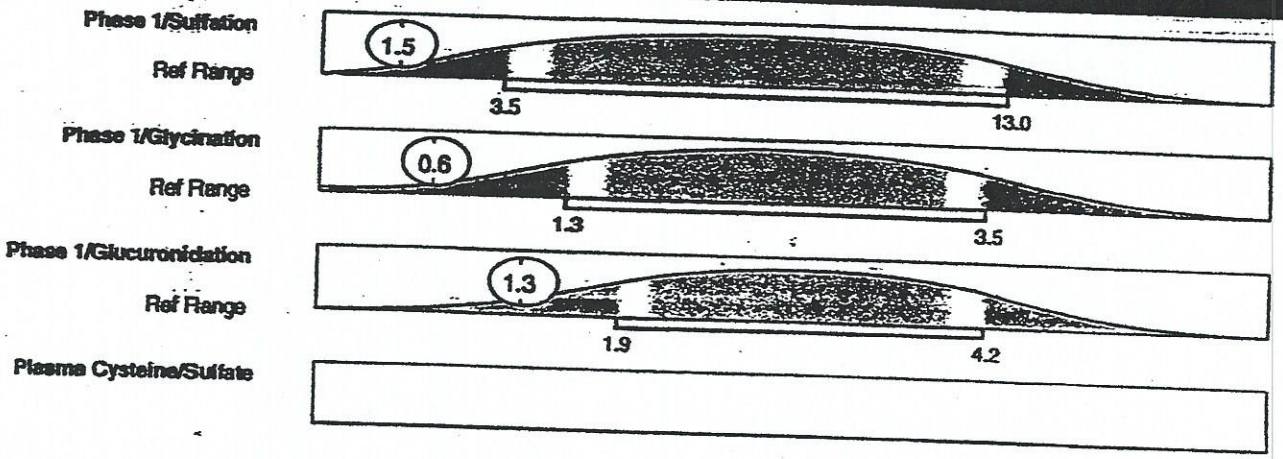
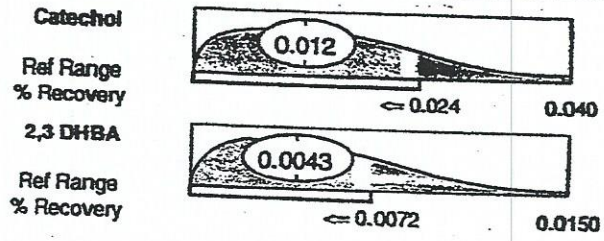
Ratios



Free Radical Markers

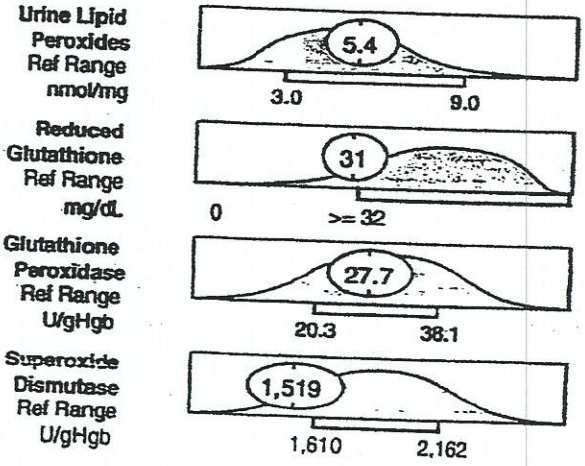
Salicylic Acid

Hydroxyl Radical



Lipids

Free Radicals



Total Urine Volume

mL per 10 hours: 1,200

Commentary

Lab Comments

No plasma received. 10/24/02 TH

Rokim Kadjar, M.D. Medical Director

Patient Name: COPP, DOUGLAS
Patient I.D.: X046461692

TRICORE REFERENCE LABORATORIES
ATTN: SENDOUT DEPARTMENT
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ALBUQUERQUE, NM. 87107

Blood Drawn	Processed	Reported	RL No.
10/23/02	10/25/02	11/11/02	135065

TEST	RESULT	ABNORMAL	REFERENCE RANGE	UNITS
*** FUNGAL PANEL 2 ***				
IgG ALTERNARIA TENUIS + A	5193		0-1600	ELISA
IgE ALTERNARIA TENUIS + A	45		0-50	ELISA
IgG ASPER FUMIGATUS	2272		0-1600	ELISA
IgE ASPER FUMIGATUS	38		0-50	ELISA
IgG ASPER NIGER	522		0-1600	ELISA
IgE ASPER NIGER	41		0-50	ELISA
IgG CANDIDA	4717		800-3200	ELISA
IgE CANDIDA	76		0-50	
IgG CLADOSPORIUM HERBARUM	420		0-1600	ELISA
IgE CLADOSPORIUM HERBARUM	57		0-50	ELISA
IgG EPICOCCUM NIGRUM	6515		0-1600	ELISA
IgE EPICOCCUM NIGRUM	43		0-50	ELISA
IgG GEOTRICHUM CANDIDUM	2174		0-1600	ELISA
IgE GEOTRICHUM CANDIDUM	35		0-50	ELISA
IgG PENICILLIUM NOTATUM	1263		0-1600	ELISA
IgE PENICILLIUM NOTATUM	48		0-50	ELISA
IgG PHOMA HERBARIUM	1554		0-1600	ELISA
IgE PHOMA HERBARIUM	46		0-50	ELISA
IgG PULLULARIA PULLULANS	3888		0-1600	
IgE PULLULARIA PULLULANS	69		0-50	
IgG RHIZOPUS NIGRICANS	736		0-1600	ELISA
IgE RHIZOPUS NIGRICANS	39		0-50	ELISA

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[redacted] LAB., LLC.
[redacted], M.D. Medical Director

Patient Name:
Patient I.D.: COPP, DOUGLAS
X0466461692

TRICORE REFERENCE LABORATORIES
ATTN: SENDOUT DEPARTMENT
2811 STANFORD N.E.
ALBUQUERQUE, NM. 87107

Blood Drawn	Processed	Reported	ISL No.
10/23/02	10/25/02	11/11/02	135965

TEST	RESULT	REFERENCE RANGE	UNITS
IgG RHODOTORULA GLUTINIS	1600	0-1600	ELISA
IgE RHODOTORULA GLUTINIS	41	0-50	ELISA

IgE titers greater than100 are indicative of atopic allergy to that fungus

IgG titers greater than 1600 are suggestive of chronic exposure to that fungus or of prior desensitization. Assay should be repeated three months later to confirm successful desensitization or avoidance of the fungus.

