005 PCS RX PLANS

COSTCO PHARMACY
DEPARTMENT

500 EUBANK BLVD SE ALBUQUERQUE NM 87123 505-332-6602

PATIENT COUNSELING INFORMATION

CONSULT YOUR PHARMACIST OR PHYSICIAN WITH A LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING IF YOU HAVE ANY QUESTIONS ABOUT ADVERSE DRUG REACTIONS.

06/07/2002

COPP,DOUGLAS
RX# 114849

PREDNISONE 20MG TAB @(SHN)

WHY AM I TAKING THIS DRUG?
To treat a hormone imbalance, allergic or inflammatory condition.

HOW SHOULD I TAKE IT?
Take with food. Don't take more than the amount prescribed. Follow your doctor's instructions. If you are long-term user, carry ID stating that you are on corticosteroids.

ARE THERE ANY SIDE EFFECTS
Increased appetite, loss of appetite, nervousness. May cause physical, mental or vision changes.

HOW DO I STORE THIS?
Store at room temperature away from moisture and sunlight. Follow label warnings about whether or not to refrigerate liquid forms. Do not freeze.

IF I SHOULD MISS A DOSE?
If taking 1 daily: take as soon as remembered but not if near time for next dose; don't "double-up" doses. If taking more than 1 daily: take as soon as remembered, do "double-up" if time for next dose. If taking every other day: consult your

WHAT ABOUT GENERICS?
Generic alternatives are available for many drugs. They are safe, effective and can save you money. Ask your pharmacist for details.

TAKE AS DIRECTED

TAKE WITH FOOD OR MILK.
TAKE OR USE THIS EXACTLY AS DIRECTED. DO NOT SKIP DOSES OR DISCONTINUE.
CALL DR. BEFORE TAKING OTC DRUGS SOME MAY AFFECT ACTION OF THIS MEDICINE.

COSTCO PHARMACY **Customer Receipt**

500 EUBANK BLVD SE
ALBUQUERQUE NM 87123 505-332-6602

COPP,DOUGLAS

27 SUMTION RD SANDIA PARK, NM 87047 505-281-7977

RX 116135 N DR.GARCIA,HENRY 07/23/2002
TIAZAC 120MG CAP # 30
NDC:00456-2612-90
MFR: FOREST PHARM IN
AUTH#Z2044962936999 3005 $33.97

May be refilled 12.00 times of 30 through 7/05/2003 3005 PCS RX PLANS

CO

COSTCO PHARMACY **Duplicate Receipt**

500 EUBANK BLVD SE
ALBUQUERQUE NM 87123 505-332-6602

COPP,DOUGLAS

27 SUMTION RD SANDIA PARK NM 87047 505-281-7977

RX 116135 N DR.GARCIA,HENRY 07/23/2002
TIAZAC 120MG CAP # 30
NDC:00456-2612-90
MFR: FOREST PHARM IN
AUTH#Z2044962936999 3005 $33.97

100 10 N/C

CO

COSTCO PHARMACY

DEPARTMENT

500 EUBANK BLVD SE ALBUQUERQUE NM 87123 505 332-6602

PATIENT COUNSELING INFORMATION

CONSULT YOUR PHARMACIST OR PHYSICIAN WITH A LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING IF YOU HAVE ANY QUESTIONS ABOUT ADVERSE DRUG REACTIONS.

07/23/2002

COPP,DOUGLAS
RX# 116135

TIAZAC 120MG CAP

WHY AM I TAKING THIS DRUG?
To treat angina (chest pain); high blood pressure.

HOW SHOULD I TAKE IT?
Once daily w/o regard to meals. Swallow whole. Don't stop drug suddenly. Tell MD of other drugs you take, other illness or allergies or if pregnant.

ARE THERE ANY SIDE EFFECTS
Dizziness, lightheadedness, headache, sore throat, bloating. Unlikely but report breathing difficulty, rash, irregular heartbeat, leg/ankle swelling.

HOW DO I STORE THIS?
Store at room temperature away from sunlight and moisture.

