

PLEASE
DO NOT
STAPLE
IN THIS
AREA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 11-2234-10190																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John										3. PATIENT'S BIRTH DATE MM DD YY M <input checked="" type="checkbox"/> SEX F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, Jane																																							
5. PATIENT'S ADDRESS (No., Street) 123 Any Street										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 123 Any Street																																							
CITY Any City					STATE CA					8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>										CITY Any City					STATE CA																																		
ZIP CODE 92127					TELEPHONE (Include Area Code) (858) 555-0100					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER G4683A																																		
a. OTHER INSURED'S POLICY OR GROUP NUMBER										b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX F <input checked="" type="checkbox"/>										c. EMPLOYER'S NAME OR SCHOOL NAME																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										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 JaneDoe																																							
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 Jdoe										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 10 11 21										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Self										17a. I.D. NUMBER OF REFERRING PHYSICIAN										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. R11 0 3. R19 7 2. K59 00 4. K92 1										23. PRIOR AUTHORIZATION NUMBER										24. A B C D E F G H I J K DATE(S) OF SERVICE To Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPSDT Family Plan EMG COB RESERVED FOR LOCAL USE																																							
25. FEDERAL TAX I.D. NUMBER 555-88-9999										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 405.00										29. AMOUNT PAID \$										30. BALANCE DUE \$									
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.) MtJackson 10/11/21										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) Mateo Jackson PhD 9876 Healthcare Ave Any Town, CA 92126										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Mateo Jackson PhD 9876 Healthcare Ave (920) 555-0101 Any Town, CA 92126																																							



Group Insurance of America | Community Plan

Health Plan (80840)

911-87726-04

Member ID: 11-2234-10190

Group Number: **AAAAA**

Member:

JOHN DOE

PCP Name: MATEO JACKSON, PhD

PCP Phone: (920)-555-0101

Payer ID: 87726

InsurRX

Rx Bin: 610494

Rx Grp: AAAAAA

Rx PCN: 00000

0501

Administered by Amer. Insurance Community Plan, Inc. **MEDICAID PLAN OF XXXX**



KOFFIGAN TOZO
OR MARY MARTIN
233 E 176TH ST APT 1B
BRONX NY 10457-5767



► New address? Please contact customer service to update.

► To redeem rewards, call 1-800-228-3001
or visit www.capitalone.com/nohasslerewards

ACCOUNT SUMMARY FOR PERIOD DECEMBER 22, 2015 - JANUARY 25, 2016

Rewards Checking 00008986028085

Previous Balance 12/21/15	\$757.29	Number of Days in Cycle	35
7 Deposits/Credits	\$10,011.98	Minimum Balance This Cycle	\$757.29
53 Checks/Debits	-\$8,427.95	Average Collected Balance	\$2,419.68
Service Charges	\$0.00		
Ending Balance 01/25/16	\$2,341.32		

Rewards Summary

Previous Balance	7600
Earned This Period	0
Transferred In This Period	0
Transferred Out This Period	0
Redeemed This Period	0
Adjustments This Period	0
Ending Balance	7600

ACCOUNT DETAIL FOR PERIOD DECEMBER 22, 2015 - JANUARY 25, 2016

Rewards Checking 00008986028085

Date	Amount	Resulting Balance	Transaction Type	Description	Debit Card
12/22	\$5,000.00	\$5,757.29	Deposit	Customer Deposit	
12/22	-\$500.00	\$5,257.29	Debit	ATM withdrawal ATM WITHDRAWAL 00E141 122115 470 PARK AVE SOUTH NEW YORK NY	
12/22	-\$23.98	\$5,233.31	Debit	Debit Card Purchase KEY FOOD #1458 614588 122115 KEY FOOD #1458 BRONX NY	4168

Attending Provider Notes

Provider: Dr Mateo Jackson, PhD

Patient: John Doe

35 yo M c/o stomach problems since last 2 months. Patient reports epigastric abdominal pain non-radiating. Pain is described as gnawing and burning, intermittent lasting 1-2 hours, and gotten progressively worse. Antacids used to alleviate pain but not anymore; nothing exacerbates pain. Pain unrelated to daytime or to meals. Patient denies constipation or diarrhea. Patient denies blood in stool but have noticed them darker. Patient also reports nausea. Denies recent illness or fever. He also reports fatigue in the last 2 weeks ago and bloating after eating.

ROS: Negative except for above findings

Meds: Motrin once/week. Tums previously.

PMHx: Back pain and muscle spasms. No Hx of surgery.

NKDA.

FHx: Uncle has a bleeding ulcer.