Some analyte-specific reagents used in these in-house procedures are classified under Class I devices by the FDA and are exempt from the premarket notification requirements of Section 510(K) of the act.

This test was developed and its performance characteristics determined by Immunosciences Lab., Inc. It does not have to be cleared by the FDA, pursuant to act 21 CFR 809 30(e).

These tests have undergone stringent quality control and assurance, and comparison studies have been performed in compliance with the State of California's requirements.

CONTINUED ON NEXT PAGE

Immunosciences Lab., Inc.

Patient Name: COPP, DOUGLAS
Patient I.D.: X046461592

REFERRING PHYSICIAN

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ATTN: SENDOUT DEPARTMENT
2811 STANFORD N.E.
ALBUQUERQUE, NM. 87107

Blood Drawn	Processed	Reported	ISL No.
10/23/02	10/25/02	11/11/02	135865

TEST	RESULTS	REFERENCE RANGE	UNITS

The number and functional capacity of circulating peripheral blood leukocytes reflects the overall state of immune competence of an individual. In variety of clinical situations, test for granulocyte, lymphocyte, and monocyte number and function have become routine in the diagnosis of disease and in monitoring immunosuppressive and immunorestorative treatments. Flow cytometric measurements allow the enumeration of different types of lymphocytes by identification of their light-scattering properties and surface antigen-binding to fluorochrome-conjugated monoclonal antibodies. The clinical significances of each lymphocyte markers namely: CD3, CD19, CD4, CD8, CD 16+56 and CD26 (TA1) are as follows: Decreased numbers of CD3+ (T-cells) lymphocytes are found in patients with autoimmune disorders including multiple sclerosis, systemic lupus erythematosus, and eczema and also thymic aplasia (DiGeorge syndrome). Increased number of CD3+ lymphocytes are noted in patients with acute infectious mononucleosis and also in cases of acquired agammaglobulinemia due to the presence of activated suppressor cells. The CD19+ (B-cells) monoclonal antibody, however, are reactive with all non-T-cell ALL (Acute Lymphoblastic Leukemia) and CML (Chronic Myelogenous Leukemia) blast crisis cells suggesting a B-cell origin of these tumor cells. CD19 monoclonal antibody may also be useful in defining early B-cells and in the study of immunodeficiency diseases. On the other hand, abnormal levels of CD4+ (T-helper) and CD8+ (T-suppressor) lymphocytes may aid in the diagnosis and/or prognosis of immunodeficiency diseases such as agammaglobulinemia, thymic aplasia, severe combined immunodeficiency, and AIDS. CD8+ cells are elevated in early HIV infection, and may begin to decline with time. At the time of an AIDS diagnosis, CD8+ cells have returned to normal levels. Increased levels of CD8+ T-lymphocytes are associated with viral infections such as Hep-B, EBV, and CMV. CD4/CD8 (H/S) ratios have been used to monitor HIV disease progression. Low numbers of CD16+56 cells are found in patients with CFIDS. When used with CD3 monoclonal antibody, NK can be used to define distinct subsets on non-MHC restricted cytolytic cells used in the identification and enumeration of lymphoproliferative diseases involving NK cells. CD26+ (TA1) is an activation marker found to be elevated in 80% of patients with Chronic Fatigue Syndrome.

References:

1. Owens, Marilyn, Lowen Michael. Flow Cytometry Principles for Clinical Laboratory Practice. Wiley-Liss, 1965.

CONTINUED ON NEXT PAGE

Immunosciences Lab., Inc.
Rubin Kludjian, M.D. Medical Director

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ALBUQUERQUE, NM. 87107

Patient Name:
Patient I.D.: COPP, DOUGLAS
X0466461692

Blood Drawn	Processed	Reported	IBL No.
10/23/02	10/25/02	11/11/02	135065

TEST	RESULTS	REFERENCE RANGE	UNITS

*** URINE D-GLUCARIC ACID ***

URINE D-GLUCARIC ACID	1.6	1-5	mol/ mol crea

The microsomal enzyme system of the liver can be activated by various drugs and chemicals. Thus, the biotransformation of endogenous and exogenous substances in the human organism and the biological availability of chemicals are decisively influenced. This process occurs since the human body cleanses itself by enzymatic detoxification from foreign chemicals (xenobiotics). Determination of glucaric acid excretion in urine has proved to be a suitable index to microsomal enzyme activity and presence of many xenobiotics. However, for confirmation measurements of urine D-glucaric acid in combination with serum gamma glutamyl transferase or gamma glutamyl transpeptidase is recommended.