IF I SHOULD MISS A DOSE?
Take the missed dose as soon as it is remembered but not if it is almost time for the next dose. If so, skip the missed dose and resume regular dosing schedule. Do not "double-up" the doses.

WHAT ABOUT GENERICS?
Generic alternatives are available for many drugs. They are safe, effective and can save you money. Ask your pharmacist for details.

TAKE 1 CAPSULE ORALLY DAILY

MAY CAUSE DROWSINESS. ALCOHOL INTENSIFYS EFFECT USE CARE USING MACHINES.
OTC DRUGS MAY AGGRAVATE CONDITION.READ LABELS. IF A WARNING SEEN, CALL DR.
TAKE OR USE THIS EXACTLY AS DIRECTED. DO NOT SKIP DOSES OR DISCONTINUE.
DO NOT CHEW OR CRUSH BEFORE SWALLOWING.
MAY CAUSE DIZZINESS.

This information is an educational service and does not address all possible uses, actions, precautions, interactions, or side effects of this medicine. If you desire any additional prescription counseling, please ask your pharmacist. [illegible] M6

COSTCO PHARMACY Customer Receipt

600 EUBANK BLVD SE
ALBUQUERQUE NM 87123 505-332-6602

CO

COPP,DOUGLAS

27 SUMTION RD SANDIA PARK NM 87047 505-281-7977

RX 114849 R DR.GARCIA,HENRY 07/29/2002

PREDNISONE 20MG TAB @(SHN) # 60

NDC:00591-6443-01

MFR: DANBURY

AUTH#221008761242999 3005 **$9.99**

No refills remaining, authorization required 3005 PCS 610415

COSTCO PHARMACY Duplicate Receipt

600 EUBANK BLVD SE
ALBUQUERQUE NM 87123 505-332-6602

CO

COPP,DOUGLAS

27 SUMTION RD SANDIA PARK NM 87047 505-281-7977

RX 114849 R DR.GARCIA,HENRY 07/29/2002

PREDNISONE 20MG TAB @(SHN) # 60

NDC:00591-6443-01

MFR: DANBURY

AUTH#221008761242999 3005 **$9.99**

COSTCO PHARMACY DEPARTMENT

600 EUBANK BLVD SE ALBUQUERQUE NM 87123 505 332-6602

PATIENT COUNSELING INFORMATION

CONSULT YOUR PHARMACIST OR PHYSICIAN WITH A LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING IF YOU HAVE ANY QUESTIONS ABOUT ADVERSE DRUG REACTIONS.

COPP,DOUGLAS
RX# 114849

PREDNISONE 20MG TAB @(SHN)

07/29/2002

WHY AM I TAKING THIS DRUG?
To treat a hormone imbalance, allergic or inflammatory condition.

HOW SHOULD I TAKE IT?
Take with food. Don't take more than the amount prescribed. Follow your doctor's instructions. If you are long-term user, carry ID stating that you are on corticosteroids.

ARE THERE ANY SIDE EFFECTS
Increased appetite, loss of appetite, nervousness. May cause physical, mental or vision changes.

HOW DO I STORE THIS?
Store at room temperature away from moisture and sunlight. Follow label warnings about whether or not to refrigerate liquid forms. Do not freeze.

IF I SHOULD MISS A DOSE?
If taking 1 daily: take as soon as remembered but not if near time for next dose; don't "double-up" doses. If taking more than 1 daily: take as soon as remembered, do "double-up" if time for next dose. If taking every other day: consult your

WHAT ABOUT GENERICS?
Generic alternatives are available for many drugs. They are safe, effective and can save you money. Ask your pharmacist for details.

TAKE AS DIRECTED

TAKE WITH FOOD OR MILK.
TAKE OR USE THIS EXACTLY AS DIRECTED. DO NOT SKIP DOSES OR DISCONTINUE.
CALL DR. BEFORE TAKING OTC DRUGS SOME MAY AFFECT ACTION OF THIS MEDICINE.