Social Hx: Smokes since 15 yo, 1/2-1 PPD. No recent EtOH use. Denies illicit drug use. Works on high elevation construction. Fast food diet. Exercises 3-4 times/week but stopped 2 weeks ago.

UNITED STATES

DRIVER LICENSE

EXPIRES 09/21/2034

DL 6383736743891101



LN DOE
FN JOHN

123 ANY STREET
ANY CITY, CA 92127

DOB 09/21/1970
SSN ON FILE

DONOR

SEX M HAIR BLK EYES BLU
HGT 5'11" WGT 185LB

US 11/05/2001266737RP/AMER/19

CLASS C
END NONE





Hospital Name

Address

Surgical Pathology Report

Patient: Doe, John
MRN: A11-8-199878
DOB: 07/08/1971
Gender: M

Accession Number: AF123456
Procedure: 03/15/2020
Attending: Dr. Mateo Jackson, MD

Clinical History: Large Gastric Mass

Specimen: Gastric Mucosa

Diagnosis

Stomach, Partial Gastrectomy:

- Malignant Epithelioid Gastrointestinal Stromal Tumor
- Tumor Size 10 x 9 x 8 cm
- Cell Type: Epithelioid and Spindled
- High cellularity; present
- Mucosal Invasion: Focally present adjacent to ulceration
- Mucosal ulceration present
- Mitotic Count: 10/50 HPF
- Myxoid background: Focally present
- Foci of necrosis present
- CD117, vimentin, and CD34: uniformly positive

Gross Description

The specimen consists of an approximately 5 x 7 cm portion of gastric mucosa that is surrounded and underlying by a lobulated mass which is 10 x 9 x 8 cm. The central portion of the mass appears to have an approximately 1.5-cm ulcer. The mucosa away from the area of ulceration is partially removed from the underlying tumor. The underlying mass appears encapsulated and lobular. Gross sections show the lesion to consist of several different patterns. A single area has a gray to gray-tan pattern with an area of central necrosis showing a fairly uniform appearance whereas; other regions of the tumor are gray white- and somewhat lobular in appearance. Areas of yellow necrosis are scattered through the tumor. Representative portions submitted.

Microscopic Description

Sections through the neoplasm show it to be primarily a high cellular neoplasm. The cells are in part arranged in fascicles and clusters with enlarged elongate nuclei having relatively fine nucleoli. In some areas, the fascicles have an interwoven appearance. Mitotic figure up to 10:50 HPF. A few areas show foci of necrosis with the cells appearing to be surrounded by somewhat myxoid stroma. Foci of displayed necrosis are present. The lesions appear circumscribed, although not specifically encapsulated. It focally involved the mucosa and shows full thickness ulceration. The tumor immediately beneath the mucosal area of ulceration has a nearly lobular somewhat spindled growth pattern. Some areas of the tumor have a slightly more rounded nuclei and somewhat epithelioid appearance. The cells appear to be arranged in groups and clusters. Some of the cells have cytoplasmic vacuoles. These areas also show a prominent mitotic activity. Some mitotic figures are abnormal and atypical. The tumor contains numerous relatively open vascular channels which appear to be part of the neoplasm. The tumor has a pseudo capsule and in some areas appear to be nearly covered.

Immunostains are strongly positive for CD117 (C-kit), CD34, and Vimentin, Smooth muscle actin, Desmin, Synaptophysin, S-100, and Ck8/18 are negative.

Comment

Immunostains were performed on the core biopsy and demonstrate that the tumor cells are positive for CD117. The findings are consistent with the above diagnosis.

MUNSON ARMY HEALTH CENTER
FT. LEAVENWORTH, KS 66027

MANDATORY CALL - IN REFILLS 913-684-6500 888-745-6435

Rx107150051964

O MTF

QQQFLMAHC.MHSGENONE ORANGE
acetaminophen 325 mg tablet

FILL: 11/24/2021

#100

REF LEFT: 0 OF 0 BY: 11/24/2022

DS: 30

OTC

Call your doctor for medical advice about side effects. You may report side effects to FDA at
1-800-FDA-1088.

KEEP OUT OF REACH OF CHILDREN

CAUTION: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed.

82

⇒ This medicine contains Acetaminophen. Taking more than recommended may cause serious liver problems.

⇒ Do not take other Acetaminophen containing product at the same time without first checking with your doctor.

⇒ Do not drink alcoholic beverages when taking this medicine.