CONTINUED ON NEXT PAGE

Immunosciences Lab., Inc.
Ralph Korpel, M.D. Medical Director

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ATTN: SENDOUT DEPARTMENT
2211 STANFORD N.E.
ALBUQUERQUE, NM. 87107

Patient Name:
Patient I.D.: COPP, DOUGLAS
X846461692

Blood Drawn	Processed	Reported	Rpt. No.
10/23/02	10/25/02	11/11/02	135065

TEST	RESULT	REFERENCE RANGE	UNITS

*** GAMMA GLUTAMYL TRANSFERAS ***

GAMMA GLUTAMYL TRANSFERAS	65.2	0-43	UNITS/ML

RESULT VERIFIED BY REPEAT ANALYSIS

Elevated GGTP levels have been observed in the following conditions:

Cholelithiasis
Chronic alcoholism
Epilepsy
Hepatic neoplasms
Hepatitis (viral, drug, chronic)
Highly vascularized brain lesions
Liver cirrhosis
Liver metastasis
Myocardial infraction
Obstructive jaundice
Pleurisy

Administration of certain drugs or ingestion of ethanol has been shown to influence serum GGTP levels. For example, increased serum GGTP activity has been observed in patients taking anti-epileptic drugs, such as phenytoin or barbiturates.

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Immunosciences Lab., Inc.
Robin Kaplan, M.D. Medical Director

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TRICORE REFERENCE LABORATORIES
ATTN: SENDOUT DEPARTMENT
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ALBUQUERQUE, NM. 87107

Patient Name:
Patient I.D: COPP, DOUGLAS
X0446461592

Blood Drawn	Processed	Reported	ISL No.
10/23/02	10/25/02	11/11/02	135865

TEST	RESULTS	REFERENCE RANGE	UNITS
*** MYELIN BASIC PROTEIN Ab ***			
IgG MYELIN BASIC PROTEIN	62	0 - 100	ELISA
IgM MYELIN BASIC PROTEIN	45	0 - 50	ELISA
IgA MYELIN BASIC PROTEIN	20	0 - 20	ELISA
BIALOGANGLIOSIDE GM1 Ab	18.00	0 - 20	ELISA
ANTI SULPHATIDE Ab	16.00	0 - 20	ELISA

Myelin is a multilaselliar membrane surrounding nerve fibers in both the central and peripheral nervous systems. It is derived from the plasma membrane of the oligodendrocyte in the central nervous system and the schwann cell in the peripheral nervous system. Myelin consists of approximately 70% lipid and 30% protein by weight. The proteins, the proteolipids, and the basic proteins constitute 85% of the total protein of the membrane of which the myelin basic proteins (MBPs), are the most completely characterized. Antibodies (IgG, IgM, IgA) against MBP and gangliosides, including GM1, GDia, GDib, GTib, and LM1, and other acidic glycolipids, including LK1 and sulphatide, of human brain and peripheral nerve, have been observed in the high percentage of patients with the following neurological conditions:
Multiple sclerosis, guillain barr's syndrome, chronic inflamatory demyelinating polyradiculo neuropathy, motor neuron disease or peripheral neuropathies, peripheral neuropathy associated with monoclonal IgM antibody (IgM gammopathy), vascular multiinfarct dementia, alzheimer's, rheumatoid arthritis, toxic chemical exposure and silicone adjuvant disease.

The major antigen of Myelin Basic Protein in this assay consist of Myelin associated Glycoprotein or MAG.
Some analyte-specific reagents used in these in-house procedures are classified under Class I devices by the FDA and are exempt from the premarket notification requirements of Section 510(K) of the act.
This test was developed and its performance characteristics determined by Isgunosciences Lab., Inc. It does not have to be cleared by the FDA, pursuant to act 21 CFR 809 30(e).

CONTINUED ON NEXT PAGE

Immunosciences Lab., Inc.

Patient Name: COPP, DOUGLAS

Patient I.D.: X84646165E

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Blood Drawn	Processed	Reported	ISL No.
10/23/02	10/25/02	11/11/02	135065

These tests have undergone stringent quality control and assurance, and comparison studies have been performed in compliance with the State of California's requirements.

CONTINUED ON NEXT PAGE

Patient Name:
Patient ID: COPP, DOUGLAS
X048461892

2811 STANFORD N.E.
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Blood Drawn	Processed	Reported	RL No.
10/23/02	10/25/02	11/11/02	135065

TEST	RESULT	UNITS	REFERENCE RANGE	UNITS
*** AUTO IMMUNE PANEL ***				
ANTI-CENTROMERE	NEGATIVE		NEGATIVE	
ANTI-MICROSOMAL	5		<20	IU/ml
ANTI-MITOCHONDRIAL	NEGATIVE		NEGATIVE	
ANTI-MYOCARDIAL	1:20		0-20	ELISA
ANTI-NATIVE DNA	NEGATIVE		NEGATIVE	
ANTI-NUCLEAR AB BY HEP-2	1:320 SPECKLED		1:20	
ANTI-PARIETAL CELL	1:23		0-40	ELISA
ANTI-RNP	N.D.		NOT DETECTED	
ANTI-SM	N.D.		NOT DETECTED	
ANTI-SMOOTH MUSCLE	1:25		0-20	ELISA
ANTI-SSA	N.D.		NOT DETECTED	
ANTI-SSB	N.D.		NOT DETECTED	
ANTI-STRIATED MUSCLE	1:19		0-20	ELISA
ANTI-THYROGLOBULIN	8		<45	IU/ml
C3-COMPLEMENT	167.0		75-140	ug/dl
C4-COMPLEMENT	36.0		10-34	ug/dl
RHEUMATOID FACTOR	25.0		0-20	IU/ml
TOTAL IMMUNE COMPLEX	52.0		0-50	ug eq/ml

N.D. = NOT DETECTED
Autoimmune diseases can be separated into two categories. One group is characterized by the presence of autoantibodies

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Patient Name: COPP, DOUGLAS
Patient I.D.: X8646461692

Blood Drawn	Processed	Reported	ISL No.
10/23/02	10/25/02	11/11/02	139065

TEST	CLINICAL ASSESSMENT	RESULT	NOTE

that are broadly reactive with nuclear or cytoplasmic antigens and that do not demonstrate any tissue specificity. Included in this group are diseases such as rheumatoid arthritis, systemic lupus erythematosus, mixed connective tissue disease, scleroderma, Sjogren's syndrome, and dermatomyositis or polymyositis. A second group of autoimmune diseases is characterized by autoantibodies which demonstrate tissue specificity. These diseases include thyroiditis, chronic liver diseases (including primary biliary cirrhosis and chronic active hepatitis), certain cases of pernicious anemia, and myasthenia gravis.