COSTCO PHARMACY — Customer Receipt

600 EUBANK BLVD SE
ALBUQUERQUE NM 87123 505-332-6602

CO

COPP,DOUGLAS

27 SUMTION RD SANDIA PARK NM 87047 505-281-7977

RX 116284 N DR.GARCIA,HENRY 07/29/2002

TIAZAC 180MG CAP # 30

NDC:00456-2613-90

MFR: FOREST PHARM IN

AUTH#221008190549998 3005 **$38.57**

May be refilled 12.00 times of 30 through 7/27/2003 3005 PCS 810415

COSTCO PHARMACY — Duplicate Receipt

600 EUBANK BLVD SE
ALBUQUERQUE NM 87123 505-332-6602

CO

COPP,DOUGLAS

27 SUMTION RD SANDIA PARK NM 87047 505-281-7977

RX 116284 N DR.GARCIA,HENRY 07/29/2002

TIAZAC 180MG CAP # 30

NDC:00456-2613-90

MFR: FOREST PHARM IN

AUTH#221008190549998 3005 **$38.57**

COSTCO PHARMACY
DEPARTMENT
600 EUBANK BLVD SE ALBUQUERQUE NM 87123 505-332-6602

PATIENT COUNSELING INFORMATION

CONSULT YOUR PHARMACIST OR PHYSICIAN WITH A LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING IF YOU HAVE ANY QUESTIONS ABOUT ADVERSE DRUG REACTIONS.

COPP,DOUGLAS
RX# 116284

07/29/2002

TIAZAC 180MG CAP

WHY AM I TAKING THIS DRUG?
To treat angina (chest pain); high blood pressure.

HOW SHOULD I TAKE IT?
Once daily w/o regard to meals. Swallow whole. Don't stop drug suddenly. Tell MD of other drugs you take, other illness or allergies or if pregnant.

ARE THERE ANY SIDE EFFECTS
Dizziness, lightheadedness, headache, sore throat, bloating. Unlikely but report breathing difficulty, rash, irregular heartbeat, leg/ankle swelling.

HOW DO I STORE THIS?
Store at room temperature away from sunlight and moisture.

IF I SHOULD MISS A DOSE?
Take the missed dose as soon as it is remembered but not if it is almost time for the next dose. If so, skip the missed dose and resume regular dosing schedule. Do not "double-up" the doses.

WHAT ABOUT GENERICS?
Generic alternatives are available for many drugs. They are safe, effective and can save you money. Ask your pharmacist for details.

TAKE 1 CAPSULE ORALLY EVERY DAY

MAY CAUSE DROWSINESS. ALCOHOL INTENSIFYS EFFECT USE CARE USING MACHINES.
OTC DRUGS MAY AGGRAVATE CONDITION.READ LABELS. IF A WARNING SEEN, CALL DR.
TAKE OR USE THIS EXACTLY AS DIRECTED. DO NOT SKIP DOSES OR DISCONTINUE.
DO NOT CHEW OR CRUSH BEFORE SWALLOWING.
MAY CAUSE DIZZINESS.

This information is an educational service and does not address all possible uses, actions, precautions, interactions, or side

Robert Friedman, M.D.
Medical Bills

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Copp, Doug

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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) 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 | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | 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 _____ 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.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | 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

AME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 724
2. 955
3. 957
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
12 26 02				90780	IV therapy		330 73					
12 27 02				90780	"		219 78					
12 30 02				90780	"		293 73					
01 02 03				90780	"		305 13					
01 04 03				90780	"		213 38					
01 06 03				90780	"		305 13					

25. FEDERAL TAX I.D. NUMBER: 555 26 0515 | SSN [X] | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ 1672 88

29. AMOUNT PAID $

30. BALANCE DUE $ 1,672 88

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.)

SIGNED [signature] MD DATE 2/25/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Robert Friedman MD
1264 B Rodeo Rd
Santa Fe, NM 87505

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 3/88)

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#19423 - #29423 - Medical Arts Press

PHYSICIAN'S OR SUPPLIER'S INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Cope, Doug

3. PATIENT'S BIRTH DATE MM DD YY; SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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) 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 NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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 _____ 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.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — 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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 9CU
2. 955
3. 957
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 07 03							293 73					
01 09 03							305 13					
01 10 03							293 73					
01 15 03							305 13					
01 14 03							293 73					
01 16 03							305 13					

25. FEDERAL TAX I.D. NUMBER SSN EIN: 555 24 0545 X

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 1811 58

29. AMOUNT PAID $

30. BALANCE DUE $ 1,511 58

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.)