TABLET

Round White Logo
012





Physician Hospital Discharge Summary

Provider: Mateo Jackson, PhD

Patient: John Doe

Provider's Pt ID: 00988277891

Patient Gender: Male

Attachment Control Number: XA/7B/00338763

Visit (Encounter)

Admitted: 07-Sep-2020

Discharged: 08-Sep-2020

Discharged to: Home with support services

Assessment

**Reported Symptoms / History
of present illness:**

35 yo M c/o stomach problems since 2 montsh ago. Patient reports epigastric abdominal pain non-radiating. Pain is described as gnawing and burning, intermittent lasting 1-2 hours, and gotten progressively worse. Antacids used to alleviate pain but not anymore; nothing exacerbrates pain. Pain unrelated to daytime or to meals. Patient denies constipation or diarrhea. Patient denies blood in stool but have noticed them darker. Patient also reports nausea. Denies recent illness or fever. He also reports fatigue since 2 weeks ago and bloating after eating.

Patient ID: NARH-36640

ROS: Negative except for above findings

Meds: Motrin once/week. Tums previously.

PMHx: Back pain and muscle spasms. No Hx of surgery. NKDA.

FHx: Uncle has a bleeding ulcer.

Social Hx: Smokes since 15 yo, 1/2-1 PPD. No recent EtOH use. Denies illicit drug use. works on high elevation construction. Fast food diet. Exercises 3-4 times/week but stopped 2 weeks ago.

Discharge

Discharge Studies Summary:

Some activity restrictions suggested, full course of antibiotics, check back with physican in case of relapse, strict diet





2022052607
J67F
1339 14291

J67F [2,742] 1 of 8 BlkPck 1

Page 1 of 4

North Pocono School District Health Plan
P.O. Box 450978
Westlake OH 44145



[-LB]

Remittance Advice

Forwarding Service Requested



SCRANTON QUINCY CLINIC COMPANY LLC
PO BOX 27944
BELFAST ME 04915-2031

J67F

1
E2,7423

Customer Service

Questions? Please contact us via the web at
www.myperformancehlth.com
or call our customer service at
877-585-8480
Monday - Friday 8:00am to 6:00pm EST

Employer: North Pocono School District
Group #: HP1002
Date: 05/25/2022
Check #: 118853

Claim#: 1270082

Patient: Patients One

Patient #:

Member:

Member ID: 87533XXXX

CLAIM
DETAIL

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Maximum Plan Allowable	Ineligible Amount	Remark Code	Deductible Amount	Copay Amount	Paid At	Payment Amount
03/28-03/28/2022	99213	\$125.00	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	100%	\$125.00
Column Totals		\$125.00	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00		\$125.00
Patient's Responsibility:										
										Other Credits or Adjustments
										Total Payment
										\$0.00
										\$125.00

Claim Summary

Claim No.	Patient Name	Billed Amount	Provider Discount	UCR Amount	Ineligible Amount	Deductible Amount	Copay Amount	Payment Amount
1270082	OLIVIA JARDINE	\$125.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$125.00
Totals		\$125.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$125.00

Payment Details

Paid To	Check No.	Amount
SCRANTON QUINCY CLINIC COMPANY LLC	118853	\$125.00

Additional Information

Please retain for tax purposes. Email us at: customerservice@myperformancehlth.com

Important Information

Please see your Benefit Plan Booklet for specific covered items, benefit maximums, co-payments, deductibles, co-insurance, benefit exclusions, definitions, preauthorizations, network requirements, and appeal rights.

APPEAL PROCESS: If you received an Adverse Benefit Determination, you have the right to appeal. You must submit your request in writing to the Claims Administrator within the appeal period as defined by your Plan Document. Please refer to your plan document for your plans appeal period.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

If you believe you've been wrongly billed, you may contact our office at 877-585-8480.

Visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act> for more information about your rights under federal law.

Not-A Real Hospital of Washington

Name: Mateo Jackson, PhD
Street Address: 9876 Healthcare Ave
City, State: AnyTown, CA
ZIP Code: 92126
Phone: (920)555-0101
E-mail: mateo.jackson@example.com

MEDICAL INSURANCE INVOICE

Invoice # 23-AUK9909

Date: April 1, 2022

Bill To

Name: John Doe
Street Address: 123 Any Street
City, State: Any City, CA
ZIP Code: 92127

Description	Amount (\$)
Full body checkup (PPD)	\$745.00
Infection check due to inflammation	\$1,233.00
In-patient service charges (PPD-01)	\$93.00

If paying by check, please include the invoice number in the check
Payment is due within 30 days.

SUBTOTAL	\$2,071.00
DISCOUNT	\$1,812.00
TAX	\$146.00
TOTAL	\$405.00

If you have any questions about this invoice, please contact us at
Phone: (858)-555-0101
Email: invoice.inquiry@example.com