The detection of circulating antibodies to nuclear antigens is an important tool in the investigation of systemic rheumatic diseases. Many techniques have been developed to detect antinuclear antibodies (ANA), but the fluorescent-ANA (FANA) or enzyme-ANA EANA) test continues to be the most widely used and accepted. When the ANA is performed by using substrate of choice such as human epidermoid cell line (HEP-2) the ANA incidence is positive in 99% of SLE; 85% of Sjogren; 80% of scleroderma; 55% of rheumatoid arthritis and 40% of juvenile chronic arthritis.

Antinuclear antibodies may be classified biochemically according to whether they bind a nucleic acid per se, a chromatin component such as histone, ribunucleoprotein (RNP), or some other nuclear constituent. Antibodies within each class can be detected readily in assays based on immunofluorescence using HEP-2 cell line, enzyme immunoassay and Western Blot Assays using biochemically purified antigens.

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Fahim Halaas M.D. Medical Director

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2811 STANFORD N.E.
ALBUQUERQUE, NM. 87107

Patient Name: COPP, DOUGLAS
Patient I.D.: X0446461692

Blood Drawn	Processed	Reported	ISL No.
10/23/02	10/25/02	11/11/02	135865

				UNITS
*** CHEMICAL ANTIBODIES ***				
IgG FORMALDEHYDE	8	16	ELISA	
IgE FORMALDEHYDE	8	16	ELISA	
IgM FORMALDEHYDE	8	64	ELISA	
IgG ISOCYANATE	8	16	ELISA	
IgE ISOCYANATE	8	16	ELISA	
IgM ISOCYANATE	8	64	ELISA	
IgG TRIMELLITIC ANHYDRIDE	8	16	ELISA	
IgE TRIMELLITIC ANHYDRIDE	8	16	ELISA	
IgM TRIMELLITIC ANHYDRIDE	8	64	ELISA	
IgG PHTHALIC ANHYDRIDE	8	16	ELISA	
IgE PHTHALIC ANHYDRIDE	8	16	ELISA	
IgM PHTHALIC ANHYDRIDE	8	64	ELISA	
IgG BENZENE RING	8	16	ELISA	
IgE BENZENE RING	8	16	ELISA	
IgM BENZENE RING	8	64	ELISA	

Formaldehyde, isocyanate, trimellitic anhydride, phthalic anhydride, benzene, hexane, styrene, and toluene are the major cause of industrial and indoor air pollution. These chemicals are found in thousands of modern products for home and industry and, therefore, millions of people are constantly exposed to low-levels of these chemicals at work and at home. The common health problems related to chemical exposure include headache, depression, fatigue, irritability allergy-like symptoms, immune dysfunctions, infections, heart disease and possibly cancer. The immunological damages are caused by chemical linking to human proteins, cells, or tissues and thereby invoking antigenic or allergenic

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Immunosciences Lab., Inc.
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Patient Name: COPP, DOUGLAS
Patient I.D.: X846461692

Blood Drawn	Processed	Reported	IBL No.
10/23/02	10/25/02	11/11/02	130065

responses. These new antigenic determinants may not only induce IgG, IgM, IgA, and IgE antibody production against the chemicals, but also to one's own body's proteins thereby possibly leading to autoimmune diseases.

... IgG or IgE ELISA UNITS GREATER THAN 16 AND IgM ELISA UNITS GREATER THAN 64 ARE SUGGESTIVE OF SENSITIVITY OR CHRONIC EXPOSURE TO THAT CHEMICAL.

Some analyte-specific reagents used in these in-house procedures are classified under Class I devices by the FDA and are exempt from the premarket notification requirements of Section 510(K) of the act.

This test was developed and its performance characteristics determined by Immunosciences Lab., Inc. It does not have to be cleared by the FDA, pursuant to act 21 CFR 809 30(e).

These tests have undergone stringent quality control and assurance, and comparison studies have been performed in compliance with the State of California's requirements.

CONTINUED ON NEXT PAGE

Immunosciences Lab., Inc.
Fahim Kaiyo, M.D. Medical Director

REFERRING PHYSICIAN

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ALBUQUERQUE, NM. 87107

Patient Name:	
Patient I.D:	COPP, DOUGLAS
	X0446461692

Blood Drawn	Processed	Reported	IBL No.
10/23/02	10/25/02	11/11/02	39865

TEST	RESULTS NORMAL ABNORMAL	REFERENCE RANGE	UNITS
*** IMMUNE COMPLEX ASSAY ***			
IgG IMMUNE COMPLEX	23	0-20	ug eq/ml
IgM IMMUNE COMPLEX	15	0-15	ug eq/ml
IgA IMMUNE COMPLEX	13	0-10	ug eq/ml

Interactions between antigens and antibodies can form molecular aggregates in the body known as immune complexes. They can deposit in blood vessels, tissue and various glands throughout the body, producing inflammation and pathological conditions. They may initially form in the circulation prior to deposition or directly in tissue. Elevated levels have been detected in many diseases including autoimmune conditions such as SLE, rheumatoid arthritis and glumerulonephritis, as well as malignancies and various infectious diseases. They have also appeared in migraine headaches, psoriasis, and other unexpected diseases.
Their presence during a disease state does not necessarily implictas them as causative factors in the disease process. Other clinical data and the condition of the patient should be taken into consideration when interpreting results.
Immune complex levels up to two times the upper range of normal may be significant but should not be considered diagnostic or prognostic unless supported by a strong clinical picture.