SIGNED MD DATE 1/25/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Robert Friedman MD
12610 Rodeo Rd
Santa Fe, NM 87505

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 3/88)

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[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
☐	☐	☐	☐	☐	☐	☐

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Cofr, Doug

3. PATIENT'S BIRTH DATE MM DD YY; SEX M ☐ F ☐

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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) 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 ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ 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 _____ 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

SIGNED _____

14. DATE OF CURRENT: MM DD YY; 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 ___

NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 784
2. 465
3. 487
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 17 03				0780	IV Therap		293 73					
2 01 20 03				0780			293 73					
3 01 21 03				0780			305 13					
4 01 27 03				0780			305 13					
5 01 28 03				0780			305 13					
6 02 07 03				0780			202 71					

25. FEDERAL TAX I.D. NUMBER: 55-2435[illegible] SSN ☐ EIN ☑

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ 1,118 10

29. AMOUNT PAID $

30. BALANCE DUE $ 1,118 10

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.)

SIGNED [signature] MD DATE 2/25/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Robert Friedman MD
1264 Rodeo Rd
Santa Fe, NM 87505

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 9/88)

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HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Coor, Doug	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single Married Other / Employed Full-Time Student Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		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) 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 NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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 _____ 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.

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	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
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 954 2. 985 3. 967 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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	E	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 14 03				90760	IV therapy			145 10					
2 02 19 03				90780	IV "			251 78					
3 02 24 03				90760	IV "			198 44					
4 02 24 03				99070	supplies			3 1 95					
5													
6													

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 388 30	29. AMOUNT PAID $	30. BALANCE DUE $ 388 30
555 20 0505 X					

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.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE PHONE #
SIGNED [signature] DATE 2/25/03		Robert Friedman M.D. 1214 Rodeo Rd Santa Fe, NM 87505 PIN# GRP#

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88) PLEASE PRINT OR TYPE

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[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): COPP, DOUG

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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) 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 NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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 _____ 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.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — 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

NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 964
2. 965
3. 967
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 2 27 03				90780	IV Therapy		113 09					
2 3 07 03				"			198 44					
3 3 11 03				"			198 44					
4 3 14 03				"			198 44					
5 3 21 03				"			198 44					
6 3 25 03				"			198 44					

25. FEDERAL TAX I.D. NUMBER SSN EIN: 555-24-0545 [X]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE: $ 1105 29

29. AMOUNT PAID: $

30. BALANCE DUE: $ 1105.29

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.)

SIGNED MD DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Robert Friedman MD
1314-E Rodeo Rd.
Santa Fe, N.M. 87505

PIN# GRP#

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

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FORM OWCP-1500
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APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): COPP DOUG

3. PATIENT'S BIRTH DATE MM DD YY; SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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) 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 NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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 _____ 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.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — 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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 954
2. 985
3. 987
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
3 28 03			90780	IV Therapy		198 44					
4 01 03			"	"		198 44					
4 04 03			"	"		198 44					
4 10 03			"	"		159 Ta					
4 22 03			"	"		117 36					
4 24 03			"	"		117 36					

25. FEDERAL TAX I.D. NUMBER SSN EIN: 555-24-0545 X

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 969 80

29. AMOUNT PAID $

30. BALANCE DUE $ 969 80

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.)

SIGNED [signature] MD DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Robert Friedman MD
1214-B Rodeo Rd
Santa Fe, NM 87505
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8.88)

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APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
COPP DOUG		
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS: Single, Married, Other; Employed, Full-Time Student, Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		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) 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 NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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 _____ 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.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — 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 PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 984 2. 985 3. 987 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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 5 01 03			90780 IV therapy		117 36					
2 5 06 03					251 78					
3 5 08 03					251 78					
4 5 13 03					251 78					
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
555-24-0545 ☑			$ 872 70	$	$ 872 70

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.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SIGNED [signature] DATE [date]		Robert Friedman MD 1264-G Rodeo Rd Santa Fe, NM 87505 PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

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HEALTH INSURANCE CLAIM FORM

PICA

PICA

MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Cop, Doug

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

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) 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 | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | 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.

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17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. L
2. L
3. L
4. L

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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
7 30 03				Medical Records Fee			90					

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ 90

29. AMOUNT PAID $

30. BALANCE DUE $ 90

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.)

R. Friedman MD 7/30/03

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE#

R. Friedman MD
1264-B Rodeo Rd
Santa Fe, NM 87505

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 3/88) PLEASE PRINT OR TYPE

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Robert A. Gordon, M.D.
Medical Bills

Member Name:	Paulina E Copp
Group No.:	N9030
Identification No.:	YIE560450095
Claim No.:	223250037520X
Patient Name:	Paulina Copp

Summary

Total Billed:	$105.00
Total Benefits Approved:	**$75.00**
Amount You May Owe Provider:	$24.49

The following shows how this claim was processed.

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
ROBERT A GORDON MD				
Provider Patient Account No.: COPPA800				
Physical History	08-19-02	95.00		95.00
Routine Lab Services	08-19-02	10.00	5.51 (3)	4.49
Totals		$105.00	$5.51	$99.49

Coverage Information

Totals	$105.00	$5.51	$99.49
Deductions:			
Applied to Your 2002 Health Care Plan Deductible		$24.49	
Total Deductions			$24.49
Total Benefits Approved			$75.00
Amount You May Owe Provider			$24.49

Total covered benefits approved for this claim: $75.00 to ROBERT A GORDON MD on 08-22-02

*** Thank You for Using the PPO Provider Network ***

You maximize your benefits and reduce out-of-pocket costs when choosing a doctor or hospital that participates in the PPO network.

Information About Out-Of-Pocket Expenses

Patient: PAULINA COPP
Benefit Period: 01-01-02 Through 12-31-02

To date this patient has met $4.49 of her/his $500.00 health care plan deductible.

of New Mexico
P. O. Box 27630
Albuquerque, NM 87125 - 7630

Claim Information

Member Name:	Paulina E Copp
Group No.:	N9030
Identification No.:	YIE560450095
Claim No.:	227350041530X
Patient Name:	Paulina Copp

Summary

Total Billed:	$185.00
Total Benefits Approved:	$0.00
Amount You May Owe Provider:	$163.67

The following shows how this claim was processed.

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
ROBERT A GORDON MD				
Provider Patient Account No.	COPPA000			
Surgery	09-25-02	185.00	21.33 (1)	163.67
Totals		$185.00	$21.33	$163.67

Coverage Information

Totals	$185.00	$21.33	$163.67
Deductions			
Applied to Your 2002 Health Care Plan Deductible		$163.67	
Total Deductions			$163.67
Total Benefits Approved			$0.00
Amount You May Owe Provider			$163.67

*** Thank You for Using the PPO Provider Network ***

You maximize your benefits and reduce out-of-pocket costs when choosing a doctor or hospital that participates in the PPO network.

Information About Out-Of-Pocket Expenses

Patient: PAULINA COPP
Benefit Period: 01-01-02 Through 12-31-02

To date this patient has met $398.85 of her/his $500.00 health care plan deductible.

Information About Amounts Not Covered

(1) The amount billed is greater than the amount allowed for this service. You will not be billed for this amount.

of New Mexico
P. O. Box 27630
Albuquerque, NM 87125 - 7630

Claim Information

Member Name:	Paulina E Copp
Group No.:	N9030
Identification No.:	YIE560450095
Claim No.:	236450033780X
Patient Name:	Paulina Copp

Summary

Total Billed:	$62.00
Total Benefits Approved:	**$34.73**
Amount You May Owe Provider:	$20.00

The following shows how this claim was processed.

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
ROBERT A GORDON MD				
Provider Patient Account No.:	COPPA000			
Medical Visits	12-27-02	62.00	7.27 (1)	54.73
Totals		$62.00	$7.27	$54.73

Coverage Information

Totals	$62.00	$7.27	$54.73
Deductions			
Your Copayment Amount		$20.00	
Total Deductions			$20.00
Benefits Approved			$34.73
Amount You May Owe Provider			$20.00

Total covered benefits approved for this claim: $34.73 to ROBERT A GORDON MD on 12-31-02.