References:
Carol Ann Toth, Douglas Pohl, and Vincent Agnello. "Methods for Detection of Immune Complexes by Utilizing C1q or Rheumatoid Factors" in Manual of Clinical Laboratory Immunology, 3rd edition, ed. Noel R. Rose, Herman Friedman and John L. Fahey (Washington, D.C., 1986), pp. 284-287.
Some analyte-specific reagents used in these in-house procedures are classified under Class I devices by the FDA and are exempt from the premarket notification requirements of Section 510(K) of the act.
This test was developed and its performance characteristics determined by Immunosciences Lab., Inc. It does not have to be cleared by the FDA, pursuant to act 21 CFR 809.10(a).
These tests have undergone stringent quality control and assurance, and comparison studies have been performed in compliance with the State of California's requirements.

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Patient Name:
Patient I.D.: COPP, DOUGLAS
X0456461692

Blood Drawn	Processed	Reported	IBL No.
10/23/02	10/25/02	11/11/02	135065

TEST	RESULTS PREVIOUS	RESULTS CURRENT	REFERENCE RANGE	UNITS

*** SECRETORY IgA ***

SECRETORY IgA	11.0	10-28	Ug/ml

Secretory IgA is the first line of defense and response to foreign antigens including bacteria, viruses, parasites, and food proteins. Secretory IgA is found only in surface mucosal secretions, and its absence is the most common immunodeficiency disorder accounting for 15% of all such cases. Frequency of certain diseases, mainly neurological (24%), gastrointestinal (28%), collagen, autoimmune (20%), and recurrent infections (23%), may occur in patients with selective IgA deficiency. These include neuropathies, endocrinopathies, atopy, Celiac Disease, asthma, food allergies, Rheumatoid Arthritis, Lupus, Malabsorption Syndrome, lymphomas, bacterial, viral and fungal infections.

High levels of Secretory IgA is associated with chronic viral syndromes, parotitis, gingivitis, and may be indicative of mucosal surfaces infection with EBV, CMV, Herpes, HIV, Streptococcus, Bacteroides and Candida albicans.
Some analyte-specific reagents used in these in-house procedures are classified under Class I devices by the FDA and are exempt from the premarket notification requirements of Section 510(K) of the act.
This test was developed and its performance characteristics determined by Immunosciences Lab., Inc. It does not have to be cleared by the FDA, pursuant to act 21 CFR 809 30(e).
These tests have undergone stringent quality control and assurance, and comparison studies have been performed in compliance with the State of California's requirements.

CONTINUED ON NEXT PAGE

Patient Name: COPP, DOUGLAS

Patient I.D.: X046461692

10/23/02 10/2..

TEST	NORMAL	ABNORMAL	REFERENCE RANGE
*** T AND B CELL FUNCTION ***			
PHYTOHEMAGGLUTININ	112.0		75-125%
CONCANAVALIN A	92.0		75-125%
POKEWEED MITOGEN	83.0		75-125%
LIPOPOLYSACCHARIDE	92.0		75-125%
S. AUREUS ANTIGENS	85.0		75-125%

Lymphocyte proliferation or transformation is the process whereby new DNA synthesis and cell division take place in lymphocyte after a stimulus of some type (chemical, bacteria, virus, or other antigens), resulting in a series of changes. This test has a broad range of applications, including assessment and monitoring of congenital immunological defects which range from complete lack of function, as in severe combined immunodeficiency disease and DiGeorge Syndrome, to a partial deficit, as in ataxia telangiectasia, Wiskott-Aldrich Syndrome, chemically induced immune dysfunction syndrome, chronic fatigue syndrome, and chronic mucocutaneous candidiasis, to normal reactivity, as in X-linked hypogammaglobulinemia. A wide variety of acquired conditions has been shown to have induced lymphocyte transformation. These conditions include exposure to a variety of chemicals, bacterial and viral infections, as well as autoimmune diseases, such as Sjogren's Syndrome and systemic lupus erythematosus. Lymphocyte transformation has also been used to monitor sequential samples from patients undergoing a variety of immunoenhancing or immunosuppressive therapies in the treatment of disease states.

Some analyte-specific reagents used in these in-house procedures are classified under Class I devices by the FDA and are exempt from the premarket notification requirements of Section 510(K) of the act.

This test was developed and its performance characteristics determined by Immunosciences Lab., Inc. It does not have to be cleared by the FDA, pursuant to act 21 CFR 809.30(e). These tests have undergone stringent quality control and assurance, and comparison studies have been performed in compliance with the State of California's requirements.

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Robin Kaplan, M.D. Medical Director

REFERRING PHYSICIAN

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ALBUQUERQUE, NM. 87107

Blood Drawn	Processed	Reported	IGL No.
10/23/02	10/25/02	11/11/02	135065

Patient Name: COPP, DOUGLAS
Patient I.D.: X046461692

TEST	RESULTS NORMAL	RESULTS ABNORMAL	REFERENCE RANGE	UNITS
*** NK CELL ACTIVITY PANEL ***				
NK CELL ACTIVITY		10.90	20-50	LUs
NK CELL ACTIVITY/CELL	9.40		5.1-10	mm3
%NATURAL KILLER CELLS	7.0		5.5-20%	mm3
% IMMUNOCOMPETENT -NKHT3+		1.0	1.5-5%	mm3
% NKHT3 NEGATIVE	6.0		4-15%	mm3
% T3 POSITIVE CELLS		81.0	53-73%	mm3