*** Thank You for Using the PPO Provider Network ***

You maximize your benefits and reduce out-of-pocket costs when choosing a doctor or hospital that participates in the PPO network.

Information About Amounts Not Covered

(1) The amount billed is greater than the amount allowed for this service. You will not be billed for this amount.

Information About Appeals

If you do not agree or do not understand the information shown on this Explanation of Benefits, please contact the Customer Service Unit at the number on the back of your identification (ID) card for assistance. You may request a review or file a complaint if you disagree with the decision for denied or reduced services. Your Customer Service Unit can provide more information.

(turn over)

1,009 NM2573

of New Mexico
P. O. Box 27630
Albuquerque, NM 87125 - 7630

Claim Information

Member Name:	Paulina E Copp
Group No.:	N9030
Identification No.:	YIE560450095
Claim No.:	310750054010X
Patient Name:	Paulina Copp

Summary

Total Billed:	$62.00
Total Benefits Approved:	$34.73
Amount You May Owe Provider:	$20.00

The following shows how this claim was processed.

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
ROBERT A GORDON MD				
Provider Patient Account No.:	COPPA000			
Medical Visits	04-16-03	62.00	7.27 (1)	54.73
Totals		**$62.00**	**$7.27**	**$54.73**

Coverage Information

Totals	**$62.00**	**$7.27**	**$54.73**
Deductions			
Your Copayment Amount		$20.00	
Total Deductions			**-$20.00**
Benefits Approved			**$34.73**
Amount You May Owe Provider			**$20.00**

Total covered benefits approved for this claim: $34.73 to ROBERT A GORDON MD on 04-18-03.

*** Thank You for Using the PPO Provider Network ***

You maximize your benefits and reduce out-of-pocket costs when choosing a doctor or hospital that participates in the PPO network.

Information About Amounts Not Covered

(1) The amount billed is greater than the amount allowed for this service. You will not be billed for this amount.

Information About Appeals

If you do not agree or do not understand the information shown on this Explanation of Benefits, please contact the Customer Service Unit at the number on the back of your identification (ID) card for assistance. You may request a review or file a complaint if you disagree with the decision for denied or reduced services. Your Customer Service Unit can provide more information.

Providers, customers, and individuals cooperate with us to stop fraud. If you ever have any questions, call our Fraud Hotline at 1-888-841-7998.

1,505 NM2575

Great Smokies Diagnistics Lab
Medical Bills

BlueCross BlueShield
of New Mexico
P. O. Box 27630
Albuquerque, NM 87125 - 7630

Explanation of Benefits (EOB). **This is not a bill.**
BLUE CHOICE PPO NS $500 DEDUCT LO
10-30-02 *EIA*

Customer Service: 1-800-432-0750

PAULINA E COPP
PO BOX 534
SANDIA PK/GOLDEN NM 87047-0534

Visit our website at www.bcbsnm.com

Claim Information

Member Name:	Paulina E Copp
Group No.:	N9030
Identification No.:	YIE560450095
Claim No.:	230152590620X
Patient Name:	Douglas Copp

Summary

Total Billed:	$128.00
Total Benefits Approved:	**$121.46**
Amount You May Owe Provider:	$6.54

The following shows how this claim was processed.

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
GREAT SMOKIES DIAGNOSTIC				
Provider Patient Account No.: I-34160533				
Laboratory Services	10-08-02	26.00	0.15 (1)	25.85
Laboratory Services	10-08-02	26.00		26.00
Laboratory Services	10-08-02	20.00	2.85 (1)	17.15
Laboratory Services	10-08-02	20.00	3.54 (1)	16.46
Laboratory Services	10-08-02	11.00		11.00
Laboratory Services	10-08-02	25.00		25.00
Totals		$128.00	$6.54	$121.46

Coverage Information

Totals	$128.00	$6.54	$121.46
Total Benefits Approved			$121.46
Amount You May Owe Provider			$6.54

Payment of $121.46 was made to PAULINA E COPP on 10-30-02 check number 40344237

Claim Information

Member Name:	Paulina E Copp
Group No.:	N9030
Identification No.:	YIE560450095
Claim No.:	231852387880X
Patient Name:	Douglas Copp

Summary

Total Billed:	$128.00
Total Benefits Approved:	**$0.00**
Amount You May Owe Provider:	$128.00

The following shows how this claim was processed.

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
GREAT SMOKIES DIAGNOSTIC				
Provider Patient Account No.:	L34280089			
Laboratory Services	10-22-02	26.00	26.00 (3)	0.00
Laboratory Services	10-22-02	26.00	26.00 (3)	0.00
Laboratory Services	10-22-02	20.00	20.00 (3)	0.00
Laboratory Services	10-22-02	20.00	20.00 (3)	0.00
Laboratory Services	10-22-02	11.00	11.00 (3)	0.00
Laboratory Services	10-22-02	25.00	25.00 (3)	0.00
Totals		$128.00	$128.00	$0.00

Coverage Information

Totals	$128.00	$128.00	$0.00
Total Benefits Approved			$0.00
Amount You May Owe Provider			$128.00

Information About Amounts Not Covered

(1) The amount billed is greater than the amount allowed for this service. You will not be billed for this amount.
(2) You have reached the maximum allowance your plan covers for multiple related surgeries. Under the terms of our agreement with the participating network provider that performed these services, you are not responsible for any charges over the allowed amount.
(3) This expense/service is not covered under the terms and conditions of your Health Care Plan. No payment can be made.

Information About Appeals

If you do not agree or do not understand the information shown on this Explanation of Benefits, please contact the Customer Service Unit at the number on the back of your identification (ID) card for assistance. You may request a review or file a complaint if you disagree with the decision for denied or reduced services. Your Customer Service Unit can provide more information.

of New Mexico
P. O. Box 27630
Albuquerque, NM 87125 - 7630

Claim Information

Member Name:	Paulina E Copp
Group No.:	N9030
Identification No.:	YIE560450095
Claim No.:	231852387870X
Patient Name:	Douglas Copp

Summary

Total Billed:	$228.00
Total Benefits Approved:	**$0.00**
Amount You May Owe Provider:	$228.00

The following shows how this claim was processed.

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
GREAT SMOKIES DIAGNOSTIC				
Provider Patient Account No: [illegible]				
Laboratory Services	10-23-02	90.00	90.00 (3)	0.00
Laboratory Services	10-23-02	20.00	20.00 (3)	0.00
Laboratory Services	10-23-02	25.00	25.00 (3)	0.00
Laboratory Services	10-23-02	93.00	93.00 (3)	0.00
Totals		$228.00	$228.00	$0.00

Coverage Information

Totals	$228.00	$228.00	$0.00
Total Benefits Approved			$0.00
Amount You May Owe Provider			$228.00

Henry A. Garcia, M.D.
High Desert Medical Associates, P.C.
Medical Bills

Kaseman Presbyterian
Medical Bills

STATEMENT

PRESBYTERIAN HEALTHCARE SERVICES

PLEASE REFER TO PATIENT'S NAME & ACCOUNT NO. ON ALL INQUIRIES AND CORRESPONDENCE.

PATIENT'S NAME	FC	ACCOUNT NO.	PAY PERIOD COVERED BY THIS STATEMENT	STATEMENT DATE
COPP, DOUGLAS F	B	001415142-8401	08/05/02 09/04/02	09/04/02

IMPORTANT: PLEASE DETACH & RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR REMITTANCE TO ASSURE PROPER CREDIT. SEE REVERSE SIDE FOR PAYMENT BY VISA, MASTERCARD, AMERICAN EXPRESS OR DISCOVER.

IF ADDING CHANGE OF ADDRESS OR CREDIT CARD INFORMATION ON REVERSE PLEASE CHECK BOX →

DOUGLAS F COPP
PO BOX 534
SANDIA PARK NM 87047-0000

SEND PAYMENT TO: KASEMAN PRESBYTERIAN 3.0
PO BOX 27888
ALBUQUERQUE NM 87125-7888

PAY THIS AMOUNT: 151.71

ENTER AMOUNT PAID →

DETACH HERE PLEASE RETURN TOP PORTION ONLY. DO NOT ENCLOSE INQUIRIES WITH YOUR PAYMENT.