One of the major mechanisms by which the immune response deals with foreign or abnormal cells is to damage or destroy them. Such immunologic cytotoxicity may lead to complete loss of viability of the target cells (cytolysis) or an inhibition of the ability of the cells to continue growing (cytostasis). Immunologic cytotoxicity can be manifested against a wide variety of target cells. These include malignant cells, normal cells from individuals unrelated to the responding host, and normal cells of the host that are infected with viruses or other microorganisms. In addition, the immune system can cause direct cytotoxic effects on some microorganisms, including bacteria, parasites, and fungi. Immunologic cytotoxicity is a principal mechanism by which the immune response copes with and often eliminates foreign materials or abnormal cells. Natural killer cell activity is influenced by a variety of conditions including stress, chemical exposure, infections, chronic fatigue syndrome, immune deficiencies and cancer. In an increasing number of studies of clinical treatments of patients with various diseases, serial monitoring of cytotoxic reactivity is performed. The objective is to determine whether the treatment can produce a significant alteration from the pretreatment levels of NK activity, Antibody Dependent Cytotoxic activity, or both. Interleukin 2, interferon and natural killer cytotoxic factor has been shown to enhance NK cell activity. Therefore enhancement of Interleukin 2 Production may be useful in reactivation of NK cells in patients with the above mentioned conditions.

****

REFERENCE RANGE:

CONTINUED ON NEXT PAGE

Immunosciences Lab., Inc.
Robin Kenyon, M.D. Medical Director

Patient Name:
Patient I.D.: COPP, DOUGLAS
X046461692

REFERRING PHYSICIAN

TRICORE REFERENCE LABORATORIES
ATTN: SENDOUT DEPARTMENT
2811 STANFORD N.E.
ALBUQUERQUE, NM. 87107

Blood Drawn	Received	Reported	IBL No.
10/23/02	10/25/02	11/11/02	135065

***** SUMMARY RESULTS *****

THE FOLLOWING ABNORMALITIES WERE DETECTED:

IgG ALTERNARIA TENUIS + A	5193	0-1600	ELISA
IgG ASPER FUMIGATUS	2272	0-1600	ELISA
IgG CANDIDA	4717	800-3200	ELISA
IgE CANDIDA	76	0-50	
IgE CLADOSPORIUM HERBARUM	57	0-50	ELISA
IgG EPICOCCUM NIGRUM	6515	0-1600	ELISA
IgG GEOTRICHUM CANDIDUM	2174	0-1600	ELISA
IgG PULLULARIA PULLULANS	3000	0-1600	
IgE PULLULARIA PULLULANS	69	0-50	
IgG RHODOTORULA GLUTINIS	1600	0-1600	ELISA
% T HELPER CELL (T4)	59.0	35-55%	**3
T-HELPER/T-SUPPRESSOR	2.7	1-2.5	**3
% IMMUNOCOMPETENT -NKHT3+	1.0	1.5-5%	**3
% T3 POSITIVE CELLS	81.0	53-79%	**3
GAMMA GLUTAMYL TRANSFERAS	65.2	0-43	UNITS/ML

RESULT VERIFIED BY REPEAT ANALYSIS

ANTI-NUCLEAR AB BY HEP-2	1:320	1:20	

SPECKLED

ANTI-SMOOTH MUSCLE	1:25	0-20	ELISA
C3-COMPLEMENT	167.0	75-140	mg/dl

CONTINUED ON NEXT PAGE

Immunosciences Lab., Inc.
Patten Kotzin, M.D. Medical Director

Patient Name: COPP, DOUGLAS
Patient ID: X046461698

REFERRING PHYSICIAN
TRICORE REFERENCE LABORATORIES
ATTN: BENDOUT DEPARTMENT
2811 STANFORD N.E.
ALBUQUERQUE, NM. 87107

Blood Drawn	Processed	Reported	IBL No.
10/23/02	10/25/02	11/11/02	135065

C4-COMPLEMENT	36.0	10-34	ug/dl
RHEUMATOID FACTOR	25.0	0-20	IU/ml
TOTAL IMMUNE COMPLEX	52.0	0-50	ug eq/ml
IgG IMMUNE COMPLEX	23	0-20	ug eq/ml
IgM IMMUNE COMPLEX	16	0-15	ug eq/ml
IgA IMMUNE COMPLEX	13	0-10	ug eq/ml
NK CELL ACTIVITY	10.90	20-50	LUs
% IMMUNOCOMPETENT -NKHT3+	1.0	1.5-5%	mm3
% T3 POSITIVE CELLS	81.0	53-79%	mm3

[illegible] / Suite 600 / Roseville CA 95747 • Tel: (916) 857-1077 • Fax: (916) 857-1063

Immunosciences Lab., Inc.
Rubin Kapur, M.D. Medical Director

REFERRING PHYSICIAN

TRICORE REFERENCE LABORATORIES
ATTN: SENDOUT DEPARTMENT
2811 STANFORD N.E.
ALBUQUERQUE, NM. 87107

Patient Name:
Patient ID: COPP, DOUGLAS
X0446461692

Blood Drawn	Processed	Reported	IBL No.
10/23/02	10/25/02	11/11/02	135865

****
****
Very Low Activity: 0 - 5 units mm3

Low Activity: 5.1 - 10 units mm3

Normal: 10.1 - 15 units mm3

High: 15.1 - 25 units mm3

Very High: >25 units mm3
****
Some analyte-specific reagents used in these in-house procedures are classified under Class I devices by the FDA and are exempt from the premarket notification requirements of Section 510(K) of the act.
This test was developed and its performance characteristics determined by Immunosciences Lab., Inc. It does not have to be cleared by the FDA, pursuant to act 21 CFR 809 30(e).
These tests have undergone stringent quality control and assurance, and comparison studies have been performed in compliance with the State of California's requirements.