PATIENT'S NAME	FC	ACCOUNT NO.
COPP, DOUGLAS F	B	001415142-8401

TRANSACTIONS MADE AFTER THIS DATE WILL APPEAR ON YOUR NEXT STATEMENT → STATEMENT DATE: 09/04/02 PAGE NO.: 1

TRANSACTION DATE	SERVICE CODE	DESCRIPTION	AMOUNT
08/04/02	00098200	ALLOWANCE-PCOM-BLUE CROSS SERVICE ON 07/30/02 BLUE CROSS PPO/POS 290	408.45-
08/14/02	00096000	PMT-BLUE CROSS SERVICE ON 07/30/02 BLUE CROSS PPO/POS 290	606.84-

IF YOU HAVE ANY QUESTIONS CONCERNING THIS STATEMENT PLEASE CONTACT: BO BUSINESS OFFICE PHONE: 505 923-5400

KASEMAN HOSPITAL BUSINESS OFFICE IS LOCATED AT, 1801 RANDOLPH S.E. ALBUQUERQUE, NM 87106
PAYMENTS MAY BE MADE AT YOUR LOCAL FACILITY.
BUSINESS OFFICE TOLL FREE NUMBER 1-800-704-4639.
BUSINESS OFFICE HOURS ARE:8:00 AM TO 5:00 PM, M-
CUSTOMER SERVICE HOURS ARE 8-12 AND 1-5, M-F.

ACCOUNT BALANCE LAST STATEMENT →	1,167.00
NEW CHARGES/ ADJUSTMENTS →	0.00
LESS NEW PAYMENTS/ CREDITS →	1,015.29-
CURRENT ACCOUNT BALANCE →	151.71
ESTIMATED AMOUNT DUE FROM INSURANCE →	0.00
PAY THIS AMOUNT →	151.71

OUTPATIENT DETAIL STATEMENT

PRESBYTERIAN HEALTHCARE SERVICES

PATIENT'S NAME	ACCOUNT NO.	ADMISSION DATE	DISCHARGE DATE	STATEMENT DATE
COPP, DOUGLAS F	001415142-2238 PC	09/03/02	09/03/02	09/07/02

PLEASE REFER TO PATIENT'S NAME & ACCOUNT NO. ON ALL INQUIRIES AND CORRESPONDENCE

IF ADDING CHANGE OF ADDRESS OR CREDIT CARD INFORMATION ON REVERSE PLEASE CHECK BOX ==>

PATIENT	DOUGLAS F COPP PO BOX 534 SANDIA PARK NM 87047-0000	PAYOR	KASEMAN PRESBYTERIAN 3.0 PO BOX 27888 ALBUQUERQUE NM 87125-7888
INS	BLUE CROSS PPO/POS 290 B03 FOR BILLING INFORMATION CALL	INS	BC BUSINESS OFFICE 505 888-6400

DETACH HERE, PLEASE RETURN TOP PORTION ONLY. DO NOT ENCLOSE INQUIRIES WITH YOUR PAYMENT

GUIDE AMOUNT PAID

PATIENT'S NAME	ACCOUNT NO.	STATEMENT DATE	PAGE NO.
COPP, DOUGLAS F	001415142-2238	09/07/02	SM01

INSURANCE PORTION COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER

SERVICE DATE	SERVICE CODE	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
		---- SUMMARY OF CHARGES ----			
		---- ANCILLARY CHARGES ----			
	002	PHARMACY	209.00	209.00	
	009	RADIOLOGY, DIAGNOSTIC	401.00	401.00	
	013	OPERATING ROOM SERVICES	1,538.00	1,538.00	
		TOTAL OF ALL CHARGES	2,148.00	2,148.00	
		DEDUCTIBLE & COINSURANCE		829.60-	829.60
		TOTAL CHARGES AND INSURANCE	2,148.00	1,318.40	
		ESTIMATED PATIENT LIABILITY			829.60