CONTINUED ON NEXT PAGE

Patient Name: COFP, DOUGLAS
Patient ID: X846461692

2811 STANFORD N.E.
ALBUQUERQUE, NM. 87107

Blood Drawn	Processed	Reported	IBL No.
10/23/02	10/25/02	11/11/02	135865

TEST	RESULT	REFERENCE RANGE	UNITS
*** AUTO IMMUNE PANEL ***			
ANTI-CENTROMERE	NEGATIVE	NEGATIVE	
ANTI-MICROSOMAL	5	<20	IU/ml
ANTI-MITOCHONDRIAL	NEGATIVE	NEGATIVE	
ANTI-MYOCARDIAL	1:20	0-20	ELISA
ANTI-NATIVE DNA	NEGATIVE	NEGATIVE	
ANTI-NUCLEAR AB BY HEP-2	1:320 SPECKLED	1:20	
ANTI-PARIETAL CELL	1:23	0-40	ELISA
ANTI-RNP	N.D.	NOT DETECTED	
ANTI-SM	N.D.	NOT DETECTED	
ANTI-SMOOTH MUSCLE	1:25	0-20	ELISA
ANTI-SSA	N.D.	NOT DETECTED	
ANTI-SSB	N.D.	NOT DETECTED	
ANTI-STRIATED MUSCLE	1:19	0-20	ELISA
ANTI-THYROGLOBULIN	8	<45	IU/ml
C3-COMPLEMENT	167.0	75-140	ug/dl
C4-COMPLEMENT	36.0	10-34	ug/dl
RHEUMATOID FACTOR	25.0	0-20	IU/ml
TOTAL IMMUNE COMPLEX	52.0	0-50	ug eq/ml

N.D. = NOT DETECTED
Autoimmune diseases can be separated into two categories. One group is characterized by the presence of autoantibodies

CONTINUED ON NEXT PAGE

500 Chipeta Way, Salt Lake City, Utah 84108
Edward R. Ashwood, M.D. Laboratory Director

Corrected pink Final

COPP, DOUGLAS F
(10298)X046461692
Male 51 years 03 Aug 1951
Primary Clinician:
Acc. #: T20756

TRI-CORE Reference Lab
2811 Stanford Drive N.E.
Albuquerque, NM 87107

Reported on: 07 Apr 2003 12:46 PM

ORDERED TEST	RESULT UNITS	RESULT FLAG	REFERENCE INTERVAL

Accession #: 0309211681
Collected on: 01 Apr 2003 02:30 PM

POLYCHLORINATED BIPHENYLS @ SEE NOTE
PCB'S PANEL, SERUM

Analyte	Results	Units	Rep. Limit
PCB'S	3.9	PPB	

(POLYCHLORINATED BIPHENYLS)
BASED ON AROCHLOR 1260.
GENERAL POPULATION: UP TO 30 PPB.
AVERAGE: 6 PPB.
ANALYSIS BY GAS CHROMATOGRAPHY (GC).
Performed at: National Medical Service, 3701 Welch Road, Willow Grove, PA 19090

Client Comments:
SPECIMEN TYPE: S

Received on: 03 Apr 2003 10:12 AM Ordering Clinician: HA, BEN

@ POLYCHLORINATED BIPHENYLS performed at National Medical Service, 3701 Welch Road, Willow Grove, PA 19090

TRICORE REFERENCE LABORATORIES
2811 Stanford Rd. Albuquerque, NM 87105 (505) 938-8922

Friedman.Robert MD
PO Box 5054
Santa Fe, NM 87502

PATIENT NAME
COPP, DOUGLAS F
PHYSICIAN
Friedman, Robert MD
REQUISITION NO. **1723234**
PT.PHONE NO **281-7977**
LAB REF NO.
COMMENTS:

PATIENT ID **X046461692**
DOB **08/03/1951**
SEX **M**
STATUS **Final**
COLLECT DATE & TIME **01/23/2003 12:40 (a)**
DATE OF SERVICE **01/23/2003 14:42**
PRINT DATE/TIME **02/03/2003 12:28**

TEST	Result In Range	Result Out of Range	Units	Reference Range	Site Code
---Footnotes---					
(a) Multiple collection dates and times apply to tests on this order.					
Collected on: 01/23/2003 12:40					
DHEA-Sulfate	469		ug/dL	80-560	
Thyroid Screen Collected on: 01/23/2003 12:40					
FT4	1.3		ng/dL	0.8-1.6	
TSH	2.040		uIU/mL	0.40-4.5	
All TSH values less than 0.400 uIU/mL represent 3rd Generation TSH. No extra charges apply.					
Misc Referral Test Collected on: 01/23/2003 12:36					
Test Name	PREGNENOLONE, SERUM				
Result	120 ng/dL				
	Reference Range: < 20 to 150 ng/dL				
Test performed by	Performed at Esoterix, Inc., 4301 Lost Hills Road, Calabasas, CA 91301				
Misc Referral Test Collected on: 01/23/2003 12:40					
Test Name	POLYCHLORINATED BIPHENYLS				
Result	NONE DETECTED				
	(NOTE)				
	Rep. Limit = 2 PPB				
	Based on Arochlor 1260.				
	Average 6 PPB.				
	Analysis by Gas Chromatography (GC).				
Test performed by	Performed at National Medical Services, 3701 Welsh Road, Willow Grove, PA 19090				
Collected on: 01/23/2003 12:40					
Digoxin		<0.3 L	ng/mL	0.8-2.0	
Note: The manufacturer has indicated that this Digoxin assay may exhibit negative interference from aldosterone inhibitors: spironolactone and canrenone. Contact the laboratory for alternate testing availability if clinically warranted.					

End of Report

white lowe.
628
1742 Fox
Jim

The Permanente Medical Group, Inc.
27400 Hesperian Boulevard
Hayward, California 94545-4299
(510) 784-4000

KAISER PERMANENTE

DOUG F COPP
802 LINCOLN AVE # B
ALAMEDA CA 94501

04/13/2000
KAISER # 08789174
DAY: (510) 523-5493
EVE: (510) 748-9257

Here are the results of your recent laboratory tests:

	TEST		RESULT	NORMAL RANGE	
04/11/00	Cholesterol	H	240mg/dL	<	239
04/11/00	Kidney Test CREAT		0.9mg/dL	<	1.3
04/11/00	Glucose Random		97mg/dL	60 -	159
04/11/00	HDL Cholesterol		47mg/dL	> 35	
04/11/00	Thyroid Test TSH		2.5uIU/mL	0.2 -	5.5
04/11/00	Complete Blood Count				
	White Cells		4.9K/uL	3.5 -	12.5
	Red Cells		4.67M/uL	4.10 -	5.70
	Hemoglobin		13.8g/dL	13.0 -	17.0
	Hematocrit		40.3%	39.0 -	51.0
	MCV		86fL	80 -	100
	Platelets		211K/uL	140 -	400

To learn more about lab tests or other health topics, sign on to our 24 hour members-only web site at www.kponline.org.

M TRAN M.D.

Excellent results / Please sign up for our cholesterol lowering classes - (Please call 784-4531.)

MT

HAY/MED /M TRAN M.D.

6306

415-
95
10

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

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): 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 _____

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. 454
2. 485
3. 457
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 12 26 02				90780	IV therap		330 73					
2 12 27 02				90780	"		219 78					
3 12 30 02				90780	"		293 73					
4 01 02 03				90780	"		305 13					
5 01 04 03				90780	"		213 38					
6 01 06 03				90780	"		305 13					

25. FEDERAL TAX I.D. NUMBER SSN EIN: 55 24 05 45 X

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 $ 1672 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 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90). FORM RRB-1500.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

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) Cope, Doug	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐
CITY STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐
ZIP CODE TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
7. INSURED'S ADDRESS (No., Street)	
CITY STATE	
ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
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 _____

ATE 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. 964 2. 965 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
01 07 03					293 73					
01 09 03					305 13					
01 10 03					293 73					
01 13 03					305 13					
01 14 03					293 73					
01 16 03					305 13					

25. FEDERAL TAX I.D. NUMBER SSN EIN 85 2405 46 ☑ ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ 1211 58
29. AMOUNT PAID $	30. BALANCE DUE $ 1511 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.)

MD 2/25/03

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 # Robert Friedman MD
1244 G Rodeo Rd
Santa Fe, NM 87505

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 12-90

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

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): Coff, 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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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. 484.
2. 485.
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 Hydr.			298 73					
2 01 20 03				0780			298 73					
3 01 24 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 SSN EIN: FCS 24 0345

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 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 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90). FORM RRB-1500.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

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): 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. 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
02 14 03				90780	IV therapy		145 10					
02 19 03				90780	IV		251 78					
02 24 03				90780	IV		198 00					
02 24 03				99070	supplies		317 93					

25. FEDERAL TAX I.D. NUMBER SSN EIN — [redacted] X

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 888 30

29. AMOUNT PAID $

30. BALANCE DUE $ 888 30

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 _____ 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
1214 15 Rocks Rd
Santa Fe, NM 87505

PIN# GRP#

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

FORM HCFA-1500 (12-90). FORM RRB-1500. FORM OWCP-1500

DUPLICATE FOR PATIENT'S RECORDS

DUPLICATE FOR INSURANCE OR BENEFIT PLAN

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. 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): COFP, 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. 984
2. 985
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
2 27 03				90780	IV Therapy		113 09					
3 07 03				"			198 44					
3 11 03				"			198 44					
3 14 03				"			198 44					
3 21 03				"			198 44					
3 25 03				"			198 44					

25. FEDERAL TAX I.D. NUMBER SSN EIN: 585-24-0545 [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
1214-E Rodeo Rd.
Santa Fe, NM 87505

PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

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FORM HCFA-1500 (12-90). FORM RRB-1500. FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

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): 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 _____

ATE 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. 784.__
2. 785.__
3. 787.__
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 3 28 03				90780	IV Therapy		198 44					
2 4 01 03				"	"		198 44					
3 4 04 03							198 44					
4 4 18 03							139 76					
5 4 22 03							117 36					
6 4 24 03							117 36					

25. FEDERAL TAX I.D. NUMBER SSN EIN: 85-24-0545 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
1264-B Rodeo Rd
Santa Fe, NM 87505

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

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

FORM HCFA-1500 (12-90). FORM RRS-1500. FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

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): 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 _____

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. 784.__
2. 785.__
3. 787.__
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 09 03						251 78					
4	5 13 03						251 78					
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 565-24-0545 ☒

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 872 70

29. AMOUNT PAID $

30. BALANCE DUE $ 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.)

SIGNED [signature] DATE [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
1264-B 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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FORM HCFA-1500 (12-90). FORM RRB-1500. FORM OWCP-1500

DO NOT STAPLE IN THIS AREA

[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 _____

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SIGNED _____

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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 — MM DD YY 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 — MM DD YY 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. ____ 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 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			90					
				Fee								

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.)

SIGNED [signature] MD DATE 7/30/03

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#

R. Friedman MD
1264-B Rodeo Rd
PIN# Santa Fe NM 87505 GRP#

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 9/88) — *PLEASE PRINT OR TYPE*

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FORM CWCP-1500
#19423 - #28423 - Medical Arts Press

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION