

*To: Coding India*

**M.D. Consulting  
Services**

921 Sherwood Drive, Lake Bluff, IL 60044  
(847) 615-2200

**WORK PROGRESS SHEET**

**Group:** \_\_\_\_\_ **DUN**

**Batch #:** \_\_\_\_\_ **#539**

**Date Work Arrived:** \_\_\_\_\_ **08/11/2025**

**Date Range** \_\_\_\_\_ **08-07-08-11-2025**

**Date Acct # Assigned:** \_\_\_\_\_

**Assigned by:** \_\_\_\_\_

**Number of Cases:** \_\_\_\_\_ **25**

**Counted by:** \_\_\_\_\_ **DV**

**Date Ins Coded** \_\_\_\_\_

**Coded by:** \_\_\_\_\_

**Date Demos Entered:** \_\_\_\_\_

**Entered by:** \_\_\_\_\_

**Date Scanned:** \_\_\_\_\_ **08/11/2025**

**Scanned by:** \_\_\_\_\_ **DV**

**Date work coded:** \_\_\_\_\_

**Coded by:** \_\_\_\_\_

**Date charges entered:** \_\_\_\_\_

**Entered by:** \_\_\_\_\_

**Date charges checked:** \_\_\_\_\_

**Checked by:** \_\_\_\_\_

**Date claims printed:** \_\_\_\_\_

**Printed by:** \_\_\_\_\_

**Accounts that were pulled because more information was needed:**

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**Date pulled:** \_\_\_\_\_

**Checklist done by:** \_\_\_\_\_

**Stapled by:** \_\_\_\_\_

**Printed fs/ops by:** \_\_\_\_\_

Patient CAROL LYNNE HOWARD - D00048231393

Other Names

Med Rec Number MR00023618 Reg Status DEP SDC  
 EMR Number T00006721 Soc Sec Num 258-96-4889  
 Birthdate 07/05/1959  
 Age 66 Birth Sex F  
 VIP  
 VIP Comment

## Patient Address

## Patient Employer

2203 FLAMINGO LN RETIRED

DUNCAN, OK 73533  
United States

## E-Mail

## Conf Comm Address

Phone Number 580-475-2011 Phone Type Cell Phone

Marital Status	Divorced	Country of Origin
Religion	None	In School
Affiliation		Registered Voter
Language	English	Veteran Status
Interpreter Needed		Organ Donor
Education Level		Marketing Comm
Citizenship		Privacy Notice Date 05/15/19
Place of Birth		

## Physical Handicaps

Ethnicity / Additional Ethnicities	Race / Additional Races
Non Hispanic or Latino	White

## Personal Contacts

Person to Notify	Relationship Spouse
HOWARD,BRIAN	
2203 FLAMINGO LN	

DUNCAN, OK 73533  
United States

Phone Number 580-736-3710 Phone Type Cell Phone

Guarantor	Guarantor Employer
GN00005894	Relationship Self
HOWARD,CAROL LYNNE	
2203 FLAMINGO LN	RETIRED

DUNCAN, OK 73533  
United States  
Email

Phone Number	Phone Type
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580-475-2011 Cell Phone

**Financial Class****Financial Class** Medicare Advantage**Standard Insurance Order**

UNITED HCARE DUAL SNP 87726

MEDICAID

SELF PAY

**Medicare Part B Order****Medicare Part D Order****Insurances**

Name	UNITED HCARE DUAL SNP 87726	Coverage Plan
Policy Number	130296015	Group Name
Address	PO BOX 5270	Group Number
City, State, Zip	KINGSTON, NY 12402-5270	Employment Status
Country	US	Employer Name
Phone	844-368-7150	Location
Fax		Copay      Deductible      Coinsurance
Email		Eligibility Status Received      Status Date 08/11/25

Release Info Yes

Exp Info Date

Assign Benefits Yes

Subscriber	HOWARD,CAROL LYNNE	Birth Sex	F
Pat Rel to Subs	Self	Soc Sec Num	258-96-4889
Address	2203 FLAMINGO LN	Marital Status	Divorced
City, State, Zip	DUNCAN, OK 73533	Race	White
Country	United States	Citizenship	United States
Email		Language	English
Birthdate	07/05/1959		

Phone Number	Phone Type
580-475-2011	Cell Phone

**Authorization Number****Referral Number**

Eff Date Exp Date Referral Type

Status

Referred By Referred To

Name	MEDICAID	Coverage Plan
Policy Number	012168590	Group Name
Address	PO BOX 18430	Group Number
City, State, Zip	OKLAHOMA CITY, OK 73154	Employment Status
Country		Employer Name
Phone	800-522-0310	Location
Fax		Copay      Deductible      Coinsurance
Email		Eligibility Status Received      Status Date 08/11/25

Release Info Yes

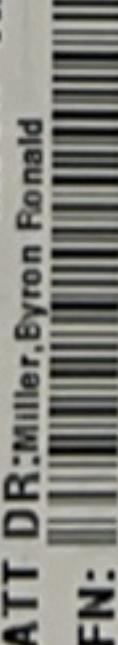
Exp Info Date

Assign Benefits Yes

Subscriber	HOWARD,CAROL LYNNE	Birth Sex	F
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Duncan Regional Hospital		Account Inquiry		Page: 3
				Date: 08/11/25 16:41
				McIntyre,Karen
Pat Rel to Subs	Self	Soc Sec Num	258-96-4889	
Address	2203 FLAMINGO LN	Marital Status	Divorced	
City, State, Zip	DUNCAN, OK 73533	Race	White	
Country	United States	Citizenship	United States	
Email		Language	English	
Birthdate	07/05/1959			
Phone Number	Phone Type			
580-475-2011	Cell Phone			
Authorization Number		Referral Number		
Eff Date	Exp Date	Referral Type	Status	Referred By Referred To
Occurrence Codes		Date	Time	Accident State
DSI	11 - Onset of Symptom-OP Ther	08/11/25		
<b>Physicians</b>			<b>Other Physicians/Association</b>	
Primary Care	Gregory,Myra A	Roberson,Matthew Wayne		
Admitting				
Attending	Miller,Byron Ronald			
Family				
Emergency				
Reg Date/Time	08/11/25 06:18	Discharge Date/Time	08/11/25 09:14	
Requested Accom		Discharge Disposition	Home/Assisted Living - 01	
Room Rate Accom				
Room/Bed				
Service				
Location	Ambulatory Care Unit			
Admit Priority	Elective			
Admit Source	Physician Referral			
Newborn Admit Src				
Entry Code				
Facility Directory				
Clergy Visit				
Adm Legal Status				
Confidential				
Conf Comment				
Admit Comment				
Dis Comment				
Reason for Visit	Age-related nuclear cataract, right eye 1			
Last Hospitalization		From Date:	Thru Date:	
<b>ICD10 Codes</b>				
<b>Reason for Visit Diagnoses</b>				
Eff Date	Code	Name	Alt	Source
08/11/25	H25.11	Age-related nuclear cataract, right eye	No	SUR
<b>Diagnosis Codes</b>				

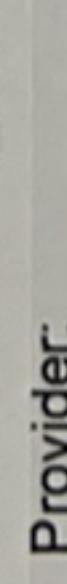
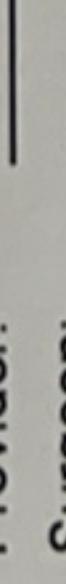
Duncan Regional Hospital	Account Inquiry			Page: 4
				Date: 08/11/25 16:41
				McIntyre, Karen
Eff Date	Num	Code	Name	POA
08/04/25 -	1	H25.11	Age-related nuclear cataract,	
Procedure Codes				
Num	Code	Name	Date	Surgeon/Assisting

MR: HOWARD, CAROL LYNNE 66  
 FN# D00048231393  
 MR# MR00023618  
 DOB: 07/05/1959 REG DT: 08/11/25  
 ATT DR: Miller, Byron Ronald  
 FN: 

Duncan Anesthesia Associates, Inc.  
ANESTHESIA CHARGE LIST

1/1/2023

9/11/25  
Johnson &  
Mile

Provider:   
Surgeon: 

Anesthesia: General SAB  MAC

Epidural CPT: 00142

Bier CPT: 20c

Other CPT:

TIVA CPT:

SURGERY	BLOCK PROCEDURE
START: <u>0820</u>	START: _____
STOP: <u>0849</u>	STOP: _____
TOTAL: <u>29</u>	TOTAL: _____

Measure Codes	
ICD10: <u>H25.11</u>	Modifier: _____
ICD10: <u></u>	Modifier: _____
ICD10: <u></u>	Modifier: _____
ICD10: <u></u>	Modifier: _____

Diagnosis:

MUST BE DOCUMENTED		Base Units: <u>1</u>	Time Units: <u>2</u>	SPECIAL PROCEDURES
<b>MEASURE #424</b> TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9		<input checked="" type="checkbox"/> PS 3 (1 unit) <input checked="" type="checkbox"/> PS 5 (3 units)	<input checked="" type="checkbox"/> 1 <i>or absent</i> <input checked="" type="checkbox"/> 2 <i>or absent</i>	<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64415 (8 units) <input checked="" type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units) <input type="checkbox"/> Epidural Steroid 62322 (8 units) <input type="checkbox"/> Daily Epidural Mgmt 01996 (3 units) <input type="checkbox"/> Art Line 36620 (3 units) <input type="checkbox"/> PICC Placement 36569 (6 units) MEASURE #76 <input type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input type="checkbox"/> Adductor Canal Block 64447 (8 units) <input type="checkbox"/> Intubation Emergency 31500 (5 units) <input type="checkbox"/> iPack Block 64999 (7 units)
<b>MEASURE #404</b>		<input type="checkbox"/> YES	<input type="checkbox"/> NO	SPECIAL PROCEDURES: <u>7</u>
IF NO SKIP TO NEXT MEASURE		<input type="checkbox"/> Yes	<input type="checkbox"/> No	TOTAL UNITS: _____
Elective Procedure		<input type="checkbox"/> Yes	<input type="checkbox"/> No	ABG/PAIN ASSESSMENT
Instructed to abstain		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> LUCID <input type="checkbox"/> NON COMMUNICATE <input type="checkbox"/> PACU <input checked="" type="checkbox"/> OUT OF 10 PAIN LEVEL <u>2</u> SCG 8 DEPRESSION ASSESS.
Abstained		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NO YES DX: <u>4</u> REQUIRED
<b>MEASURE #430</b> Inhalation Anes Recvd		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ASA SCORE <u>4</u> REQUIRED
IF NO SKIP TO NEXT MEASURE		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3 Pt Risk Factors		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
PONV Therapy		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Duncan Regional Hospital

Account Inquiry

Page: 1

Date: 08/11/25 16:48

McIntyre, Karen

Patient JANET ELAINE ADKINS - D00048130603

Other Names

Med Rec Number MR00026718

Reg Status

DEP SDC

EMR Number T00000087

Soc Sec Num

444-48-9688

Birthdate 06/15/1957

Age 68 Birth Sex F

VIP

VIP Comment

Patient Address

Patient Employer

202 EMERY ROAD

DUNCAN REGIONAL HOSPITAL

PO BOX 2000

DUNCAN, OK 73533-2408

DUNCAN, OK 73534

E-Mail jeadkins@swbell.net

580-252-5300

Conf Comm Address

Occupation DIRECTOR FIN/DSS

Employer Status Full-Time

Phone Number

Phone Type

580-252-3673

Home Phone

580-467-5638

Cell Phone

Marital Status Single

Country of Origin

Religion Baptist

In School

Affiliation

Registered Voter

Language English

Veteran Status

Interpreter Needed

Organ Donor

Education Level

Marketing Comm

Citizenship

Privacy Notice Date 04/19/19

Place of Birth

Physical Handicaps

Ethnicity / Additional Ethnicities

Race / Additional Races

Non Hispanic or Latino

White

Personal Contacts

Person to Notify

Relationship Child

ADKINS, MICHAEL

1017 NW 13TH ST

MOORE, OK 73160

Phone Number

Phone Type

405-923-5136

Cell Phone

Guarantor

Guarantor Employer

GN00118279

Relationship Self

DUNCAN REGIONAL HOSPITAL

ADKINS, JANET ELAINE

PO BOX 2000

202 EMERY ROAD

DUNCAN, OK 73534

DUNCAN, OK 73533-2408

580-252-5300

Email jeadkins@swbell.net

Occupation DIRECTOR FIN/DSS

Emp Status Full-Time

Phone Number

Phone Type

580-467-5638      Cell Phone  
 580-252-3673      Home Phone

**Financial Class****Financial Class** Employee Accounts**Standard Insurance Order**

DRH EMPLOYEE INSURANCE 75261  
 SELF PAY

**Medicare Part B Order****Medicare Part D Order****Insurances**

<b>Name</b>	DRH EMPLOYEE INSURANCE 75261	<b>Coverage Plan</b>	WSDRH	
<b>Policy Number</b>	WBA1113407	<b>Group Name</b>		
<b>Address</b>	PO BOX 99906	<b>Group Number</b>	WSDRH	
<b>City, State, Zip</b>	GRAPEVINE, TX 76099-9706	<b>Employment Status</b>		
<b>Country</b>	US	<b>Employer Name</b>		
<b>Phone</b>	844-448-9194	<b>Location</b>		
<b>Fax</b>	469-417-1960	<b>Copay</b>	<b>Deductible</b>	<b>Coinsurance</b>
<b>Email</b>		<b>Eligibility Status Received</b>	<b>Status Date</b> 08/11/25	

**Release Info** Yes**Exp Info Date****Assign Benefits** Yes**Subscriber** ADKINS,JANET ELAINE**Birth Sex** F**Pat Rel to Subs** Self**Soc Sec Num** 444-48-9688**Address** 202 EMERY ROAD**Marital Status** Single**City, State, Zip** DUNCAN, OK 73533-2408**Race** White**Country****Citizenship****Email** jeadkins@swbell.net**Language** English**Birthdate** 06/15/1957**Phone Number**      **Phone Type**

580-467-5638      Cell Phone  
 580-252-3673      Home Phone

**Occurrence Codes****Date****Time****Accident State**

DSI      11 - Onset of Symptom-OP Ther      08/11/25

**Physicians****Other Physicians/Association****Primary Care** Schreckengost,Melissa K**Admitting****Attending** Watkins,Kayla Michele**Family****Emergency****Reg Date/Time** 08/11/25 09:10**Discharge Date/Time** 08/11/25 12:18**Requested Accom****Discharge Disposition** Home/Assisted Living - 01**Room Rate Accom****Room/Bed****Service****Location** Ambulatory Care Unit**Admit Priority** Elective**Admit Source** Physician Referral**Newborn Admit Src**

[Entry Code](#)[Facility Directory](#)[Clergy Visit](#)[Adm Legal Status](#)[Confidential](#)[Conf Comment](#)[Admit Comment](#)[Dis Comment](#)**Reason for Visit** Encounter for screening for malignant neoplasm of**Last Hospitalization****From Date:****Thru Date:****ICD10 Codes****Reason for Visit Diagnoses**

<b>Eff Date</b>	<b>Code</b>	<b>Name</b>	<b>Alt</b>	<b>Source</b>
08/11/25	Z12.11	Encounter for screening for malignant ne	No	SUR
08/11/25	I26.99	Other pulmonary embolism without acute c	No	SUR
08/11/25	I72.8	Aneurysm of other specified arteries	No	SUR
08/11/25	I71.60	Thoracoabdominal aortic aneurysm, withou	No	SUR
<b>Diagnosis Codes</b>				
<b>Eff Date</b>	<b>Num</b>	<b>Code</b>	<b>Name</b>	<b>POA</b>
07/10/25 -	1	Z12.11	Encounter for screening for ma	E
07/10/25 -	2	I26.99	Other pulmonary embolism witho	
07/10/25 -	3	I72.8	Aneurysm of other specified ar	
07/10/25 -	4	I71.60	Thoracoabdominal aortic aneury	
<b>Procedure Codes</b>				
<b>Num</b>	<b>Code</b>	<b>Name</b>	<b>Date</b>	<b>Surgeon/Assisting</b>

MR:   
**ADKINS, JANET ELAINE**  
 FN# D00048130603 68  
 MR# MR00026718  
 DOB: 06/15/1957 REG DT: 08/11/25  
 ATT DR: Watkins, Kayla Michele  
 FN: 

**Duncan Anesthesia Associates, Inc.**  
**ANESTHESIA CHARGE LIST**

1/1/2023

BILLING OFFICE USE POS 21	BLOCK PROCEDURE START: _____ STOP: _____ TOTAL: _____
POS 22	Measure Codes

Provider: Surgeon: K. WATKINS

Anesthesia: General SAB MAC Epidural Bier Other TIVA

Procedure: Colon surgery CPT: 04812 ICD10: Z12.11 Modifier: \_\_\_\_\_  
 CPT: \_\_\_\_\_ ICD10: \_\_\_\_\_ Modifier: \_\_\_\_\_  
 CPT: \_\_\_\_\_ ICD10: \_\_\_\_\_ Modifier: \_\_\_\_\_  
 CPT: \_\_\_\_\_ ICD10: \_\_\_\_\_ Modifier: \_\_\_\_\_

**Diagnosis:**

MUST BE DOCUMENTED	Base Units:	SPECIAL PROCEDURES
MEASURE #424 <input checked="" type="radio"/> TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9	<input checked="" type="radio"/> 1	<input type="radio"/> Femoral Single 64447 (8 units) <input type="radio"/> Brachial Plexus Single 64415 (8 units) <input type="radio"/> Lumbar Epidural Continuous 62319 (8 units) <input type="radio"/> Thoracic Epidural Continuous 62318 (8 units) <input type="radio"/> Lumbar Puncture 62270 (8 units) <input type="radio"/> Sciatic Single 64445 (7 units) <input type="radio"/> Ultrasound 76942-26 (2 units) <input type="radio"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units) <input type="radio"/> Epidural Steroid 62322 (8 units) <input type="radio"/> Daily Epidural Mgmt 01996 (3 units) <input type="radio"/> Art Line 36620 (3 units) <input type="radio"/> PICC Placement 36569 (6 units) MEASURE #76 <input type="radio"/> Lumbar Blood Patch 62273 (8 units) <input type="radio"/> Adductor Canal Block 64447 (8 units) <input type="radio"/> Intubation Emergency 31500 (5 units) <input type="radio"/> iPack Block 64999 (7 units)
SMOKER <input type="radio"/> YES <input checked="" type="radio"/> NO		
IF NO SKIP TO NEXT MEASURE Elective Procedure <input type="radio"/> Yes <input type="radio"/> No Instructed to abstain <input type="radio"/> Yes <input type="radio"/> No Abstained <input type="radio"/> Yes <input type="radio"/> No		
MEASURE #404		
SPECIAL PROCEDURES: TOTAL UNITS: <input checked="" type="radio"/>		
ABG7 PAIN ASSESSMENT <input checked="" type="radio"/> LUCID <input type="radio"/> NON COMMUNICATE <input checked="" type="radio"/> PACU <input type="radio"/> OICU PAIN LEVEL <input checked="" type="radio"/> OUT OF 10 SCG 8 DEPRESSION ASSESS. <input checked="" type="radio"/> YES <input type="radio"/> NO DX: _____ REQUIRED		
MEASURE #430 Inhalation Anes Recvd	<input type="radio"/> Yes <input checked="" type="radio"/> No	
IF NO SKIP TO NEXT MEASURE		
3 Pt Risk Factors	<input type="radio"/> Yes <input type="radio"/> No	
PONV Therapy	<input type="radio"/> Yes <input type="radio"/> No	
ASA SCORE	<input checked="" type="radio"/> 3	REQUIRED

Patient TERRI JEAN CALDWELL - D00048240022

Other Names

Med Rec Number MR00036288

Reg Status

DEP SDC

EMR Number T00001412

Soc Sec Num

447-74-7099

Birthdate 02/10/1963

Age 62 Birth Sex F

VIP

VIP Comment

## Patient Address

## Patient Employer

413 NORTH I ST

NON EMPLOYED

DUNCAN, OK 73533

United States

## E-Mail

Conf Comm Address

Phone Number	Phone Type
580-736-0863	Cell Phone

Marital Status Single

Country of Origin

Religion

In School

Affiliation

Registered Voter

Language English

Veteran Status

Interpreter Needed

Organ Donor

Education Level

Marketing Comm

Citizenship

Privacy Notice Date 12/17/20

Place of Birth

## Physical Handicaps

Ethnicity / Additional Ethnicities	Race / Additional Races
Non Hispanic or Latino	White

## Personal Contacts

Person to Notify	Relationship	Aunt
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PETTIGREW, Verna

413 NORTH I ST

DUNCAN, OK 73533

United States

Phone Number	Phone Type
580-736-0863	Cell Phone

## Guarantor

## Guarantor Employer

GN00070120 Relationship Self

NON EMPLOYED

CALDWELL, TERRI JEAN

413 NORTH I ST

DUNCAN, OK 73533

United States

Email

Phone Number	Phone Type
--------------	------------

580-736-0863 Cell Phone

**Financial Class****Financial Class** Medicare**Standard Insurance Order**    **Medicare Part B Order**    **Medicare Part D Order**

MEDICARE

MEDICAID

SELF PAY

**Insurances**

<b>Name</b>	MEDICARE	<b>Coverage Plan</b>
<b>Policy Number</b>	8X01QV7XA09	<b>Group Name</b>
<b>Address</b>	PO BOX 3114	<b>Group Number</b>
	ATTN: PART A CLAIMS	<b>Employment Status</b>
<b>City, State, Zip</b>	MECHANICSBURG, PA 17055-1829	<b>Employer Name</b>
<b>Country</b>	US	<b>Location</b>
<b>Phone</b>	855-252-8782	<b>Copay</b> <b>Deductible</b> <b>Coinsurance</b>
<b>Fax</b>		<b>Eligibility Status</b> Received <b>Status Date</b> 08/11/25
<b>Email</b>		

<b>Release Info</b>	Yes	<b>Exp Info Date</b>
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<b>Assign Benefits</b>	Yes
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<b>Subscriber</b>	CALDWELL, TERRI JEAN	<b>Birth Sex</b>	F
<b>Pat Rel to Subs</b>	Self	<b>Soc Sec Num</b>	447-74-7099
<b>Address</b>	413 NORTH I ST	<b>Marital Status</b>	Single
<b>City, State, Zip</b>	DUNCAN, OK 73533	<b>Race</b>	White
<b>Country</b>	United States	<b>Citizenship</b>	United States
<b>Email</b>		<b>Language</b>	English
<b>Birthdate</b>	02/10/1963		

<b>Phone Number</b>	<b>Phone Type</b>
580-736-0863	Cell Phone

<b>Name</b>	MEDICAID	<b>Coverage Plan</b>
<b>Policy Number</b>	B13877148	<b>Group Name</b>
<b>Address</b>	PO BOX 18430	<b>Group Number</b>
<b>City, State, Zip</b>	OKLAHOMA CITY, OK 73154	<b>Employment Status</b>
<b>Country</b>		<b>Employer Name</b>
<b>Phone</b>	800-522-0310	<b>Location</b>
<b>Fax</b>		<b>Copay</b> <b>Deductible</b> <b>Coinsurance</b>
<b>Email</b>		<b>Eligibility Status</b> Received <b>Status Date</b> 08/11/25

<b>Release Info</b>	Yes	<b>Exp Info Date</b>
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<b>Assign Benefits</b>	Yes
------------------------	-----

<b>Subscriber</b>	CALDWELL, TERRI JEAN	<b>Birth Sex</b>	F
<b>Pat Rel to Subs</b>	Self	<b>Soc Sec Num</b>	447-74-7099
<b>Address</b>	413 NORTH I ST	<b>Marital Status</b>	Single
<b>City, State, Zip</b>	DUNCAN, OK 73533	<b>Race</b>	White
<b>Country</b>	United States	<b>Citizenship</b>	United States
<b>Email</b>		<b>Language</b>	English

Birthdate 02/10/1963

Phone Number 580-736-0863  
 Phone Type Cell Phone

Occurrence Codes	Date	Time	Accident State
DSI 11 - Onset of Symptom-OP Ther	08/11/25		

**Physicians****Other Physicians/Association**

Primary Care Jones, Jeffrey C

Sheaman, Landon T Garrett

Admitting

Attending Miller, Byron Ronald

Family

Emergency

Reg Date/Time 08/11/25 06:16

Discharge Date/Time 08/11/25 09:50

Requested Accom

Discharge Disposition Home/Assisted Living - 01

Room Rate Accom

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

Facility Directory

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit Age-related nuclear cataract, right eye 1

Last Hospitalization

From Date:

Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
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08/11/25 H25.11 Age-related nuclear cataract, right eye No SUR

**Diagnosis Codes**

Eff Date	Num	Code	Name	POA
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08/06/25 - 1 H25.11 Age-related nuclear cataract,

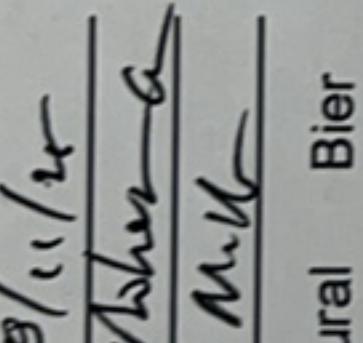
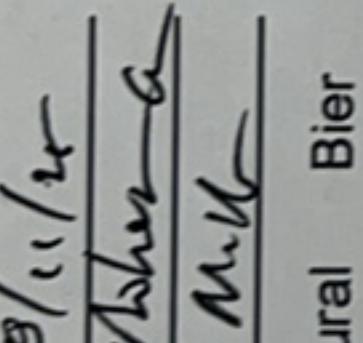
**Procedure Codes**

Num	Code	Name	Date	Surgeon/Assisting
-----	------	------	------	-------------------

MR: **CALDWELL, TERRI JEAN** 62  
 FN# **D00048240022**  
 MNR# **MRO00036288**  
 DOB: **02/10/1963** REG DT: **08/11/2023**  
 ATT DR: **Miller, Byron Ronald**  
 FN: 

**Duncan Anesthesia Associates, Inc.**  
**ANESTHESIA CHARGE LIST**

1/1/2023

Provider:   
 Surgeon:   
 Anesthesia: General SAB MAC  
 Procedure: *cautious - 20c* Epidural Bier Other TIVA

CPT: *2014C* ICD10: *H25.0* Modifier:  
 CPT: *2014C* ICD10: *H25.0* Modifier:  
 CPT: *2014C* ICD10: *H25.0* Modifier:  
 CPT: *2014C* ICD10: *H25.0* Modifier:

**BLOCK PROCEDURE**

START: *0858*

STOP: *0925*

TOTAL: *22*

**SURGERY**

START: *0858*

STOP: *0925*

TOTAL: *22*

**Measure Codes**

**Diagnosis:**

**SPECIAL PROCEDURES**

- Femoral Single 64447 (8 units)
- Brachial Plexus Single 64415 (8 units)
- Lumbar Epidural Continuous 62319 (8 units)
- Thoracic Epidural Continuous 62318 (8 units)
- Lumbar Puncture 62270 (8 units)
- Sciatic Single 64445 (7 units)
- Ultrasound 76942-26 (2 units)
- Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units)
- Epidural Steroid 62322 (8 units)
- Daily Epidural Mgmt 01996 (3 units)
- Art Line 36620 (3 units)
- PICC Placement 36569 (6 units) **MEASURE #76**
- Lumbar Blood Patch 62273 (8 units)
- Adductor Canal Block 64447 (8 units)
- Intubation Emergency 31500 (5 units)
- iPack Block 64999 (7 units)

**MUST BE DOCUMENTED**

Base Units: γ  
Time Units: 2

**MEASURE #424**  
 TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME  
 TEMP GREATER OR EQUAL 95.9

**MEASURE #404**

**SMOKER**  
 YES  NO

**IF NO SKIP TO NEXT MEASURE**  
 Elective Procedure  Yes  No  
 Instructed to abstain  Yes  No  
 Abstained  Yes  No

**MEASURE #430**

Inhalation Anes Recvd  Yes  No  
**IF NO SKIP TO NEXT MEASURE**

**3 Pt Risk Factors**  
 Yes  No  
 Yes  No

**PONV Therapy**  
 Yes  No  
 Yes  No

**ASA SCORE** 7 **REQUIRED**

Duncan Regional Hospital

Account Inquiry

Page: 1

Date: 08/11/25 16:38

McIntyre, Karen

**Patient** ALTON RAY STANDRIDGE - D00048231427**Other Names****Med Rec Number** MR00038765**Reg Status**

DEP SDC

**EMR Number** T00013048**Soc Sec Num**

585-60-3981

**Birthdate** 12/16/1954**Age** 70      **Birth Sex** M**VIP****VIP Comment****Patient Address****Patient Employer**

2335 N 44TH ST

RETIRED

DUNCAN, OK 73533

United States

**E-Mail** ALTONSTANDRIDGE@GMAIL.COM**Conf Comm Address****Phone Number****Phone Type**

580-560-1749

Cell Phone

**Marital Status** Divorced**Country of Origin****Religion** Baptist

In School

**Affiliation**

Registered Voter

**Language** English

Veteran Status

**Interpreter Needed**

Organ Donor

**Education Level**

Marketing Comm

**Citizenship****Privacy Notice Date** 05/29/24**Place of Birth****Physical Handicaps****Ethnicity / Additional Ethnicities****Race / Additional Races**

Non Hispanic or Latino

White

**Personal Contacts****Person to Notify****Relationship** Cousin

WALKINGSTICK, DONALD

2335 N 44TH ST

DUNCAN, OK 73533

United States

**Phone Number****Phone Type**

580-736-6536

Cell Phone

**Guarantor****Guarantor Employer**

GN00003940

**Relationship** Self

RETIRED

STANDRIDGE, ALTON RAY

2335 N 44TH ST

DUNCAN, OK 73533

United States

**Email** ALTONSTANDRIDGE@GMAIL.COM**Phone Number****Phone Type**

580-560-1749 Cell Phone

**Financial Class****Financial Class** Medicare Advantage**Standard Insurance Order**

HUMANA CHOICE PPO (MCARE)

SELF PAY

**Medicare Part B Order****Medicare Part D Order****Insurances**

Name	HUMANA CHOICE PPO (MCARE)	Coverage Plan	9A311001
Policy Number	H45040790	Group Name	
Address	PO BOX 14601	Group Number	9A311001
City, State, Zip	LEXINGTON, KY 40512-4601	Employment Status	
Country	US	Employer Name	
Phone	800-457-4708	Location	
Fax		Copay	Deductible
Email		Eligibility Status Received	Coinsurance
			Status Date 08/11/25

Release Info	Yes	Exp Info Date
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Assign Benefits	Yes
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Subscriber	STANDRIDGE, ALTON RAY	Birth Sex	M
Pat Rel to Subs	Self	Soc Sec Num	585-60-3981
Address	2335 N 44TH ST	Marital Status	Divorced
City, State, Zip	DUNCAN, OK 73533	Race	White
Country	United States	Citizenship	United States
Email	ALTONSTANDRIDGE@GMAIL.COM	Language	English
Birthdate	12/16/1954		

Phone Number	Phone Type
580-560-1749	Cell Phone

Occurrence Codes	Date	Time	Accident State
DSI	11 - Onset of Symptom-OP Ther	08/11/25	

**Physicians****Other Physicians/Association**

Primary Care Want,Colton Lane

Admitting

Attending Miller,Byron Ronald

Family

Emergency

Reg Date/Time 08/11/25 10:12

Discharge Date/Time 08/11/25 13:01

Requested Accom

Discharge Disposition Home/Assisted Living - 01

Room Rate Accom

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

**Facility Directory**

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit      Age-related nuclear cataract, left eye 1

Last Hospitalization

From Date:

Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

<b>Eff Date</b>	<b>Code</b>	<b>Name</b>	<b>Alt</b>	<b>Source</b>
08/11/25	H25.12	Age-related nuclear cataract, left eye	No	SUR
<b>Diagnosis Codes</b>				
<b>Eff Date</b>	<b>Num</b>	<b>Code</b>	<b>Name</b>	<b>POA</b>
08/04/25 -	1	H25.12	Age-related nuclear cataract,	
<b>Procedure Codes</b>				
<b>Num</b>	<b>Code</b>	<b>Name</b>	<b>Date</b>	<b>Surgeon/Assisting</b>

**MR:** STANDRIDGE, ALTON RAY 70  
**FN#** D00048231427  
**MFR#** MR00038765  
**DOB:** 12/16/1954 **REG DT:** 08/11/2025  
**ATT DR:** Miller, Byron Ronald  
**FN:** 

**Duncan Anesthesia Associates, Inc.**  
**ANESTHESIA CHARGE LIST**

1/1/2023

*Alexander*  
*Mile*

		SURGERY		BLOCK PROCEDURE	
Provider:		START:	12:40	START:	
Surgeon:		STOP:	12:35	STOP:	
		TOTAL:	35	TOTAL:	

Anesthesia:	General	SAB	MAC	Epidural	Bier	Other	TIVA	ICD10: 00142	ICD10: 1415-12	Modifier:
Procedure:				CPT: 00142	CPT: 00142					
				CPT: 00142	CPT: 00142					
				CPT: 00142	CPT: 00142					
				CPT: 00142	CPT: 00142					

**Diagnosis:**

<b>MUST BE DOCUMENTED</b>		Base Units: <u>1</u> / <u>2</u>	<b>SPECIAL PROCEDURES</b>	
<b>MEASURE #424</b>		Time Units: <u>1</u> or <u>depth</u>	<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64415 (8 units) <input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 units) <input type="checkbox"/> Epidural Steroid 62322 (8 units) <input type="checkbox"/> Daily Epidural Mgmt 01996 (3 units) <input type="checkbox"/> Art Line 36620 (3 units) <input type="checkbox"/> PICC Placement 36569 (6 units) <b>MEASURE #76</b> <input type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input type="checkbox"/> Adductor Canal Block 64447 (8 units) <input type="checkbox"/> Intubation Emergency 31500 (5 units) <input type="checkbox"/> iPack Block 64999 (7 units)	
<b>MEASURE #404</b>		<b>SPECIAL PROCEDURES:</b> <u>8</u>		
SMOKER		TOTAL UNITS: <u>8</u>		
<b>IF NO SKIP TO NEXT MEASURE</b>		<b>ABG7 PAIN ASSESSMENT</b>		
Elective Procedure		O Yes <input checked="" type="checkbox"/> No		
Instructed to abstain		O Yes <input checked="" type="checkbox"/> No		
Abstained		O Yes <input checked="" type="checkbox"/> No		
<b>MEASURE #430</b>		<b>Oxygen Saturation</b>		
Inhalation Anes Recvd		O Yes <input checked="" type="checkbox"/> No		
<b>IF NO SKIP TO NEXT MEASURE</b>		<b>ASA Score</b>		
3 Pt Risk Factors		O Yes <input checked="" type="checkbox"/> No		
PONV Therapy		O Yes <input checked="" type="checkbox"/> No		
		<b>ASA SCORE</b> <u>7</u> <b>REQUIRED</b>		
				<b>NUR4154</b>

Patient MARDY LYNN MEADOWS - D00048241681

Other Names

Med Rec Number MR00069688      Reg Status DEP SDC  
 EMR Number T00078536      Soc Sec Num 445-54-9405  
 Birthdate 06/09/1956  
 Age 69      Birth Sex M  
 VIP  
 VIP Comment

## Patient Address

## Patient Employer

2710 S 42ND      RETIRED

DUNCAN, OK 73533  
United States**E-Mail** mardym56@yahoo.com**Conf Comm Address**

**Phone Number** 580-470-5154      **Phone Type** Cell Phone

<b>Marital Status</b> Married	<b>Country of Origin</b>
<b>Religion</b>	In School
<b>Affiliation</b>	Registered Voter
<b>Language</b> English	Veteran Status
<b>Interpreter Needed</b>	Organ Donor
<b>Education Level</b>	Marketing Comm
<b>Citizenship</b>	<b>Privacy Notice Date</b> 07/23/17
<b>Place of Birth</b>	

## Physical Handicaps

<b>Ethnicity / Additional Ethnicities</b>	<b>Race / Additional Races</b>
Non Hispanic or Latino	White

## Personal Contacts

<b>Person to Notify</b>	<b>Relationship</b> Spouse
MEADOWS,CINDY	
2710 S 42ND	

DUNCAN, OK 73533  
United States

**Phone Number** 580-470-5143      **Phone Type** Home Phone

**Guarantor**

GN00008107	<b>Relationship</b> Self	<b>Guarantor Employer</b>
MEADOWS,MARDY LYNN		RETIRED
2710 S 42ND		

DUNCAN, OK 73533  
United States  
**Email** mardym56@yahoo.com

**Phone Number**      **Phone Type**

580-470-5154 Cell Phone

**Financial Class****Financial Class** Medicare Advantage**Standard Insurance Order**

HUMANA CHOICE PPO (MCARE)

SELF PAY

**Medicare Part B Order****Medicare Part D Order****Insurances**

Name	HUMANA CHOICE PPO (MCARE)	Coverage Plan	9A790001
Policy Number	H73780541	Group Name	
Address	PO BOX 14601	Group Number	9A790001
City, State, Zip	LEXINGTON, KY 40512-4601	Employment Status	
Country	US	Employer Name	
Phone	800-457-4708	Location	
Fax		Copay	Deductible
Email		Eligibility Status Received	Coinsurance Status Date 08/11/25

Release Info	Yes	Exp Info Date
Assign Benefits	Yes	

Subscriber	MEADOWS,MARDY LYNN	Birth Sex	M
Pat Rel to Subs	Self	Soc Sec Num	445-54-9405
Address	2710 S 42ND	Marital Status	Married
City, State, Zip	DUNCAN, OK 73533	Race	White
Country	United States	Citizenship	United States
Email	mardym56@yahoo.com	Language	English
Birthdate	06/09/1956		

Phone Number	Phone Type
580-470-5154	Cell Phone

Authorization Number	Referral Number
----------------------	-----------------

NO AUTH REQUIRED

Eff Date	Exp Date	Referral Type	Status	Referred By Referred To
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Occurrence Codes	Date	Time	Accident State
DSI      11 - Onset of Symptom-OP Ther	08/11/25		

**Physicians****Other Physicians/Association**

Primary Care Jones,Jeffrey C

Admitting

Attending Gibbon,Jordan B

Family

Emergency

Reg Date/Time 08/11/25 06:21

Discharge Date/Time 08/11/25 11:25

Requested Accom

Discharge Disposition Home/Assisted Living - 01

Room Rate Accom

Room/Bed

Service

Location	Ambulatory Care Unit
----------	----------------------

Admit Priority      Elective

Admit Source      Physician Referral

Newborn Admit Src

Entry Code

Facility Directory

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit      RT ANKLE ACHILLES TEAR

Last Hospitalization

From Date:

Thru Date:

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**ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
Diagnosis Codes				
Eff Date	Num	Code	Name	POA
Procedure Codes				
Num	Code	Name	Date	Surgeon/Assisting

MR:  
MEADOWS, MARDY LYNN  
FN# D00048241681 69  
MR# MR00069688

69

DOB: 06/09/1956 REG DT: 08/11/25

ATT DR: Gibbon, Jordan B

FN: 

## Duncan Anesthesia Associates, Inc.

### ANESTHESIA CHARGE LIST

1/1/2023

BILLING OFFICE USE  
POS 21  
POS 22

Provider: J. Palmer

Surgeon: J. Gibbon

Anesthesia:

General

SAB

MAC

Epidural

Bier

Other TIVA

Procedure:  ① Ankle Achilles Repair CPT: 01472 ICD10: W25.571 Modifier:   
 ② Plantar fascia Release CPT: ICD10: W79.671 Modifier:   
 CPT: ICD10:   
 CPT: ICD10:

Diagnosis: ② Ankle Achilles Tear

		Measure Codes
<b>SURGERY</b>	<b>BLOCK PROCEDURE</b>	
START: <u>0803</u>	START: <u>D154</u>	
STOP: <u>1003</u>	STOP: <u>0802</u>	
TOTAL: <u>120min</u>	TOTAL: <u>8min</u>	

MUST BE DOCUMENTED		SPECIAL PROCEDURES
MEASURE #424	Base Units: <u>5</u>	<input type="checkbox"/> Femoral Single 64447 (8 units)
● TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9	Time Units: <u>8</u>	<input type="checkbox"/> Brachial Plexus Single 64415 (8 units)
MEASURE #404	<input type="checkbox"/> PS 3 (1 unit) + <input type="checkbox"/> PS 4 (2 units) <input type="checkbox"/> PS 5 (3 units) <input type="checkbox"/> Age: 99100 (<1 or >70)(1 unit) <input type="checkbox"/> Emergency: 99140 (2 units)	<input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units)
SMOKER	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units)
IF NO SKIP TO NEXT MEASURE	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Instructed to abstain <input type="checkbox"/> Abstained	<input type="checkbox"/> Lumbar Puncture 62270 (8 units)
Elective Procedure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Sciatic Single 64445 (7 units)
MEASURE #430	SPECIAL PROCEDURES: <u>9</u>	<input type="checkbox"/> Ultrasound 76942-26 (2 units)
Inhalation Anes Recvd	TOTAL UNITS: <u>23</u>	<input type="checkbox"/> Epidural Steroid 62322 (8 units)
IF NO SKIP TO NEXT MEASURE		<input type="checkbox"/> Epidural Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units)
3 Pt Risk Factors	ABG7 PAIN ASSESSMENT <input type="checkbox"/> LUCID <input type="checkbox"/> NON COMMUNICATE <input checked="" type="checkbox"/> PACU <input type="checkbox"/> OICU	<input type="checkbox"/> Daily Epidural Mgmt 01996 (3 units)
PONV Therapy	PAIN LEVEL <u>10</u> OUT OF 10 SCG 8 DEPRESSION ASSESS. <input type="checkbox"/> YES <input type="checkbox"/> NO DX: <u>Negative</u> REQUIRED <input checked="" type="checkbox"/> ASA SCORE <u>3</u> REQUIRED	<input type="checkbox"/> Art Line 36620 (3 units) <input type="checkbox"/> PICC Placement 36569 (6 units) MEASURE #76 <input type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input type="checkbox"/> Adductor Canal Block 64447 (8 units) <input type="checkbox"/> Intubation Emergency 31500 (5 units) <input type="checkbox"/> iPack Block 64999 (7 units)

Patient GEORGE DANNY WILLIAMS - D00048157549

Other Names

Med Rec Number MR00076616

Reg Status

DEP SDC

WILLIAMS,DANNY

EMR Number T00035565

Soc Sec Num

440-50-0789

Birthdate 03/16/1947

Age 78 Birth Sex M

VIP

VIP Comment

## Patient Address

## Patient Employer

177379 N 2910 RD

RETIRED

DUNCAN, OK 73533

United States

**E-Mail** dot2dotndan@yahoo.com

Conf Comm Address

Phone Number

Phone Type

580-467-6991

Cell Phone

Marital Status Married

Country of Origin

Religion

In School

Affiliation

Registered Voter

Language English

Veteran Status

Interpreter Needed

Organ Donor

Education Level

Marketing Comm

Citizenship

Privacy Notice Date 06/14/19

Place of Birth

## Physical Handicaps

Ethnicity / Additional Ethnicities

Race / Additional Races

Non Hispanic or Latino

White

## Personal Contacts

Person to Notify

Relationship Spouse

WILLIAMS,DOROTHY

177379 N 2910 RD

DUNCAN, OK 73533

United States

Phone Number

Phone Type

580-467-2030

Cell Phone

## Guarantor

## Guarantor Employer

GN00025419

Relationship Self

RETIRED

WILLIAMS,GEORGE DANNY

177379 N 2910 RD

DUNCAN, OK 73533

United States

**Email** dot2dotndan@yahoo.com

Phone Number

Phone Type

580-467-6991 Cell Phone

**Financial Class****Financial Class** Medicare**Standard Insurance Order**    **Medicare Part B Order**    **Medicare Part D Order**

MEDICARE

SELF PAY

**Insurances**

Name	MEDICARE	Coverage Plan
Policy Number	5AN2MK6GM18	Group Name
Address	PO BOX 3114	Group Number
	ATTN: PART A CLAIMS	Employment Status
City, State, Zip	MECHANICSBURG, PA 17055-1829	Employer Name
Country	US	Location
Phone	855-252-8782	Copay      Deductible      Coinsurance
Fax		Eligibility Status Received      Status Date 08/11/25
Email		

Release Info	Yes	Exp Info Date
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Assign Benefits	Yes
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Subscriber	WILLIAMS,GEORGE DANNY	Birth Sex	M
Pat Rel to Subs	Self	Soc Sec Num	440-50-0789
Address	177379 N 2910 RD	Marital Status	Married
City, State, Zip	DUNCAN, OK 73533	Race	White
Country	United States	Citizenship	United States
Email	dot2dotndan@yahoo.com	Language	English
Birthdate	03/16/1947		

Phone Number	Phone Type
580-467-6991	Cell Phone

Occurrence Codes	Date	Time	Accident State
DSI	11 - Onset of Symptom-OP Ther	08/11/25	

**Physicians****Other Physicians/Association**

Primary Care Stewart, William Thomas

Admitting

Attending Watkins, Kayla Michele

Family

Emergency

Reg Date/Time 08/11/25 08:02

Discharge Date/Time 08/11/25 11:10

Requested Accom

Discharge Disposition Home/Assisted Living - 01

Room Rate Accom

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

**Facility Directory**

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit      SCREENING

Last Hospitalization

From Date:

Thru Date:

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ICD10 Codes

## Reason for Visit Diagnoses

Eff Date	Code	Name	Alt	Source
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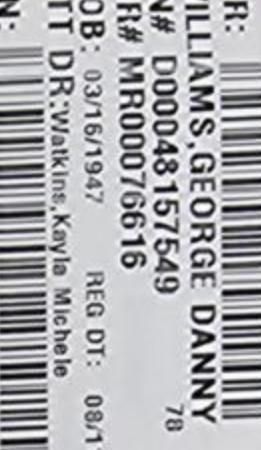
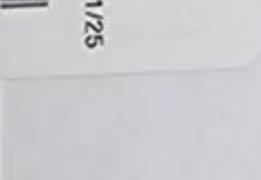
## Diagnosis Codes

Eff Date	Num	Code	Name	POA
----------	-----	------	------	-----

## Procedure Codes

Num	Code	Name	Date	Surgeon/Assisting
-----	------	------	------	-------------------

MR:  
WILLIAMS, GEORGE DANNY  
FN# D00048157549  
MR# MR00076616  
DOB: 03/16/1947 REG DT: 08/11/25  
ATT DR: Watkins, Kayla Michele

FN:   
Provider:   
Surgeon: 

## Duncan Anesthesia Associates, Inc.

### ANESTHESIA CHARGE LIST

1/1/2023

BILLING OFFICE USE
POS 21
POS 22

SURGERY	BLOCK PROCEDURE
START: 1015	START:
STOP: 1033	STOP:
TOTAL: 18-	TOTAL:

Anesthesia: General SAB  MAC Epidural Bier Other TIVA  
 Procedure: Colorectal CPT: 00811 ICD10: Z12.11 Modifier: \_\_\_\_\_  
 CPT: 00811 ICD10: 286.0100 Modifier: \_\_\_\_\_  
 CPT:  ICD10:  Modifier: \_\_\_\_\_  
 CPT:  ICD10:  Modifier: \_\_\_\_\_

### Diagnosis:

MUST BE DOCUMENTED	Base Units:	Time Units:	SPECIAL PROCEDURES	
			<input type="radio"/> Femoral Single 64447 (8 units)	<input type="radio"/> Brachial Plexus Single 64415 (8 units)
<b>MEASURE #424</b> <input checked="" type="checkbox"/> TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9	<u>1</u>	<u>1</u>	<input type="radio"/> Lumbar Epidural Continuous 62319 (8 units)	<input type="radio"/> Thoracic Epidural Continuous 62318 (8 units)
<b>MEASURE #404</b>	<u>1</u>	<u>1</u>	<input type="radio"/> Lumbar Puncture 62270 (8 units)	<input type="radio"/> Sciatic Single 64445 (7 units)
SMOKER <input type="radio"/> YES <input checked="" type="radio"/> NO	<u>1</u>	<u>1</u>	<input type="radio"/> Ultrasound 76942-26 (2 units)	<input type="radio"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units)
<b>IF NO SKIP TO NEXT MEASURE</b> Elective Procedure <input type="radio"/> Yes <input type="radio"/> No	<u>1</u>	<u>1</u>	<input type="radio"/> Epidural Steroid 62322 (8 units)	<input type="radio"/> Daily Epidural Mgmt 01996 (3 units)
Instructed to abstain <input type="radio"/> Yes <input type="radio"/> No	<u>1</u>	<u>1</u>	<input type="radio"/> Art Line 36620 (3 units)	<input type="radio"/> PICC Placement 36569 (6 units) <b>MEASURE #76</b>
Abstained <input type="radio"/> Yes <input type="radio"/> No	<u>1</u>	<u>1</u>	<input type="radio"/> Lumbar Blood Patch 62273 (8 units)	<input type="radio"/> Adductor Canal Block 64447 (8 units)
<b>MEASURE #430</b> Inhalation Anes Recvd <input type="radio"/> Yes <input checked="" type="radio"/> No	<u>1</u>	<u>1</u>	<input type="radio"/> Intubation Emergency 31500 (5 units)	<input type="radio"/> iPack Block 64999 (7 units)
<b>IF NO SKIP TO NEXT MEASURE</b>				
3 Pt Risk Factors <input type="radio"/> Yes <input type="radio"/> No	<u>1</u>	<u>1</u>		
PONV Therapy	<u>1</u>	<u>1</u>		
<b>ABG7 PAIN ASSESSMENT</b>				
LUCID <input type="radio"/> NON COMMUNICATE	<u>1</u>	<u>1</u>		
<input checked="" type="checkbox"/> PACU <input type="radio"/> OICU	<u>1</u>	<u>1</u>		
<b>PAIN LEVEL</b> <u>2</u> OUT OF 10	<u>1</u>	<u>1</u>		
SCG 8 DEPRESSION ASSESS.	<u>1</u>	<u>1</u>		
YES <input type="radio"/> NO	<u>1</u>	<u>1</u>		
RX: <u>AS A SCORE</u> <u>2</u> REQUIRED	<u>1</u>	<u>1</u>		

Patient MEAGAN PATRICIA MORRISTON - D00048237267

Other Names

Med Rec Number MR00081814

Reg Status

DEP SDC

MORRISTON, BABY GIRL

EMR Number T00091711

Soc Sec Num

443-17-7813

Birthdate 07/18/2002

Age 23 Birth Sex F

VIP

VIP Comment

## Patient Address

## Patient Employer

2108 W OAK AVE

COMPLETEOK HOME HEALTH

1 SW 11TH ST SUITE 120

DUNCAN, OK 73533

United States

LAWTON, OK 73501

E-Mail MEG.MORRISTON@GMAIL.COM

580-351-6565

Conf Comm Address

## Phone Number

## Phone Type

580-721-9110

Cell Phone

Marital Status Single

Country of Origin

Religion None

In School

Affiliation

Registered Voter

Language English

Veteran Status

Interpreter Needed

Organ Donor

Education Level

Marketing Comm

Citizenship

Privacy Notice Date 06/23/23

Place of Birth

## Physical Handicaps

Ethnicity / Additional Ethnicities

Race / Additional Races

Non Hispanic or Latino

White

## Personal Contacts

Next of Kin

Relationship Father

MORRISTON, KELLY

3322 S WOODS DR

MARLOW, OK 73055

United States

## Phone Number

## Phone Type

580-251-1692

Cell Phone

Person to Notify

Relationship Mother

SNOW, BRANDI

2108 W OAK AVE

DUNCAN, OK 73533

United States

## Phone Number

## Phone Type

580-470-5180

Cell Phone

## Guarantor

## Guarantor Employer

GN00113528

Relationship Self

COMPLETEOK HOME HEALTH

MORRISTON,MEAGAN PATRICIA  
2108 W OAK AVE

1 SW 11TH ST SUITE 120

LAWTON, OK 73501  
580-351-6565

DUNCAN, OK 73533  
United States  
Email meg.morriston@gmail.com

Phone Number 580-721-9110  
Phone Type Cell Phone

**Financial Class**

Financial Class Medicaid

**Standard Insurance Order Medicare Part B Order Medicare Part D Order**

OKLAHOMA COMPLETE HEALTH  
SELF PAY

**Insurances**

Name	OKLAHOMA COMPLETE HEALTH	Coverage Plan
Policy Number	033373274	Group Name
Address	PO BOX 8001	Group Number
	ATTN CLAIM DEPARTMENT	Employment Status
City, State, Zip	FARMINGTON, MO 63640-8001	Employer Name
Country		Location
Phone	833-752-1664	Copay      Deductible      Coinsurance
Fax		Eligibility Status Received      Status Date 08/11/25
Email		

Release Info	Yes	Exp Info Date
Assign Benefits	Yes	

Subscriber	MORRISTON,MEAGAN PATRICIA	Birth Sex	F
Pat Rel to Subs	Self	Soc Sec Num	443-17-7813
Address	2108 W OAK AVE	Marital Status	Single
City, State, Zip	DUNCAN, OK 73533	Race	White
Country	United States	Citizenship	United States
Email	meg.morriston@gmail.com	Language	English
Birthdate	07/18/2002		

Phone Number 580-721-9110  
Phone Type Cell Phone

Occurrence Codes	Date	Time	Accident State
DSI	11 - Onset of Symptom-OP Ther	08/11/25	

**Physicians****Other Physicians/Association**

Primary Care Fuller,Jacob A

Admitting

Attending Watkins,Kayla Michele

Family

Emergency

Reg Date/Time 08/11/25 08:58  
Requested Accom  
Room Rate Accom

Discharge Date/Time 08/11/25 12:48  
Discharge Disposition Home/Assisted Living - 01

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

Facility Directory

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit GERD, EPIGASTRIC PAIN, RT GROIN PAIN

Last Hospitalization From Date: Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
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**Diagnosis Codes**

Eff Date	Num	Code	Name	POA
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**Procedure Codes**

Num	Code	Name	Date	Surgeon/Assisting
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MR:   
**MORRISTON, MEAGAN PATRICIA**  
 FN# D00048237267 23  
 MFR# MR00081814

DOB: 07/18/2002 REG DT: 08/11/25  
 ATT DR: Watkins,Kayla Michele  
 FN: 

**Duncan Anesthesia Associates, Inc.**  
**ANESTHESIA CHARGE LIST**

1/1/2023

BILLING OFFICE USE
POS 21
POS 22

Provider: 8-11-25  
 Surgeon: K. WATKINS

SURGERY	BLOCK PROCEDURE
START: <u>1203</u>	START: _____
STOP: <u>1207</u>	STOP: _____
TOTAL: <u>4</u>	TOTAL: _____

Anesthesia: General SAB MAC Epidural Bier Other TIVA  
 Procedure: ECD CPT: 0073 ICD10: K21.9 Modifier: \_\_\_\_\_  
 CPT: \_\_\_\_\_ ICD10: K10.13 Modifier: \_\_\_\_\_  
 CPT: \_\_\_\_\_ ICD10: K10.31 Modifier: \_\_\_\_\_  
 CPT: \_\_\_\_\_ ICD10: \_\_\_\_\_

**Diagnosis:**

MUST BE DOCUMENTED	Base Units	SPECIAL PROCEDURES
MEASURE #424 <input checked="" type="radio"/> TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9	<u>5</u> Time Units <u>+</u>	<input type="radio"/> Femoral Single 64447 (8 units) <input type="radio"/> Brachial Plexus Single 64415 (8 units) <input type="radio"/> Lumbar Epidural Continuous 62319 (8 units) <input type="radio"/> Thoracic Epidural Continuous 62318 (8 units) <input type="radio"/> Lumbar Puncture 62270 (8 units) <input type="radio"/> Sciatic Single 64445 (7 units) <input type="radio"/> Ultrasound 76942-26 (2 units) <input type="radio"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units)
IF NO SKIP TO NEXT MEASURE <input checked="" type="radio"/> Elective Procedure Yes <input type="radio"/> No <input checked="" type="radio"/> Instructed to abstain Yes <input type="radio"/> No <input checked="" type="radio"/> Abstained Yes <input type="radio"/> No	TOTAL UNITS: <u>6</u>	<input type="radio"/> Epidural Steroid 62322 (8 units) <input type="radio"/> Daily Epidural Mgmt 01996 (3 units) <input type="radio"/> Art Line 36620 (3 units) <input type="radio"/> PICC Placement 36569 (6 units) MEASURE #76
MEASURE #430 <input type="radio"/> Inhalation Anes Recvd Yes <input checked="" type="radio"/> No	ABG7 PAIN ASSESSMENT <input checked="" type="radio"/> LUCID <input type="radio"/> NON COMMUNICATE <input type="radio"/> PACU <input type="radio"/> OICU <input type="radio"/> PAIN LEVEL <u>0</u> OUT OF 10 <input type="radio"/> SCG & DEPRESSION ASSESS <input checked="" type="radio"/> YES <input type="radio"/> NO <input type="radio"/> DX _____ REQUIRED <input checked="" type="radio"/> ASA SCORE <u>2</u> REQUIRED <input type="radio"/> iPack Block 64999 (7 units)	<input type="radio"/> Art Line 36620 (3 units) <input type="radio"/> PICC Placement 36569 (6 units) MEASURE #76 <input type="radio"/> Lumbar Blood Patch 62273 (8 units) <input type="radio"/> Adductor Canal Block 64447 (8 units) <input type="radio"/> Intubation Emergency 31500 (5 units) <input type="radio"/> iPack Block 64999 (7 units)
IF NO SKIP TO NEXT MEASURE <input type="radio"/> 3 Pt Risk Factors Yes <input type="radio"/> No <input type="radio"/> PONV Therapy Yes <input type="radio"/> No		

**Patient** DAVID ALAN McDOWELL - D00048231476**Other Names****Med Rec Number** MR00083689**Reg Status**

DEP SDC

**EMR Number** T00035414**Soc Sec Num**

442-66-8099

**Birthdate** 02/24/1962**Age** 63      **Birth Sex** M**VIP****VIP Comment****Patient Address****Patient Employer**

5212 CLEAR SPRINGS DRIVE

COMCAST

DUNCAN, OK 73533

5220 ASHVILLE HWY

United States

KNOXVILLE, TN 37924

**E-Mail** DAVIDMEADOWS1146@GMAIL.COM

UNKNOWN

**Conf Comm Address**

Occupation CABLE TV TECHNICIAN

Employer Status Full-Time

**Phone Number****Phone Type**

865-438-7437

Cell Phone

**Marital Status** Married**Country of Origin****Religion**

In School

**Affiliation**

Registered Voter

**Language** English

Veteran Status

**Interpreter Needed**

Organ Donor

**Education Level**

Marketing Comm

**Citizenship**

Privacy Notice Date 03/02/06

**Place of Birth****Physical Handicaps****Ethnicity / Additional Ethnicities****Race / Additional Races**

Non Hispanic or Latino

White

**Personal Contacts****Next of Kin****Relationship** Other Relationship

POSEY,WALTER

RT 2, BOX 266

DUNCAN, OK 73533

**Phone Number****Phone Type**

580-255-7101

Cell Phone

**Person to Notify****Relationship** Spouse

MCDOWELL,BRANDI

4505 SUNFLOWER

KNOXVILLE, TN 37909

**Phone Number****Phone Type**

865-450-4530

Cell Phone

**Guarantor****Guarantor Employer**

GN00143267

**Relationship** Self

COMCAST

MCDOWELL, DAVID ALAN  
5212 CLEAR SPRINGS DRIVE

5220 ASHVILLE HWY

KNOXVILLE, TN 37924

DUNCAN, OK 73533  
United States  
Email DAVIDMEADOWS1146@GMAIL.COM

Occupation CABLE TV TECHNICIAN  
Emp Status Full-Time

Phone Number 865-438-7437  
Phone Type Cell Phone

**Financial Class**

Financial Class Blue Cross

**Standard Insurance Order**

BC BS OF OKLAHOMA  
SELF PAY

**Medicare Part B Order****Medicare Part D Order****Insurances**

Name	BC BS OF OKLAHOMA	Coverage Plan	043039
Policy Number	YAQ869425361M	Group Name	
Address	PO BOX 655924	Group Number	043039
City, State, Zip	DALLAS, TX 75266-5924	Employment Status	
Country		Employer Name	
Phone	800-722-3730	Location	
Fax		Copay	Deductible
Email		Eligibility Status	Received
		Status Date	08/11/25

Release Info Yes  
Assign Benefits Yes

**Exp Info Date**

Subscriber	MCDOWELL, DAVID ALAN	Birth Sex	M
Pat Rel to Subs	Self	Soc Sec Num	442-66-8099
Address	5212 CLEAR SPRINGS DRIVE	Marital Status	Married
City, State, Zip	DUNCAN, OK 73533	Race	White
Country	United States	Citizenship	United States
Email	DAVIDMEADOWS1146@GMAIL.COM	Language	English
Birthdate	02/24/1962		

Phone Number 865-438-7437  
Phone Type Cell Phone

Occurrence Codes	Date	Time	Accident State
DSI	11 - Onset of Symptom-OP Ther	08/11/25	

**Physicians****Other Physicians/Association**

Primary Care McGouran, Francis James III

Admitting

Attending Miller, Byron Ronald

Family

Emergency

Reg Date/Time 08/11/25 08:47  
Requested Accom  
Room Rate Accom

Discharge Date/Time 08/11/25 10:38  
Discharge Disposition Home/Assisted Living - 01

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

Facility Directory

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit Age-related nuclear cataract, left eye 1

Last Hospitalization From Date: Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
08/11/25	H25.12	Age-related nuclear cataract, left eye	No	SUR
<b>Diagnosis Codes</b>				
Eff Date	Num	Code	Name	POA
08/04/25 -	1	H25.12	Age-related nuclear cataract,	
<b>Procedure Codes</b>				
Num	Code	Name	Date	Surgeon/Assisting

MR: **MCDOWELL, DAVID ALAN** 63  
 FN# **D00048231476**  
 MFR# **MR00083689**  
 DOB: **02/24/1962** REG DT: **08/11/25**  
 ATT DR: **Miller, Byron Ronald**  
 FN: 

**Duncan Anesthesia Associates, Inc.**  
**ANESTHESIA CHARGE LIST**

1/1/2023

*3/11/25*  
*Byron C*  
*M.H.*

Provider: \_\_\_\_\_  
Surgeon: \_\_\_\_\_

Anesthesia: General SAB **(MAC)** Epidural Bier Other TIVA

Procedure:	<i>Cataractos c-2r</i>	CPT:	<i>21142</i>	ICD10:	<i>H25.12</i>	Modifier:	_____
		CPT:		ICD10:		Modifier:	_____
		CPT:		ICD10:		Modifier:	_____
		CPT:		ICD10:		Modifier:	_____

**Diagnosis:**

<b>MUST BE DOCUMENTED</b>	Base Units:	<u>Y</u>	<b>SPECIAL PROCEDURES</b>
	Time Units:	<u>2</u>	
<b>MEASURE #424</b>			
TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9			
<b>MEASURE #404</b>			
<input type="radio"/> YES <input checked="" type="radio"/> NO			
<b>SPECIAL PROCEDURES:</b> <u>6</u>			
TOTAL UNITS: _____			
<b>ABG7 PAIN ASSESSMENT</b>			
<input checked="" type="checkbox"/> LUCID			
<input type="checkbox"/> NON COMMUNICATE			
<input type="checkbox"/> PACU			
<input type="checkbox"/> OUT OF 10			
<input type="checkbox"/> PAIN LEVEL <u>8</u>			
<input type="checkbox"/> SCG 8 DEPRESSION ASSESS.			
<input type="checkbox"/> NO REQUIRED			
<input type="checkbox"/> YES			
<input type="checkbox"/> DX: _____			
<input checked="" type="checkbox"/> ASA SCORE <u>Y</u> REQUIRED			
<b>IF NO SKIP TO NEXT MEASURE</b>			
<input type="checkbox"/> Elective Procedure			
<input type="checkbox"/> Instructed to abstain			
<input type="checkbox"/> Abstained			
<b>MEASURE #430</b>			
<input checked="" type="checkbox"/> Inhalation Anes Recvd <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
<b>IF NO SKIP TO NEXT MEASURE</b>			
<input type="checkbox"/> 3 Pt Risk Factors			
<input type="checkbox"/> PONV Therapy			
<b>MEASURE #76</b>			
<input type="checkbox"/> Art Line 36620 (3 units)			
<input type="checkbox"/> Epidural Steroid 62322 (8 units)			
<input type="checkbox"/> Daily Epidural Mgmt 01996 (3 units)			
<input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units)			
<input type="checkbox"/> O Femoral Single 64447 (8 units)			
<input type="checkbox"/> O Brachial Plexus Single 64415 (8 units)			
<input type="checkbox"/> O Lumbar Epidural Continuous 62319 (8 units)			
<input type="checkbox"/> O Thoracic Epidural Continuous 62318 (8 units)			
<input type="checkbox"/> O Lumbar Puncture 62270 (8 units)			
<input type="checkbox"/> O Sciatic Single 64445 (7 units)			
<input type="checkbox"/> O Ultrasound 76942-26 (2 units)			
<input type="checkbox"/> O Daily Epidural Mgmt 01996 (3 units)			
<input type="checkbox"/> O Art Line 36620 (3 units)			
<input type="checkbox"/> O PICC Placement 36569 (6 units) <b>MEASURE #76</b>			
<input type="checkbox"/> O Lumbar Blood Patch 62273 (8 units)			
<input type="checkbox"/> O Adductor Canal Block 64447 (8 units)			
<input type="checkbox"/> O Intubation Emergency 31500 (5 units)			
<input type="checkbox"/> O iPack Block 64999 (7 units)			

**Patient** THOMAS WAYNE HAWKINS - D00048203988**Other Names****Med Rec Number** MR00084985**Reg Status**

DEP SDC

**EMR Number** T00018357**Soc Sec Num**

223-27-4128

**Birthdate** 10/25/1965**Age** 59      **Birth Sex** M**VIP****VIP Comment****Patient Address****Patient Employer**

294617 E 1670 RD

HALLIBURTON SERVICES

1015 W BOIS D'ARC

MARLOW, OK 73055

DUNCAN, OK 73534

**E-Mail** thawkt@gmail.com

580-251-4838

**Conf Comm Address****Occupation** DRAFTER**Employer Status** Full-Time**Phone Number****Phone Type**

580-467-5837

Cell Phone

**Marital Status** Married**Country of Origin****Religion** Baptist

In School

**Affiliation**

Registered Voter

**Language** English

Veteran Status

**Interpreter Needed**

Organ Donor

**Education Level**

Marketing Comm

**Citizenship****Privacy Notice Date** 10/23/23**Place of Birth****Physical Handicaps****Ethnicity / Additional Ethnicities****Race / Additional Races**

Non Hispanic or Latino

White

**Personal Contacts****Next of Kin****Relationship** Parent

HAWKINS, CLAUDE

RT 4 BOX 233G1

DUNCAN, OK 73533

**Phone Number****Phone Type**

580-606-8552

Cell Phone

**Person to Notify****Relationship** Spouse

HAWKINS, TINA

294617 E 1670 RD

MARLOW, OK 73055

**Phone Number****Phone Type**

580-467-7203

Cell Phone

**Guarantor****Guarantor Employer**

GN00034087

**Relationship** Self

HALLIBURTON SERVICES

HAWKINS,THOMAS WAYNE  
294617 E 1670 RD

1015 W BOIS D'ARC

MARLOW, OK 73055

DUNCAN, OK 73534

580-251-4838

Occupation DRAFTER

Emp Status Full-Time

Email thawkt@gmail.com

Phone Number 580-467-5837  
Phone Type Cell Phone

**Financial Class**

Financial Class Blue Cross

**Standard Insurance Order**

BC BS--Halliburton  
SELF PAY

**Medicare Part B Order****Medicare Part D Order**

Name BC BS--Halliburton

Policy Number HGC903422336

Address PO BOX 655924

City, State, Zip DALLAS, TX 75265-5924

Country

Phone 800-451-0287

Fax

Email

Release Info Yes

Assign Benefits Yes

Subscriber HAWKINS,THOMAS WAYNE

Pat Rel to Subs Self

Address 294617 E 1670 RD

City, State, Zip MARLOW, OK 73055

Country

Email thawkt@gmail.com

Birthdate 10/25/1965

Phone Number 580-467-5837  
Phone Type Cell Phone

**Occurrence Codes**

DSI 11 - Onset of Symptom-OP Ther

Date 08/11/25

Time

Accident State

Primary Care Tate,Steven A

Admitting

Attending Watkins,Kayla Michele

Family

Emergency

Reg Date/Time 08/11/25 06:22

Requested Accom

Room Rate Accom

Discharge Date/Time 08/11/25 09:55

Discharge Disposition Home/Assisted Living - 01

**Physicians****Other Physicians/Association**

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

Facility Directory

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit RIH

Last Hospitalization

From Date:

Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
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**Diagnosis Codes**

Eff Date	Num	Code	Name	POA
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**Procedure Codes**

Num	Code	Name	Date	Surgeon/Assisting
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MR# HAWKINS, THOMAS WAYNE  
FN# D00048203988 59  
MI# MRE0084985

DOB: 10/25/1968 REG DT: 08/11/2026

ATT DR: Watkins, Kevin Melele  
FN:  HEG DT: 08/11/2026



## Duncan Anesthesia Associates, Inc.

### ANESTHESIA CHARGE LIST

1/1/2023

BILLING OFFICE USE  
POS 21 POS 22

Patient: 874125  
Surgeon: H.P.  
Anesthesia: General

Procedure:	<u>R</u> Robot Assis. Robotic CPT: <u>00840</u>	CPT:	<u>00840</u>	ICD10:	<u>K40.90</u>	Modifier:	
		CPT:		ICD10:	<u>Q10.31</u>	Modifier:	
		CPT:		ICD10:		Modifier:	
		CPT:		ICD10:		Modifier:	

Measure Codes	

#### Diagnosis:

MUST BE DOCUMENTED	Base Units:	SPECIAL PROCEDURES
MEASURE #424 TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9	<u>60</u>	<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64415 (8 units) <input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units)
MEASURE #404 SMOKER <input type="radio"/> YES <input checked="" type="radio"/> NO	<u>TOTAL UNITS:</u> <u>12</u>	<input type="checkbox"/> ABG7 PAIN ASSESSMENT <input type="checkbox"/> LUCID <input type="checkbox"/> NON COMMUNICATE <input type="checkbox"/> PACU <input type="checkbox"/> OICU <u>PAIN LEVEL</u> <u>OUT OF 10</u> <u>SCG 8 DEPRESSION ASSESS.</u> <u>YES</u> <u>ONO</u> <u>REQUIRED</u> <u>Dx:</u> <u>ASA SCORE</u> <u>2</u> <u>REQUIRED</u>
MEASURE #430 Inhalation Anes Recvd <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Art Line 36620 (3 units) <input type="checkbox"/> PICC Placement 36569 (6 units) MEASURE #76 <input type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input type="checkbox"/> Adductor Canal Block 64447 (8 units) <input type="checkbox"/> Intubation Emergency 31500 (5 units) <input type="checkbox"/> iPack Block 64999 (7 units)
IF NO SKIP TO NEXT MEASURE Elective Procedure <input type="checkbox"/> Yes <input type="checkbox"/> No Instructed to abstain <input type="checkbox"/> Yes <input type="checkbox"/> No Abstained <input type="checkbox"/> Yes <input type="checkbox"/> No		
IF NO SKIP TO NEXT MEASURE Elective Procedure <input type="checkbox"/> Yes <input type="checkbox"/> No Instructed to abstain <input type="checkbox"/> Yes <input type="checkbox"/> No Abstained <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Patient** DAVID LEE DITMORE - D00048230494**Other Names****Med Rec Number** MR00090213**Reg Status**

DEP SDC

**EMR Number**

T00018008

**Soc Sec Num**

445-52-3322

**Birthdate** 08/02/1950**Age** 75      **Birth Sex** M**VIP****VIP Comment****Patient Address****Patient Employer**

164484 5 MILE RD

RETIRED

MARLOW, OK 73055

United States

**E-Mail** DAVID.DITMORE2393@GMAIL.COM**Conf Comm Address**

<b>Phone Number</b>	<b>Phone Type</b>
580-641-2393	Cell Phone

**Marital Status** Married**Country of Origin****Religion** Baptist

In School

**Affiliation**

Registered Voter

**Language** English

Veteran Status

**Interpreter Needed**

Organ Donor

**Education Level**

Marketing Comm

**Citizenship****Privacy Notice Date** 10/31/24**Place of Birth****Physical Handicaps****Ethnicity / Additional Ethnicities****Race / Additional Races**

Non Hispanic or Latino

White

**Personal Contacts****Next of Kin****Relationship** Spouse

DITMORE,HETTIE

164484 5 MILE RD

MARLOW, OK 73055

<b>Phone Number</b>	<b>Phone Type</b>
580-641-0393	Cell Phone

**Person to Notify****Relationship** Child

COLE,BRANDI

RR 4 BOX 132 B

MARLOW, OK 73055

<b>Phone Number</b>	<b>Phone Type</b>
580-641-0233	Cell Phone

**Guarantor Employer**

GN00003137

**Relationship** Self

RETIRED

DITMORE, DAVID LEE  
164484 5 MILE RD

MARLOW, OK 73055  
United States  
Email david.ditmore2393@gmail.com

Phone Number      Phone Type  
580-641-2393      Cell Phone

**Financial Class**

**Financial Class** Medicare

— Standard Insurance Order — — — Medicare Part B Order — — — Medicare Part D Order —  
MEDICARE  
BC BS FEDERAL EMPLOYEE PROGRAM  
SELF PAY

**Insurances**

Name	MEDICARE	Coverage Plan
Policy Number	8VY9PM9UF32	Group Name
Address	PO BOX 3114	Group Number
	ATTN: PART A CLAIMS	Employment Status
City, State, Zip	MECHANICSBURG, PA 17055-1829	Employer Name      RETIRED
Country	US	Location
Phone	855-252-8782	Copay      Deductible      Coinsurance
Fax		Eligibility Status Received      Status Date 08/07/25
Email		

Release Info	Yes	Exp Info Date
Assign Benefits	Yes	

Subscriber	DITMORE, DAVID LEE	Birth Sex      M
Pat Rel to Subs	Self	Soc Sec Num      445-52-3322
Address	164484 5 MILE RD	Marital Status      Married
City, State, Zip	MARLOW, OK 73055	Race      White
Country	United States	Citizenship      United States
Email	david.ditmore2393@gmail.com	Language      English
Birthdate	08/02/1950	

Phone Number      Phone Type  
580-641-2393      Cell Phone

Name	BC BS FEDERAL EMPLOYEE PROGRAM	Coverage Plan      105
Policy Number	R58034276	Group Name
Address	PO BOX 655924	Group Number      105
City, State, Zip	DALLAS, TX 75266-5924	Employment Status
Country		Employer Name      RETIRED
Phone	1-800-722-3130	Location
Fax		Copay      Deductible      Coinsurance
Email		Eligibility Status Received      Status Date 08/07/25

Release Info	Yes	Exp Info Date
Assign Benefits	Yes	

**Subscriber** DITMORE,DAVID LEE      **Birth Sex** M  
**Pat Rel to Subs** Self      **Soc Sec Num** 445-52-3322  
**Address** 164484 5 MILE RD      **Marital Status** Married  
**City, State, Zip** MARLOW, OK 73055      **Race** White  
**Country** United States      **Citizenship** United States  
**Email** david.ditmore2393@gmail.com      **Language** English  
**Birthdate** 08/02/1950

**Phone Number** 580-641-2393      **Phone Type** Cell Phone

Occurrence Codes	Date	Time	Accident State
DSI      11 - Onset of Symptom-OP Ther	08/11/25		

**Physicians****Other Physicians/Association****Primary Care** None,Physician**Admitting****Attending** Miller,Douglas Che**Family****Emergency****Reg Date/Time** 08/11/25 06:41**Discharge Date/Time** 08/11/25 13:31**Requested Accom****Discharge Disposition** Home/Assisted Living - 01**Room Rate Accom****Room/Bed****Service****Location** Cardiac Cath Lab**Admit Priority** Elective**Admit Source** Physician Referral**Newborn Admit Src****Entry Code****Facility Directory** Yes**Clergy Visit** Yes**Adm Legal Status****Confidential****Conf Comment****Admit Comment****Dis Comment****Reason for Visit** Atherosclerosis of native arteries of extremities**Last Hospitalization****From Date:****Thru Date:****ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
08/11/25	I70.213	Atherosclerosis of native arteries of ex	No	SUR
08/11/25	M79.604	Pain in right leg	No	SUR
08/11/25	M79.605	Pain in left leg	No	SUR
08/11/25	I65.23	Occlusion and stenosis of bilateral caro	No	SUR
08/11/25	R42	Dizziness and giddiness	No	SUR

**Diagnosis Codes**

Eff Date	Num	Code	Name	POA
08/04/25 -	1	I70.213	Atherosclerosis of native arte	
08/04/25 -	2	M79.604	Pain in right leg	
08/04/25 -	3	M79.605	Pain in left leg	
08/04/25 -	4	I65.23	Occlusion and stenosis of bila	
08/04/25 -	5	R42	Dizziness and giddiness	
Procedure Codes				
Num	Code	Name	Date	Surgeon/Assisting

MR:   
DITMORE, DAVID LEE  
FN# D00048230494  
MR# MR00090213

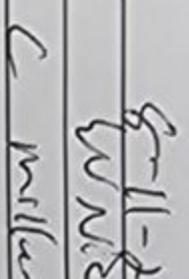
75

DOB: 08/02/1950 REG DT: 08/11/25

ATT DR: Miller, Douglas Che

FN: 

- Surgeon:

  
Miller

### Duncan Anesthesia Associates, Inc.

#### ANESTHESIA CHARGE LIST

1/1/2023

BILLING OFFICE USE  
POS 21 POS 22

SURGERY	BLOCK PROCEDURE
START: 0716	START:
STOP: 0725	STOP:
TOTAL: 42m	TOTAL:

#### Diagnosis:

MUST BE DOCUMENTED	Base Units	Time Units	SPECIAL PROCEDURES
<b>MEASURE #424</b> <input checked="" type="checkbox"/> TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9	<input checked="" type="checkbox"/> 6	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64415 (8 units) <input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units) <input type="checkbox"/> Epidural Steroid 62322 (8 units) <input type="checkbox"/> Daily Epidural Mgmt 01996 (3 units)
<b>MEASURE #404</b> <b>SMOKER</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
<b>IF NO SKIP TO NEXT MEASURE</b> <input type="checkbox"/> Elective Procedure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Instructed to abstain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Abstained <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>SPECIAL PROCEDURES:</b>			
<b>TOTAL UNITS:</b>	1		
<b>ABG7 PAIN ASSESSMENT</b>			
<input type="checkbox"/> LUCID <input checked="" type="checkbox"/> NON COMMUNICATE <input checked="" type="checkbox"/> PACU <input checked="" type="checkbox"/> OICU <input type="checkbox"/> PAIN LEVEL <input checked="" type="checkbox"/> OUT OF 10 <input checked="" type="checkbox"/> SCG 8 DEPRESSION ASSESS <input checked="" type="checkbox"/> YES <input type="checkbox"/> O NO <input type="checkbox"/> REQUIRED			
<b>MEASURE #430</b> <b>Inhalation Anes Recvd</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			<b>MEASURE #76</b> <input type="checkbox"/> PICC Placement 36569 (6 units) <input type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input type="checkbox"/> Adductor Canal Block 64447 (8 units) <input type="checkbox"/> Intubation Emergency 31500 (5 units) <input type="checkbox"/> iPack Block 64999 (7 units)
<b>IF NO SKIP TO NEXT MEASURE</b>			
<b>3 PT Risk Factors</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>PONV Therapy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input checked="" type="checkbox"/> ASA SCORE <input type="checkbox"/> 3 REQUIRED			

Patient CHARLES KEITH WILLIAMS Jr - D00048231534

Other Names

Med Rec Number MR00113091

Reg Status

DEP SDC

WILLIAMS,CHARLES KEITH

EMR Number T00116066

Soc Sec Num

447-58-8780

WILLIAMS JR,CHARLES KEITH

Birthdate 06/28/1956

Age 69 Birth Sex M

VIP

VIP Comment

## Patient Address

## Patient Employer

1314 NORMANDY CT

RETIRED

DUNCAN, OK 73533

United States

E-Mail CKWILLIAMSJR56@GMAIL.COM

Conf Comm Address

Phone Number	Phone Type
580-656-7617	Cell Phone
580-656-7618	Cell Phone

Marital Status	Married	Country of Origin
Religion	None	In School
Affiliation		Registered Voter
Language	English	Veteran Status
Interpreter Needed		Organ Donor
Education Level		Marketing Comm
Citizenship		Privacy Notice Date 02/15/24
Place of Birth		

## Physical Handicaps

Ethnicity / Additional Ethnicities	Race / Additional Races
Non Hispanic or Latino	White

## Personal Contacts

Next of Kin	Relationship Child
VIGIL,ALICIA	
1314 NORMANDY CT	

DUNCAN, OK 73533  
United States

Phone Number	Phone Type
405-606-1670	Cell Phone

Person to Notify	Relationship Spouse
WILLIAMS,KIMMIE	
1314 NORMANDY CT	

DUNCAN, OK 73533  
United States

Phone Number	Phone Type
580-656-7618	Cell Phone

Guarantor	Guarantor Employer
GN00026115	Relationship Self
	RETIRED

WILLIAMS, CHARLES KEITH Jr  
1314 NORMANDY CT

DUNCAN, OK 73533  
United States  
Email CKWILLIAMSJR56@GMAIL.COM

Phone Number	Phone Type
580-656-7617	Cell Phone
580-656-7618	Cell Phone

**Financial Class**

**Financial Class** Medicare

— Standard Insurance Order —	— Medicare Part B Order —	— Medicare Part D Order —
MEDICARE		
THE CAPITOL LIFE INS CO AESSION		
SELF PAY		

**Insurances**

Name	MEDICARE	Coverage Plan
Policy Number	1D81TN5QC28	Group Name
Address	PO BOX 3114	Group Number
	ATTN: PART A CLAIMS	Employment Status
City, State, Zip	MECHANICSBURG, PA 17055-1829	Employer Name
Country	US	Location
Phone	855-252-8782	Copay      Deductible      Coinsurance
Fax		Eligibility Status Received      Status Date 08/11/25
Email		

Release Info	Yes	Exp Info Date
Assign Benefits	Yes	

Subscriber	WILLIAMS, CHARLES KEITH Jr	Birth Sex	M
Pat Rel to Subs	Self	Soc Sec Num	447-58-8780
Address	1314 NORMANDY CT	Marital Status	Married
City, State, zip	DUNCAN, OK 73533	Race	White
Country	United States	Citizenship	United States
Email	CKWILLIAMSJR56@GMAIL.COM	Language	English
Birthdate	06/28/1956		

Phone Number	Phone Type
580-656-7617	Cell Phone
580-656-7618	Cell Phone

Name	THE CAPITOL LIFE INS CO AESSION	Coverage Plan
Policy Number	TER6206048	Group Name
Address	1021 REAMS FLEMING BLVD	Group Number
		Employment Status
City, State, Zip	FRANKLIN, TN 37067	Employer Name
Country	USA	Location
Phone	866-237-3010	Copay      Deductible      Coinsurance
Fax		Eligibility Status Received      Status Date 08/11/25
Email		

Release Info	Yes	Exp Info Date
--------------	-----	---------------

Assign Benefits Yes

<b>Subscriber</b>	WILLIAMS,CHARLES KEITH Jr	<b>Birth Sex</b>	M
<b>Pat Rel to Subs</b>	Self	<b>Soc Sec Num</b>	447-58-8780
<b>Address</b>	1314 NORMANDY CT	<b>Marital Status</b>	Married
<b>City, State, Zip</b>	DUNCAN, OK 73533	<b>Race</b>	White
<b>Country</b>	United States	<b>Citizenship</b>	United States
<b>Email</b>	CKWILLIAMSJR56@GMAIL.COM	<b>Language</b>	English
<b>Birthdate</b>	06/28/1956		

<b>Phone Number</b>	<b>Phone Type</b>
580-656-7617	Cell Phone
580-656-7618	Cell Phone

**Accident Data**

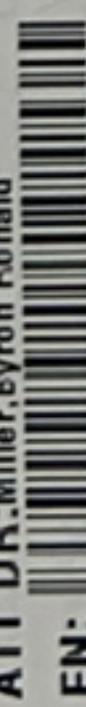
<b>Type</b>	Within 24 Hours
<b>Date/Time</b>	Accident Comments
<b>Place of Accident</b>	Description
<b>Police Involved</b>	
<b>Nature of Injury</b>	
<b>Originally Treated at</b>	

<b>Occurrence Codes</b>	<b>Date</b>	<b>Time</b>	<b>Accident State</b>
DSI	11 - Onset of Symptom-OP Ther	08/11/25	

**Physicians****Other Physicians/Association****Primary Care** Tate,Steven A**Admitting****Attending** Miller,Byron Ronald**Family****Emergency****Reg Date/Time** 08/11/25 09:27**Discharge Date/Time** 08/11/25 12:28**Requested Accom****Discharge Disposition** Home/Assisted Living - 01**Room Rate Accom****Room/Bed****Service****Location** Ambulatory Care Unit**Admit Priority** Elective**Admit Source** Physician Referral**Newborn Admit Src****Entry Code****Facility Directory** Yes**Clergy Visit** Yes**Adm Legal Status****Confidential****Conf Comment****Admit Comment****Dis Comment****Reason for Visit** Age-related nuclear cataract, left eye 1**Last Hospitalization****From Date:****Thru Date:**

**ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
08/11/25	H25.12	Age-related nuclear cataract, left eye	No	SUR
<b>Diagnosis Codes</b>				
Eff Date	Num	Code	Name	POA
08/04/25 -	1	H25.12	Age-related nuclear cataract,	
<b>Procedure Codes</b>				
Num	Code	Name	Date	Surgeon/Assisting

MR: WILLIAMS, CHARLES KEITH Jr  
 FN# D00048231534 69  
 MFR# MR00113091  
 DOB: 06/28/1956 REG DT: 08/11/25  
 ATT DR: Miller, Byron Ronald  
 FN: 

Duncan Anesthesia Associates, Inc.  
ANESTHESIA CHARGE LIST

1/1/2023

9/11/23  
ASW

Provider:

Surgeon:

Anesthesia: General SAB MAC Epidural Bier Other TIVA

Procedure: <u>central vs c 20c</u>	CPT: <u>62142</u>	ICD10: <u>425.12</u>	Modifier:
	CPT: <u></u>	ICD10: <u></u>	Modifier:
	CPT: <u></u>	ICD10: <u></u>	Modifier:
	CPT: <u></u>	ICD10: <u></u>	Modifier:

Diagnosis:

MUST BE DOCUMENTED		Base Units: <u>4</u>	Time Units: <u>3</u>	SPECIAL PROCEDURES	
<b>MEASURE #424</b>		<input checked="" type="checkbox"/> PS 3 (1 unit) <input type="checkbox"/> PS 4 (2 units) <input type="checkbox"/> PS 5 (3 units) <input type="checkbox"/> Age: 99100 [<1 or >70] (1 unit) <input type="checkbox"/> Emergency: 99140 (2 units)		<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64415 (8 units) <input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 units) <input type="checkbox"/> Epidural Steroid 62322 (8 units) <input type="checkbox"/> Daily Epidural Mgmt 01996 (3 units) <input type="checkbox"/> Art Line 36620 (3 units) <input type="checkbox"/> PICC Placement 36569 (6 units) <b>MEASURE #76</b> <input type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input type="checkbox"/> Adductor Canal Block 64447 (8 units) <input type="checkbox"/> Intubation Emergency 31500 (5 units) <input type="checkbox"/> iPack Block 64999 (7 units)	
<b>IF NO SKIP TO NEXT MEASURE</b>		TOTAL UNITS: <u>8</u>		<b>ABG7 PAIN ASSESSMENT</b> <input checked="" type="checkbox"/> LUCID <input type="checkbox"/> NON COMMUNICATE <input type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> PAIN LEVEL <u>8</u> OUT OF 10 <input type="checkbox"/> SCG & DEPRESSION ASSESS. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REQUIRED  <b>ASA SCORE</b> <u>3</u> <b>REQUIRED</b>	
<b>MEASURE #430</b>		Inhalation Anes Recvd <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<b>IF NO SKIP TO NEXT MEASURE</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>3 Pt Risk Factors</b> <b>PONV Therapy</b>	

**Patient** SAVANNA ROSE WHITAKER - D00047364633**Other Names****Med Rec Number** MR00118661**Reg Status****DIS IN**

WHITAKER,SAVANNA LYNN

**EMR Number** T00120434**Soc Sec Num****606-06-9743****Birthdate** 03/24/1998**Age** 27      **Birth Sex** F**VIP****VIP Comment****Patient Address****Patient Employer**

1809 S 14TH ST

CHICKASHA, OK 73018

United States

**E-Mail** WHITAKER.SAVANNA@YAHOO.COM**Conf Comm Address**

<b>Phone Number</b>	<b>Phone Type</b>
760-223-1258	Cell Phone

**Marital Status** Single**Country of Origin****Religion****In School****Affiliation****Registered Voter****Language** English**Veteran Status****Interpreter Needed****Organ Donor****Education Level****Marketing Comm****Citizenship****Privacy Notice Date** 08/07/25**Place of Birth****Physical Handicaps****Ethnicity / Additional Ethnicities****Race / Additional Races**

Non Hispanic or Latino

White

**Personal Contacts****Person to Notify****Relationship** Significant Other

SMITH,JOSHUA

1809 S 14TH ST

CHICKASHA, OK 73018

United States

<b>Phone Number</b>	<b>Phone Type</b>
760-223-1337	Cell Phone

**Guarantor****Guarantor Employer****GN00183317**      **Relationship** Self

WHITAKER,SAVANNA ROSE

1809 S 14TH ST

CHICKASHA, OK 73018

United States

**Email** WHITAKER.SAVANNA@YAHOO.COM**Phone Number****Phone Type**

760-223-1258 Cell Phone

**Financial Class****Financial Class** Medicaid**Standard Insurance Order**    **Medicare Part B Order**    **Medicare Part D Order**

OKLAHOMA COMPLETE HEALTH

SELF PAY

**Insurances**

Name	OKLAHOMA COMPLETE HEALTH	Coverage Plan
Policy Number	B37282665	Group Name
Address	PO BOX 8001	Group Number
	ATTN CLAIM DEPARTMENT	Employment Status
City, State, Zip	FARMINGTON, MO 63640-8001	Employer Name
Country		Location
Phone	833-752-1664	Copay      Deductible
Fax		Eligibility Status Sent
Email		Coinsurance      Status Date 08/07/25

Release Info	Yes	Exp Info Date
Assign Benefits	Yes	

Subscriber	WHITAKER,SAVANNA ROSE	Birth Sex	F
Pat Rel to Subs	Self	Soc Sec Num	606-06-9743
Address	1809 S 14TH ST	Marital Status	Single
City, State, Zip	CHICKASHA, OK 73018	Race	White
Country	United States	Citizenship	United States
Email	WHITAKER.SAVANNA@YAHOO.COM	Language	English
Birthdate	03/24/1998		

Phone Number	Phone Type
760-223-1258	Cell Phone

Occurrence Codes	Date	Time	Accident State
DSI	11 - Onset of Symptom-OP Ther	08/07/25	

**Physicians****Other Physicians/Association**

Primary Care	Nair,Sibin	None,Physician
Admitting	Cornejo,Juan Adrian	Palmer,Jacob O
Attending	Cornejo,Juan Adrian	
Family		
Emergency		

Reg Date/Time	08/07/25 05:30	Discharge Date/Time	08/09/25 12:42
Requested Accom	Private	Discharge Disposition	Home/Assisted Living - 01
Room Rate Accom	P		
Room/Bed	107-01		
Service	Obstetrics		
Location	Birth Center		
Admit Priority	Elective		
Admit Source	Physician Referral		
Newborn Admit Src			
Entry Code			

**Facility Directory**

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit      INTRAUTERINE PREGNANCY

Last Hospitalization

From Date:

Thru Date:

**ICD10 Codes**

Admit Diagnosis    Z37.9      Outcome of delivery, unspecified

**Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
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08/07/25	Z37.9	Outcome of delivery, unspecified	No	OM
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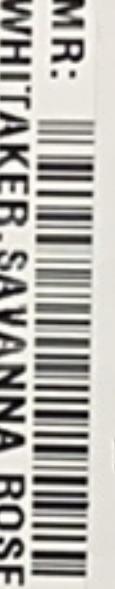
**Diagnosis Codes**

Eff Date	Num	Code	Name	POA
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08/07/25 -	1	Z37.9	Outcome of delivery, unspecified	E
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**Procedure Codes**

Num	Code	Name	Date	Surgeon/Assisting
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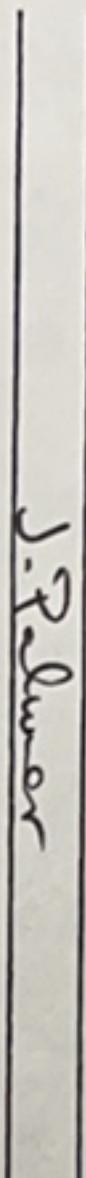
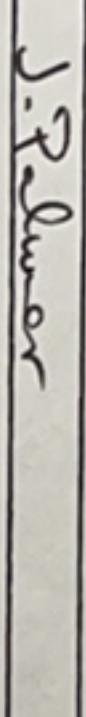
MR:   
**WHITAKER, SAVANNA ROSE**  
 FN# D00047364633  
 MR# MR00118661 27  
 DOB: 03/24/1998 RM: 107  
 ATT DR:Cornejo, Juan Adrian AD: 0807725  
 FN: 

Duncan Anesthesia-Associates, Inc.  
 ANESTHESIA CHARGE LIST

1/1/2013

BILLING OFFICE USE	POS 21
	POS 22

DATE: 8-7-25

DOCTOR: J.R.Dunn  
 PROVIDER:   
 SURGEON: 

ANESTHESIA: GENERAL TAB MAC EPIFUDURAL BIER OTHER TIVA

PROCEDURE	Labor Epidural	CPT:	01967	ICD10:	Modifier
		CPT:		ICD10:	Modifier
		CPT:		ICD10:	Modifier
		CPT:		ICD10:	Modifier

DIAGNOSIS: 108

MUST BE DOCUMENTED		Time Units	5	SPECIAL PROCEDURES	
MEASURE #424		Time Units	11	<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64415 (8 units) <input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) Y <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block Post-op Pain 64450 Hip/64415 Shoulder (5 units) <input type="checkbox"/> Epidural Steroid 62322 (8 units) <input type="checkbox"/> Daily Epidural Mgmt 01996 (3 units) <input type="checkbox"/> Art Line 36620 (3 units) <input type="checkbox"/> PICC Placement 96569 (6 units) MEASURE #76 <input type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input type="checkbox"/> Adductor Canal Block 64447 (8 units) <input type="checkbox"/> Intubation Emergency 31500 (5 units) <input type="checkbox"/> Pack Block 64999 (7 units)	
IF NO STOP TO NEXT MEASURE		TOTAL UNITS:	7	ABG/PAIN ASSESSMENT	
Elective Procedure		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> LUCID <input type="checkbox"/> NON COMMUNICATE <input type="checkbox"/> PACU ~ OICU	
Instructed to breath		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Non <input type="checkbox"/> Non	
Aborted		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Non <input type="checkbox"/> Non	
MEASURE #430		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Non <input type="checkbox"/> Non	
Inhalation Anest Recd		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Non <input type="checkbox"/> Non	
IF NO STOP TO NEXT MEASURE		PAIN LEVEL <u>8</u> OUT OF 10	SCA & DEPRESSION ASSES.	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO dx. <u>Neck</u> REQUIRED	
3 Pt Risk Factors		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Non <input type="checkbox"/> Non	
PONV Therapy		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Non <input type="checkbox"/> Non	
ASA SCORE		<u>2</u>	REQUIRED	<input type="checkbox"/> Non <input type="checkbox"/> Non	

**Patient** DESTINIE LOUISE MULLEN - D00048237770**Other Names**

Med Rec Number MR00136310      Reg Status DEP SDC  
EMR Number T00134567      Soc Sec Num 444-15-4279  
Birthdate 01/14/2001  
Age 24      Birth Sex F  
VIP  
VIP Comment

**Patient Address****Patient Employer**

618 N K ST

DUNCAN, OK 73533  
United States**E-Mail****Conf Comm Address**

Phone Number      Phone Type  
580-860-2026      Cell Phone

Marital Status Single      Country of Origin  
Religion None      In School  
Affiliation      Registered Voter  
Language English      Veteran Status  
Interpreter Needed      Organ Donor  
Education Level      Marketing Comm  
Citizenship      Privacy Notice Date 04/20/25  
Place of Birth

**Physical Handicaps**

Ethnicity / Additional Ethnicities  
Non Hispanic or Latino

Race / Additional Races  
White

**Personal Contacts**

Next of Kin      Relationship Parent  
MULLEN,WYNEMA  
618 N K ST

DUNCAN, OK 73533  
United States

Phone Number      Phone Type  
405-250-9516      Cell Phone

Person to Notify      Relationship Sibling  
MULLEN,JENNIFER  
618 N K ST

DUNCAN, OK 73533  
United States

Phone Number      Phone Type  
405-264-3955      Cell Phone

**Guarantor****Guarantor Employer**

GN00124175      Relationship Self

MULLEN,DESTINIE LOUISE  
618 N K ST

DUNCAN, OK 73533  
United States  
[Email](#)

**Phone Number** 580-860-2026      **Phone Type** Cell Phone

**Financial Class**

**Financial Class** Medicaid

— Standard Insurance Order — — Medicare Part B Order — — Medicare Part D Order —

HUMANA HEALTHY HORIZONS  
SELF PAY

**Insurances**

<b>Name</b>	HUMANA HEALTHY HORIZONS	<b>Coverage Plan</b>	1A789	
<b>Policy Number</b>	H73948605	<b>Group Name</b>		
<b>Address</b>	PO BOX 14601	<b>Group Number</b>	1A789	
<b>City, State, Zip</b>	LEXINGTON, KY 40512-4601	<b>Employment Status</b>		
<b>Country</b>		<b>Employer Name</b>		
<b>Phone</b>	855-223-9868	<b>Location</b>		
<b>Fax</b>		<b>Copay</b>	<b>Deductible</b>	<b>Coinsurance</b>
<b>Email</b>		<b>Eligibility Status</b>	Received	<b>Status Date</b> 08/11/25

**Release Info** Yes      **Exp Info Date**  
**Assign Benefits** Yes

<b>Subscriber</b>	MULLEN,DESTINIE LOUISE	<b>Birth Sex</b>	F
<b>Pat Rel to Subs</b>	Self	<b>Soc Sec Num</b>	444-15-4279
<b>Address</b>	618 N K ST	<b>Marital Status</b>	Single
<b>City, State, Zip</b>	DUNCAN, OK 73533	<b>Race</b>	White
<b>Country</b>	United States	<b>Citizenship</b>	United States
<b>Email</b>		<b>Language</b>	English
<b>Birthdate</b>	01/14/2001		

**Phone Number** 580-860-2026      **Phone Type** Cell Phone

<b>Occurrence Codes</b>	<b>Date</b>	<b>Time</b>	<b>Accident State</b>
DSI	11 - Onset of Symptom-OP Ther	08/11/25	

**Physicians****Other Physicians/Association**

<b>Primary Care</b>	None,Physician	Sheaman,Landon T Garrett
<b>Admitting</b>		Roberson,Matthew Wayne
<b>Attending</b>	Miller,Byron Ronald	
<b>Family</b>		
<b>Emergency</b>		

<b>Reg Date/Time</b>	08/11/25 11:30	<b>Discharge Date/Time</b>	08/11/25 15:56
<b>Requested Accom</b>		<b>Discharge Disposition</b>	Home/Assisted Living - 01
<b>Room Rate Accom</b>			

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

Facility Directory

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit LACRIMAL GLAND TUMOR RIGHT

Last Hospitalization From Date: Thru Date:

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ICD10 Codes

## Reason for Visit Diagnoses

Eff Date	Code	Name	Alt	Source
----------	------	------	-----	--------

## Diagnosis Codes

Eff Date	Num	Code	Name	POA
----------	-----	------	------	-----

## Procedure Codes

Num	Code	Name	Date	Surgeon/Assisting
-----	------	------	------	-------------------

MR: MULLEN, DESTINIE LOUISE  
 FN# D00048237770 24  
 MFR# MR00136310  
 DOB: 01/14/2001 REG DT: 08/11/25  
 ATT DR: Miller, Byron Ronald



Duncan Anesthesia Associates, Inc.  
ANESTHESIA CHARGE LIST

1/1/2023

Provider: Byron, An  
Surgeon: M.L.

Anesthesia: General SAB MAC Epidural Bier Other TIVA

Procedure: Excision of eyelid mass, CPT: 01103 ICD10: Q9103  
upper eyelid mass, CPT: 01103 ICD10: Q9103  
CPT: 01103 ICD10: Q9103  
CPT: 01103 ICD10: Q9103

Diagnosis:

MUST BE DOCUMENTED		Base Units: <u>5</u>	SPECIAL PROCEDURES
		Time Units: <u>4</u>	<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64445 (8 units) <input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 units) <input type="checkbox"/> Epidural Steroid 62322 (8 units) <input type="checkbox"/> Daily Epidural Mgmt 01996 (3 units) <input type="checkbox"/> Art Line 36620 (3 units) <input type="checkbox"/> PICC Placement 36569 (6 units) MEASURE #76
MEASURE #424 <input checked="" type="checkbox"/> TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9			<input type="checkbox"/> PS 3 (1 unit) <input type="checkbox"/> PS 4 (2 units) <input type="checkbox"/> PS 5 (3 units) <input type="checkbox"/> Age: 99100 [ <u>&lt;1 or &gt;70</u> ] (1 unit) <input type="checkbox"/> Emergency: 99140 (2 units)
MEASURE #404 <input type="checkbox"/> SMOKER <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		TOTAL UNITS: <u>9</u>	SPECIAL PROCEDURE#  ABG7 PAIN ASSESSMENT TOTAL UNITS: <u>9</u>
IF NO SKIP TO NEXT MEASURE Elective Procedure <input type="checkbox"/> Yes <input type="checkbox"/> No Instructed to abstain <input type="checkbox"/> Yes <input type="checkbox"/> No Abstained <input type="checkbox"/> Yes <input type="checkbox"/> No			<input checked="" type="checkbox"/> HUCID <input checked="" type="checkbox"/> NON COMMUNICATE <input checked="" type="checkbox"/> PACU <input checked="" type="checkbox"/> PAIN LEVEL <u>OUT OF 10</u> <input checked="" type="checkbox"/> SCG 8 DEPRESSION ASSESS. <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> DX: <u>                </u> REQUIRED <input checked="" type="checkbox"/> ASA SCORE <u>2</u> REQUIRED
MEASURE #430 Inhalation Anes Recvd <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No IF NO SKIP TO NEXT MEASURE 3 Pt Risk Factors <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No PONV Therapy <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			<input checked="" type="checkbox"/> PICC Placement 36569 (6 units) <input checked="" type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input checked="" type="checkbox"/> Adductor Canal Block 64447 (8 units) <input checked="" type="checkbox"/> Intubation Emergency 31500 (5 units) <input checked="" type="checkbox"/> iPack Block 64999 (7 units)

Duncan Regional Hospital

Account Inquiry

Page: 1

Date: 08/11/25 16:33

McIntyre,Karen

Patient PHILLIP MICHAEL BROWN - D00048170708

Other Names

Med Rec Number MR00138518

Reg Status

DEP SDC

PHILLIP,BROWN

EMR Number T00136389

Soc Sec Num

549-73-3391

Birthdate 02/01/1974

Age 51 Birth Sex M

VIP

VIP Comment

Patient Address

Patient Employer

401 S 2ND ST

PROFAC HOLDINGS LLC

DUNCAN, OK 73533

United States

E-Mail

Conf Comm Address

Phone Number Phone Type

573-208-8942 Cell Phone

573-741-9194 Cell Phone

Marital Status Married

Country of Origin

Religion Assembly of God

In School

Affiliation

Registered Voter

Language English

Veteran Status

Interpreter Needed

Organ Donor

Education Level

Marketing Comm

Citizenship

Privacy Notice Date 06/11/25

Place of Birth

Physical Handicaps

Ethnicity / Additional Ethnicities

Race / Additional Races

Non Hispanic or Latino

White

Personal Contacts

Person to Notify

Relationship Spouse

BROWN,SHEILA

401 S 2ND ST

DUNCAN, OK 73533

United States

Phone Number Phone Type

573-741-9194 Cell Phone

Guarantor

Guarantor Employer

GN00037832

Relationship Self

PROFAC HOLDINGS LLC

BROWN,PHILLIP M

401 S 2ND ST

DUNCAN, OK 73533

United States

Email

Phone Number

Phone Type

573-208-8942      Cell Phone  
 573-741-9194      Cell Phone

**Financial Class**

Financial Class Blue Cross

**Standard Insurance Order      Medicare Part B Order      Medicare Part D Order**

BC BS OF OKLAHOMA  
 SELF PAY

**Insurances**

Name	BC BS OF OKLAHOMA	Coverage Plan	211217
Policy Number	TWX836063455	Group Name	
Address	PO BOX 655924	Group Number	211217
City, State, Zip	DALLAS, TX 75266-5924	Employment Status	
Country		Employer Name	
Phone	800-722-3730	Location	
Fax		Copay	Deductible
Email		Eligibility Status Received	Status Date 08/11/25

Release Info	Yes	Exp Info Date
Assign Benefits	Yes	

Subscriber	BROWN,PHILLIP M	Birth Sex	M
Pat Rel to Subs	Self	Soc Sec Num	549-73-3391
Address	401 S 2ND ST	Marital Status	Married
City, State, Zip	DUNCAN, OK 73533	Race	White
Country	United States	Citizenship	United States
Email		Language	English
Birthdate	02/01/1974		

Phone Number	Phone Type
573-208-8942	Cell Phone
573-741-9194	Cell Phone

Occurrence Codes	Date	Time	Accident State
DSI	11 - Onset of Symptom-OP Ther	08/11/25	

**Physicians****Other Physicians/Association**

Primary Care Hurst,Melissa Marie

Admitting

Attending Watkins,Kayla Michele

Family

Emergency

Reg Date/Time 08/11/25 08:27

Discharge Date/Time 08/11/25 12:00

Requested Accom

Discharge Disposition Home/Assisted Living - 01

Room Rate Accom

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

**Entry Code**

Facility Directory Yes

Clergy Visit Yes

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit SCREENING

Last Hospitalization

From Date:

Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
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**Diagnosis Codes**

Eff Date	Num	Code	Name	POA
----------	-----	------	------	-----

**Procedure Codes**

Num	Code	Name	Date	Surgeon/Assisting
-----	------	------	------	-------------------

MR:   
**BROWN, PHILLIP MICHAEL**  
 FN# D00048170708  
 MR# MR00133518  
 DOB: 02/01/1974 REG DT: 08/11/25  
 ATT DR: Watkins, Kayla Michele  
 FN: 

## Duncan Anesthesia Associates, Inc.

### ANESTHESIA CHARGE LIST

1/1/2023

BILLING OFFICE USE POS 21	POS 22
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Provider: Surgeon: K. W. Atkin  
 Anesthesia: General SAB (MAC) Epidural Bier Other TIVA

Procedure: Cesarean CPT: 00811 ICD10: Z12.11 Modifier: \_\_\_\_\_  
 CPT: 0812 ICD10: P6C.0 Modifier: \_\_\_\_\_  
 CPT:  ICD10: 163.893 Modifier: \_\_\_\_\_  
 CPT:  ICD10:  Modifier: \_\_\_\_\_

#### Diagnosis:

MUST BE DOCUMENTED	Base Units:	Time Units:	SPECIAL PROCEDURES
<b>MEASURE #424</b> TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9	<u>3</u>	<u>/</u>	<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64415 (8 units) <input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units)
<b>MEASURE #404</b> SMOKER <input type="radio"/> YES <input checked="" type="radio"/> NO	<u>0</u>	<u>0</u>	<input type="checkbox"/> Elective Procedure <input type="checkbox"/> Instructed to abstain <input type="checkbox"/> Abstained
<b>IF NO SKIP TO NEXT MEASURE</b> Abstained <input type="radio"/> Yes <input type="radio"/> No  <b>IF NO SKIP TO NEXT MEASURE</b> Inhalation Anes Recvd <input type="radio"/> Yes <input checked="" type="radio"/> No	<u>0</u>	<u>0</u>	<b>TOTAL UNITS:</b> <u>0</u>  <b>ABG7 PAIN ASSESSMENT</b> <input type="checkbox"/> LUCID <input type="checkbox"/> NON COMMUNICATE <input type="checkbox"/> PACU OICU <b>PAIN LEVEL</b> <u>C</u> OUT OF 10 <b>SCCG 8 DEPRESSION ASSESS.</b> <input type="checkbox"/> YES O NO <b>DX:</b> <u> </u> REQUIRED <b>ASA SCORE</b> <u>2</u> REQUIRED <input type="checkbox"/> iPack Block 64999 (7 units)
3 Pt Risk Factors <input type="radio"/> Yes <input type="radio"/> No PONV Therapy <input type="radio"/> Yes <input type="radio"/> No	<u>0</u>	<u>0</u>	

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Patient BILLY RAYBURN BREWER Sr - D00048231500

Other Names

Med Rec Number MR00142930

Reg Status

DEP SDC

BREWER,BILLY

EMR Number T00140189

Soc Sec Num

449-06-4840

BREWER,BILLY RAYBURN

Birthdate 02/20/1955

Age 70 Birth Sex M

VIP

VIP Comment

## Patient Address

## Patient Employer

280852 E 1780 RD

RETIRED

COMANCHE, OK 73529

United States

## E-Mail

Conf Comm Address

Phone Number	Phone Type
580-721-1489	Cell Phone

Marital Status Widowed

Country of Origin

Religion Pentecostal

In School

Affiliation

Registered Voter

Language English

Veteran Status

Interpreter Needed

Organ Donor

Education Level

Marketing Comm

Citizenship

Privacy Notice Date 03/08/24

Place of Birth

## Physical Handicaps

Ethnicity / Additional Ethnicities	Race / Additional Races
Non Hispanic or Latino	White

## Personal Contacts

Person to Notify	Relationship	Child
WYATT,NATASHA		

PAULS VALLEY, OK 73075

United States

Phone Number	Phone Type
NONE	Home Phone

## Guarantor

## Guarantor Employer

GN00074957 Relationship Self

RETIRED

BREWER,BILLY RAYBURN Sr

280852 E 1780 RD

COMANCHE, OK 73529

United States

Email

Phone Number	Phone Type
--------------	------------

580-721-1489 Cell Phone

**Financial Class****Financial Class** Medicare**Standard Insurance Order**    **Medicare Part B Order**    **Medicare Part D Order**

MEDICARE

SELF PAY

**Insurances**

Name	MEDICARE	Coverage Plan
Policy Number	7GK0UK7EW34	Group Name
Address	PO BOX 3114	Group Number
	ATTN: PART A CLAIMS	Employment Status
City, State, Zip	MECHANICSBURG, PA 17055-1829	Employer Name
Country	US	Location
Phone	855-252-8782	Copay      Deductible      Coinsurance
Fax		Eligibility Status Received      Status Date 08/11/25
Email		

Release Info	Yes	Exp Info Date
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Assign Benefits	Yes
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Subscriber	BREWER,BILLY RAYBURN Sr	Birth Sex	M
Pat Rel to Subs	Self	Soc Sec Num	449-06-4840
Address	280852 E 1780 RD	Marital Status	Widowed
City, State, Zip	COMANCHE, OK 73529	Race	White
Country	United States	Citizenship	United States
Email		Language	English
Birthdate	02/20/1955		

Phone Number	Phone Type
580-721-1489	Cell Phone

Occurrence Codes	Date	Time	Accident State
DSI	11 - Onset of Symptom-OP Ther	08/11/25	

**Physicians****Other Physicians/Association**

Primary Care Tate,Steven A

Roberson,Matthew Wayne

Admitting

Attending Miller,Byron Ronald

Family

Emergency

Reg Date/Time 08/11/25 08:54

Discharge Date/Time 08/11/25 11:22

Requested Accom

Discharge Disposition Home/Assisted Living - 01

Room Rate Accom

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

**Facility Directory**

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit      Age-related nuclear cataract, left eye 2

Last Hospitalization

From Date:

Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

<b>Eff Date</b>	<b>Code</b>	<b>Name</b>	<b>Alt</b>	<b>Source</b>
08/11/25	H25.12	Age-related nuclear cataract, left eye	No	SUR
<b>Diagnosis Codes</b>				
<b>Eff Date</b>	<b>Num</b>	<b>Code</b>	<b>Name</b>	<b>POA</b>
08/04/25 -	1	H25.12	Age-related nuclear cataract,	
<b>Procedure Codes</b>				
<b>Num</b>	<b>Code</b>	<b>Name</b>	<b>Date</b>	<b>Surgeon/Assisting</b>

MR: BREWER,BILLY RAYBURN Sr  
 FN# D000482231500 70  
 MNR# MR00142930  
 DOB: 02/20/1955 REG DT: 08/11/25  
 ATT DR:Miller,Byron Ronald  
 FN: 

Duncan Anesthesia Associates, Inc.  
ANESTHESIA CHARGE LIST

1/1/2023

Rutherford  
Mil

		BLOCK PROCEDURE	
SURGERY	START:	STOP:	TOTAL:

Anesthesia:	General	SAB	MAC	Epidural	Bier	Other	TIVA
Procedure:	<u>Cystostomy - 20L</u>			CPT: <u>02142</u>		ICD10: <u>475.12</u>	Modifier: _____

Provider:	<u>DR:Miller,Byron Ronald</u>	CPT:	<u>02142</u>	ICD10:	<u>475.12</u>
Surgeon:	<u>Mil</u>	CPT:		ICD10:	
Anesthesia:	General	SAB	MAC	ICD10:	
Procedure:	<u>Cystostomy - 20L</u>	CPT:		ICD10:	
		CPT:		ICD10:	
		CPT:		ICD10:	
		CPT:		ICD10:	

Diagnosis:

MUST BE DOCUMENTED	Base Units:	Time Units:	SPECIAL PROCEDURES
<input checked="" type="checkbox"/> MEASURE #424 TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9	<u>4</u>	<u>2</u>	<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64415 (8 units) <input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 622270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units) <input type="checkbox"/> Epidural Steroid 62322 (8 units) <input type="checkbox"/> Daily Epidural Mgmt 01996 (3 units) <input type="checkbox"/> Art Line 36620 (3 units)
<input type="checkbox"/> MEASURE #404 SMOKER <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> ABG7 PAIN ASSESSMENT <input checked="" type="checkbox"/> TOTAL UNITS: <u>6</u>		<input type="checkbox"/> Non Communicate <input type="checkbox"/> LUCID <input type="checkbox"/> PACU <input type="checkbox"/> OUT OF 10 <input type="checkbox"/> PAIN LEVEL <input type="checkbox"/> SCG 8 DEPRESSION ASSESS. <input type="checkbox"/> NO REQUIRED <input type="checkbox"/> YES DX <input type="checkbox"/> ASA SCORE <u>3</u> REQUIRED
<input type="checkbox"/> IF NO SKIP TO NEXT MEASURE <input checked="" type="checkbox"/> Elective Procedure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Instructed to abstain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Abstained	<input type="checkbox"/> MEASURE #430 Inhalation Anes Recvd <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> IF NO SKIP TO NEXT MEASURE <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 3 Pt Risk Factors <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> PONV Therapy		<input type="checkbox"/> PICC Placement 36569 (6 units) MEASURE #76 <input type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input type="checkbox"/> Adductor Canal Block 64447 (8 units) <input type="checkbox"/> Intubation Emergency 31500 (5 units) <input type="checkbox"/> iPack Block 64999 (7 units)

**Patient** RICHARD WILLIAM VANSILL - D00048243646**Other Names**

**Med Rec Number** MR00145774    **Reg Status** ADM IN  
**EMR Number** T00142686    **Soc Sec Num** 443-56-9319  
**Birthdate** 01/26/1953  
**Age** 72    **Birth Sex** M  
**VIP**  
**VIP Comment**

**Patient Address****Patient Employer**

1405 S KING PL

DUNCAN, OK 73533

**E-Mail****Conf Comm Address**

<b>Phone Number</b>	<b>Phone Type</b>
NONE	Home Phone

<b>Marital Status</b>	Single	<b>Country of Origin</b>
<b>Religion</b>	None	In School
<b>Affiliation</b>		Registered Voter
<b>Language</b>	English	Veteran Status
<b>Interpreter Needed</b>		Organ Donor
<b>Education Level</b>		Marketing Comm
<b>Citizenship</b>		<b>Privacy Notice Date</b> 08/06/25
<b>Place of Birth</b>		

**Physical Handicaps**

<b>Ethnicity / Additional Ethnicities</b>	<b>Race / Additional Races</b>
Non Hispanic or Latino	White

**Personal Contacts**

<b>Person to Notify</b>	<b>Relationship</b>	Neighbor
FRANKLIN, CHARLOTTE		

DUNCAN, OK 73533  
United States

<b>Phone Number</b>	<b>Phone Type</b>
580-736-9985	Cell Phone

**Guarantor****Guarantor Employer**

GN00038696	<b>Relationship</b>	Self
VANSILL, RICHARD WILLIAM		
1405 S KING PL		

DUNCAN, OK 73533

**Email**

<b>Phone Number</b>	<b>Phone Type</b>
---------------------	-------------------

NONE Home Phone

**Financial Class****Financial Class** Medicare**Standard Insurance Order** **Medicare Part B Order** **Medicare Part D Order**

MEDICARE

SELF PAY

**Insurances**

Name	MEDICARE	Coverage Plan
Policy Number	7CV7W05VV51	Group Name
Address	PO BOX 3114	Group Number
	ATTN: PART A CLAIMS	Employment Status
City, State, Zip	MECHANICSBURG, PA 17055-1829	Employer Name
Country	US	Location
Phone	855-252-8782	Copay      Deductible      Coinsurance
Fax		Eligibility Status Received      Status Date 08/06/25
Email		

Release Info	Yes	Exp Info Date
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Assign Benefits	Yes
-----------------	-----

Subscriber	VANSILL,RICHARD WILLIAM	Birth Sex	M
Pat Rel to Subs	Self	Soc Sec Num	443-56-9319
Address	1405 S KING PL	Marital Status	Single
City, State, Zip	DUNCAN, OK 73533	Race	White
Country		Citizenship	
Email		Language	English
Birthdate	01/26/1953		

Phone Number	Phone Type
NONE	Home Phone

Occurrence Codes	Date	Time	Accident State
DSI	11 - Onset of Symptom-OP Ther	08/06/25	

**Physicians****Other Physicians/Association**

Primary Care	None,Physician	Sheaman,Landon T Garrett
Admitting	Koduri,Vijay	Gibbon,Jordan B
Attending	Koch,Karley	Watkins,Kayla Michele
Family		Carter,Mihaela
Emergency	Petersen,James Robert	

Reg Date/Time	08/06/25 23:28	Discharge Date/Time
Requested Accom	Private	Discharge Disposition
Room Rate Accom	P	
Room/Bed	202-01	
Service	Medical	
Location	Tower 2	

Admit Priority	Emergency
Admit Source	Home
Newborn Admit Src	
Entry Code	

Facility Directory No

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit OSTEOMYELITIS SEPSIS

Last Hospitalization

From Date:

Thru Date:

**ICD10 Codes**

Admit Diagnosis B87.9 Myiasis, unspecified

**Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
08/06/25	B87.9	Myiasis, unspecified	No	OM
08/06/25	L03.90	Cellulitis, unspecified	No	OM
08/06/25	A41.9	Sepsis, unspecified organism	No	EmrClinDoc
08/06/25	M86.9	Osteomyelitis, unspecified	No	EmrClinDoc
08/06/25	N39.0	Urinary tract infection, site not specif	No	EmrClinDoc
08/06/25	Z72.0	Tobacco use	No	EmrClinDoc
08/06/25	M79.89	Other specified soft tissue disorders	No	EmrClinDoc
08/06/25	I73.9	Peripheral vascular disease, unspecified	No	EmrClinDoc
08/06/25	E11.40	Type 2 diabetes mellitus with diabetic n	No	EmrClinDoc
08/06/25	I69.30	Unspecified sequelae of cerebral infarct	No	EmrClinDoc

**Diagnosis Codes**

Eff Date	Num	Code	Name	POA
08/06/25 -	1	B87.9	Myiasis, unspecified	
08/06/25 -	2	L03.90	Cellulitis, unspecified	
08/06/25 -	3	A41.9	Sepsis, unspecified organism	
08/06/25 -	4	M86.9	Osteomyelitis, unspecified	
08/06/25 -	5	N39.0	Urinary tract infection, site	
08/06/25 -	6	Z72.0	Tobacco use	E
08/06/25 -	7	M79.89	Other specified soft tissue di	
08/06/25 -	8	I73.9	Peripheral vascular disease, u	
08/06/25 -	9	E11.40	Type 2 diabetes mellitus with	
08/06/25 -	10	I69.30	Unspecified sequelae of cerebr	E

**Procedure Codes**

Num	Code	Name	Date	Surgeon/Assisting

MR:   
 VANSILL, RICHARD WILLIAM  
 FN# D00048243646  
 MR# MR0014574  
 72  
 DOB: 01/26/1953 RM: 202  
 ATT DR: Koch, Karley AD: 08/06/25  
 FN: 

**Duncan Anesthesia Associates, Inc.**

**ANESTHESIA CHARGE LIST**

1/1/2023

BILLING OFFICE USE	POS 21
	POS 22

DOS:

PROVIDER: WNTS S-1175  
SURGEON: C Miller

ANESTHESIA: GENERAL SAB  MAC EPIDURAL BIER OTHER TIVA

PROCEDURE:

L1 lower extencty CPT: 01916 ICD10: T70.213 Modifier:  
Anesthesia via CPT:  ICD10:  Modifier:  
L2 lower Apparue CPT:  ICD10:  Modifier:  
 CPT:  ICD10:  Modifier:

DIAGNOSIS: Osteopelitis, flr healm w/ur cc

**MUST BE DOCUMENTED**

MEASURE #424

TEMP 30 MINS BEFORE OR 15 MINS AFTER

ANESTHESIA END TIME

TEMP GREATER OR EQUAL 95.9

MEASURE #404

YES  NO

IF NO SKIP TO NEXT MEASURE

Elective Procedure

Instructed to abstain

Abstained

MEASURE #430

Inhalation Anes Recvd

IF NO SKIP TO NEXT MEASURE

3 Pt Risk Factors

PoNV Therapy

Base Units:

Time Units:

6

2

**SPECIAL PROCEDURES**

Femoral Single 64447 (8 units)

Brachial Plexus Single 64415 (8 units)

Lumbar Epidural Continuous 62319 (8 units)

Thoracic Epidural Continuous 62318 (8 units)

Lumbar Puncture 62270 (8 units)

Emergency: 99140 (2 units)

Sciatic Single 64445 (7 units)

Ultrasound 76942-26 (2 units)

Nerve Block Post-op Pain 64450 Hip/64415 Shoulder (5 Units)

Epidural Steroid 62322 (8 units)

Daily Epidural Mgmt 01996 (3 units)

Art Line 36620 (3 units)

PICC Placement 36569 (6 units) MEASURE #76

Lumbar Blood Patch 62273 (8 units)

Adductor Canal Block 64447 (8 units)

Intubation Emergency 31500 (5 units)

iPack Block 64999 (7 units)

Measure Codes	
SURGERY	BLOCK PROCEDURE
START: <u>0811</u>	START: <u></u>
STOP: <u>0846</u>	STOP: <u></u>
TOTAL: <u>34</u>	TOTAL: <u></u>

Patient STEFANI LYNNAE WEST - D00048177380

Other Names

Med Rec Number MR00150361

Reg Status

DEP SDC

SKINNER,STEFANI LYNNAE

EMR Number T00146131

Soc Sec Num

440-06-8603

WEST,STEFANI

Birthdate 08/19/1991

Age 33 Birth Sex F

VIP

VIP Comment

## Patient Address

## Patient Employer

169764 N 2865 RD

NONE EMPLOYED

MARLOW, OK 73055

United States

E-Mail STEFANI@WEST.GS

Conf Comm Address

Phone Number

Phone Type

580-656-3836

Cell Phone

Marital Status Married

Country of Origin

Religion

In School

Affiliation

Registered Voter

Language English

Veteran Status

Interpreter Needed

Organ Donor

Education Level

Marketing Comm

Citizenship

Privacy Notice Date 12/16/20

Place of Birth

## Physical Handicaps

Ethnicity / Additional Ethnicities

Race / Additional Races

Non Hispanic or Latino

White

## Personal Contacts

Person to Notify

Relationship Spouse

WEST,BEAU

169764 N 2865 RD

MARLOW, OK 73055

United States

Phone Number

Phone Type

580-641-3226

Cell Phone

## Guarantor

## Guarantor Employer

GN00022299

Relationship Self

NONE EMPLOYED

WEST,STEFANI LYNNAE

169764 N 2865 RD

MARLOW, OK 73055

United States

Email STEFANI@WEST.GS

Phone Number

Phone Type

580-656-3836 Cell Phone

**Financial Class****Financial Class** Blue Cross**Standard Insurance Order**

BC BS OF OKLAHOMA

SELF PAY

**Medicare Part B Order****Medicare Part D Order****Insurances**

Name BC BS OF OKLAHOMA

Policy Number YUQ927780780

Address PO BOX 655924

City, State, Zip DALLAS, TX 75266-5924

Country

Phone 800-722-3730

Fax

Email

Release Info Yes

Assign Benefits Yes

Subscriber WEST, BEAU

Pat Rel to Subs Spouse

Address 1320 NORMANDY RD

City, State, Zip DUNCAN, OK 73533

Country

Email

Birthdate 06/26/1988

Phone Number

Phone Type

580-641-3226

**Occurrence Codes**

DSI 11 - Onset of Symptom-OP Ther

**Date****Time****Accident State**

08/11/25

**Physicians****Other Physicians/Association**

Primary Care Burton, Sherrie R

Admitting

Attending Watkins, Kayla Michele

Family

Emergency

Reg Date/Time 08/11/25 08:25

Requested Accom

Room Rate Accom

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

Discharge Date/Time 08/11/25 12:47

Discharge Disposition Home/Assisted Living - 01

Facility Directory Yes

Clergy Visit Yes

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit UMBILICAL HERNIA

Last Hospitalization

From Date:

Thru Date:

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ICD10 Codes

## Reason for Visit Diagnoses

Eff Date	Code	Name	Alt	Source
----------	------	------	-----	--------

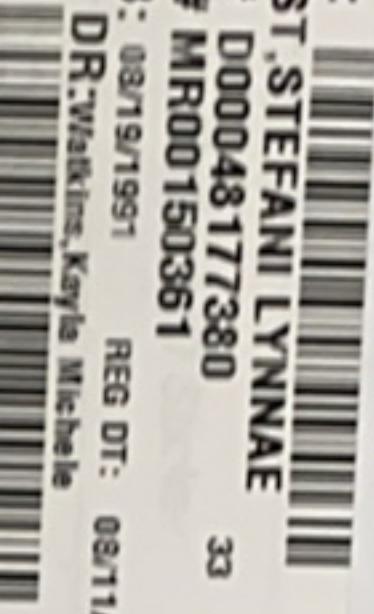
## Diagnosis Codes

Eff Date	Num	Code	Name	POA
----------	-----	------	------	-----

## Procedure Codes

Num	Code	Name	Date	Surgeon/Assisting
-----	------	------	------	-------------------

MR:  
WEST, STEFANI LYNNE  
FN# D00048177380 33  
MR# MR00150361  
DOB: 08/19/1991 REG DT: 08/11/25  
ATT DR: Watkins, Kayla Michele

FN:   
Provider: Watkins  
Surgeon: H.P.

**Duncan Anesthesia Associates, Inc.**  
**ANESTHESIA CHARGE LIST**

1/1/2023

BILLING OFFICE USE POS 21	POS 22
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SURGERY  
START: 1/20/2023  
STOP: 1/20/2023  
TOTAL: 1 hour

BLOCK PROCEDURE  
START: \_\_\_\_\_  
STOP: \_\_\_\_\_  
TOTAL: \_\_\_\_\_

Anesthesia:  General    SAB    MAC    Epidural    Bier    Other    TIVA

Procedure:  Robot Lap Umbilical    CPT: Q5840    ICD10: K42.1    Modifier: \_\_\_\_\_  
 Hernia Repair    CPT: \_\_\_\_\_    ICD10: \_\_\_\_\_    Modifier: \_\_\_\_\_  
 CPT: \_\_\_\_\_    ICD10: \_\_\_\_\_    Modifier: \_\_\_\_\_  
 CPT: \_\_\_\_\_    ICD10: \_\_\_\_\_    Modifier: \_\_\_\_\_

Diagnosis:

MUST BE DOCUMENTED	Base Units: <u>6</u> Time Units: <u>5</u>	SPECIAL PROCEDURES
MEASURE #424 TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9		<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64415 (8 units) <input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units) <input type="checkbox"/> Epidural Steroid 62322 (8 units) <input type="checkbox"/> Daily Epidural Mgmt 01996 (3 units)
MEASURE #404 SMOKER <input type="radio"/> YES <input checked="" type="radio"/> NO		SPECIAL PROCEDURES: _____ TOTAL UNITS: <u>11</u>
IF NO SKIP TO NEXT MEASURE Elective Procedure <input type="radio"/> Yes <input type="radio"/> No Instructed to abstain <input type="radio"/> Yes <input type="radio"/> No Abstained <input type="radio"/> Yes <input type="radio"/> No		ABG7 PAIN ASSESSMENT <input type="checkbox"/> LUCID <input checked="" type="checkbox"/> NON COMMUNICATE <input type="checkbox"/> PACU    OICU PAIN LEVEL _____ OUT OF 10 SCG 8 DEPRESSION ASSESS. <input type="checkbox"/> YES <input type="checkbox"/> NO Rx: <u>     </u> REQUIRED
3 Pt Risk Factors PONV Therapy		<input type="checkbox"/> ASA SCORE <u>1</u> REQUIRED <input type="checkbox"/> Art Line 36620 (3 units) <input type="checkbox"/> PICC Placement 36569 (6 units) MEASURE #76 <input type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input type="checkbox"/> Adductor Canal Block 64447 (8 units) <input type="checkbox"/> Intubation Emergency 31500 (5 units) <input type="checkbox"/> iPack Block 64999 (7 units)

**Patient** DANA DENISE SHEA - D00047807821**Other Names****Med Rec Number** MR00154070**Reg Status**

DEP SDC

SHEA,DANA

**EMR Number** T00149528**Soc Sec Num**

448-76-2817

**Birthdate** 02/18/1965**Age** 60      **Birth Sex** F**VIP****VIP Comment****Patient Address****Patient Employer**

814 W PAYNE ST

UNKNOWN

MARLOW, OK 73055-1604

United States

**E-Mail** SHEADD06@GMAIL.COM**Conf Comm Address**

<b>Phone Number</b>	<b>Phone Type</b>
580-756-7954	Cell Phone

**Marital Status** Married**Country of Origin****Religion** None**In School****Affiliation****Registered Voter****Language** English**Veteran Status****Interpreter Needed****Organ Donor****Education Level****Marketing Comm****Citizenship****Privacy Notice Date** 04/25/25**Place of Birth****Physical Handicaps**

<b>Ethnicity / Additional Ethnicities</b>	<b>Race / Additional Races</b>
Non Hispanic or Latino	White

**Personal Contacts****Person to Notify****Relationship** Spouse

SHEA,MICHAEL

814 W PAYNE ST

MARLOW, OK 73055-1604

United States

<b>Phone Number</b>	<b>Phone Type</b>
580-756-7953	Cell Phone

**Guarantor****Guarantor Employer**

GN00012246

**Relationship** Self

UNKNOWN

SHEA,DENA DENISE

814 W PAYNE ST

MARLOW, OK 73055-1604

United States

**Email** SHEADD06@GMAIL.COM

<b>Phone Number</b>	<b>Phone Type</b>
---------------------	-------------------

Duncan Regional Hospital		Account Inquiry		Page: 2
				Date: 08/11/25 16:38
				McIntyre,Karen
580-756-7954	Cell Phone			
<b>Financial Class</b>				
<b>Financial Class</b> Medicaid				
<b>Standard Insurance Order</b>		<b>Medicare Part B Order</b>		<b>Medicare Part D Order</b>
HUMANA HEALTHY HORIZONS				
SELF PAY				
<b>Insurances</b>				
Name	HUMANA HEALTHY HORIZONS		Coverage Plan	
Policy Number	H73874195		Group Name	
Address	PO BOX 14601		Group Number	
City, State, Zip	LEXINGTON, KY 40512-4601		Employment Status	
Country			Employer Name	
Phone	855-223-9868		Location	
Fax			Copay	Deductible
Email			Eligibility Status Received	Coinsurance
Release Info	Yes		Status Date 08/11/25	
Assign Benefits	Yes			
Subscriber	SHEA,DANA DENISE		Birth Sex	F
Pat Rel to Subs	Self		Soc Sec Num	448-76-2817
Address	814 W PAYNE ST		Marital Status	Married
City, State, Zip	MARLOW, OK 73055-1604		Race	White
Country	United States		Citizenship	United States
Email	SHEADD06@GMAIL.COM		Language	English
Birthdate	02/18/1965			
Phone Number	Phone Type			
580-756-7954	Cell Phone			
Authorization Number	<b>Referral Number</b>			
NO AUTH REQUIRED				
Eff Date	Exp Date	Referral Type	Status	Referred By Referred To
<b>Accident Data</b>				
Type	Within 24 Hours			
Date/Time	Accident Comments			
Place of Accident	Description			
Police Involved				
Nature of Injury				
Originally Treated at				
Occurrence Codes	Date	Time	Accident State	
DSI	11 - Onset of Symptom-OP Ther		08/11/25	
<b>Physicians</b>				
<b>Primary Care</b> Murray,Nathan Daniel				
Admitting				
<b>Other Physicians/Association</b>				
Sheaman,Landon T Garrett				

**Attending** Gibbon, Jordan B**Family****Emergency**

Reg Date/Time 08/11/25 07:22

Discharge Date/Time 08/11/25 15:33

Requested Accom

Discharge Disposition Home/Assisted Living - 01

Room Rate Accom

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

Facility Directory

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit LT FOOT ARTHRITIS

Last Hospitalization

From Date:

Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
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**Diagnosis Codes**

Eff Date	Num	Code	Name	POA
----------	-----	------	------	-----

**Procedure Codes**

Num	Code	Name	Date	Surgeon/Assisting
-----	------	------	------	-------------------

MR:  
SHEA,DANA DENISE  
FN# D00047807821 60  
MR# MR00154070  
DOB: 02/18/1965 REG DT: 08/11/25  
ATT DR: Gibbons,Jordan B

FN:   
Provider: J. Palmer  
Surgeon: J. Gibbons

Duncan Anesthesia Associates, Inc.  
ANESTHESIA CHARGE LIST

1/1/2023

BILLING OFFICE USE  
POS 21  
POS 22

8-11-25  
J. Palmer  
J. Gibbons

Procedure: <u>L Foot L4 Tarsometatarsal fusion</u>	CPT: <u>01480</u>	ICD10: <u>M79.472</u>	Modifier: <u></u>
	CPT: <u></u>	ICD10: <u></u>	Modifier: <u></u>
	CPT: <u></u>	ICD10: <u></u>	Modifier: <u></u>
	CPT: <u></u>	ICD10: <u></u>	Modifier: <u></u>

Measure Codes	

Diagnosis:

MUST BE DOCUMENTED	SPECIAL PROCEDURES
Base Units: <u>3</u> Time Units: <u>14</u>	<input type="radio"/> Femoral Single 64447 (8 units) <input type="radio"/> Brachial Plexus Single 64415 (8 units) <input type="radio"/> Lumbar Epidural Continuous 62319 (8 units) <input type="radio"/> Thoracic Epidural Continuous 62318 (8 units) <input type="radio"/> Lumbar Puncture 62270 (8 units) <input type="radio"/> Age: 99100 [<1 or >70] (1 unit) <input type="radio"/> Emergency: 99140 (2 units) <input checked="" type="radio"/> Sciatic Single 64445 (7 units) <input checked="" type="radio"/> Ultrasound 76942-26 (2 units) <input checked="" type="radio"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units) <input checked="" type="radio"/> Epidural Steroid 62322 (8 units) <input checked="" type="radio"/> Daily Epidural Mgmt 01996 (3 units) <input checked="" type="radio"/> Art Line 36620 (3 units) <input checked="" type="radio"/> PICC Placement 36569 (6 units) MEASURE #76 <input checked="" type="radio"/> O Intubation Emergency 31500 (5 units) <input checked="" type="radio"/> iPack Block 64999 (7 units)
IF NO SKIP TO NEXT MEASURE Elective Procedure Instructed to abstain Abstained	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No
MEASURE #424 ● TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9	<input checked="" type="radio"/> PS 3 (1 unit)+ <input type="radio"/> PS 4 (2 units) <input type="radio"/> PS 5 (3 units) <input type="radio"/> Age: 99100 [<1 or >70] (1 unit) <input type="radio"/> Emergency: 99140 (2 units)
SMOKER	<input type="radio"/> YES <input checked="" type="radio"/> NO
IF NO SKIP TO NEXT MEASURE Elective Procedure Instructed to abstain Abstained	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No
MEASURE #404	<input checked="" type="radio"/> TOTAL UNITS: <u>27</u> <input checked="" type="radio"/> SPECIAL PROCEDURES: <u>9</u>
MEASURE #430 Inhalation Anes Recvd	<input checked="" type="radio"/> Yes <input type="radio"/> No
IF NO SKIP TO NEXT MEASURE	<input checked="" type="radio"/> ABG7 PAIN ASSESSMENT <input type="radio"/> LUCID <input type="radio"/> NON COMMUNICATE <input checked="" type="radio"/> PACU OICU <input checked="" type="radio"/> PAIN LEVEL <u>2</u> OUT OF 10 <input checked="" type="radio"/> SCG 8 DEPRESSION ASSESS. <input checked="" type="radio"/> YES <input checked="" type="radio"/> NO <input checked="" type="radio"/> DX: <u>Negative</u> REQUIRED <input checked="" type="radio"/> ASA SCORE <u>3</u> REQUIRED
3 Pt Risk Factors PONV Therapy	<input type="radio"/> Yes <input checked="" type="radio"/> No <input checked="" type="radio"/> Yes <input type="radio"/> No

Patient LLOYD D COKER - D00048154181

Other Names

Med Rec Number MR00194581      Reg Status DEP SDC  
 EMR Number T00197031      Soc Sec Num 442-58-1883  
 Birthdate 06/08/1958  
 Age 67      Birth Sex M  
 VIP  
 VIP Comment

## Patient Address

## Patient Employer

171445 N 2770 RD      RETIRED

DUNCAN, OK 73533  
United States

E-Mail REFUSED

Conf Comm Address

Phone Number      Phone Type  
 580-369-8158      Cell Phone  
 580-369-8555      Cell Phone

Marital Status Married      Country of Origin  
 Religion      In School  
 Affiliation      Registered Voter

Language English      Veteran Status  
 Interpreter Needed      Organ Donor

Education Level      Marketing Comm  
 Citizenship      Privacy Notice Date 01/05/21  
 Place of Birth

## Physical Handicaps

Ethnicity / Additional Ethnicities      Race / Additional Races  
 Non Hispanic or Latino      White

## Personal Contacts

Person to Notify      Relationship Spouse  
 COKER,MARGRET  
 171445 N 2770 RD

DUNCAN, OK 73533  
United States

Phone Number      Phone Type  
 580-369-8555      Cell Phone

## Guarantor

## Guarantor Employer

GN00144803      Relationship Self      RETIRED  
 COKER,LLOYD D  
 171445 N 2770 RD

DUNCAN, OK 73533  
United States  
Email REFUSED

Phone Number      Phone Type

580-369-8158      Cell Phone  
 580-369-8555      Cell Phone

**Financial Class****Financial Class** Medicare**Standard Insurance Order**    **Medicare Part B Order**    **Medicare Part D Order**

MEDICARE

TRICARE FOR LIFE/WPS

SELF PAY

**Insurances**

<b>Name</b>	MEDICARE	<b>Coverage Plan</b>
<b>Policy Number</b>	6FK7JY1MP38	<b>Group Name</b>
<b>Address</b>	PO BOX 3114	<b>Group Number</b>
	ATTN: PART A CLAIMS	<b>Employment Status</b>
<b>City, State, Zip</b>	MECHANICSBURG, PA 17055-1829	<b>Employer Name</b>
<b>Country</b>	US	<b>Location</b>
<b>Phone</b>	855-252-8782	<b>Copay</b> <b>Deductible</b> <b>Coinsurance</b>
<b>Fax</b>		<b>Eligibility Status</b> Received <b>Status Date</b> 08/11/25
<b>Email</b>		

<b>Release Info</b>	Yes	<b>Exp Info Date</b>
---------------------	-----	----------------------

<b>Assign Benefits</b>	Yes
------------------------	-----

<b>Subscriber</b>	COKER,LLOYD D	<b>Birth Sex</b>	M
<b>Pat Rel to Subs</b>	Self	<b>Soc Sec Num</b>	442-58-1883
<b>Address</b>	171445 N 2770 RD	<b>Marital Status</b>	Married
<b>City, State, Zip</b>	DUNCAN, OK 73533	<b>Race</b>	White
<b>Country</b>	United States	<b>Citizenship</b>	United States
<b>Email</b>	REFUSED	<b>Language</b>	English
<b>Birthdate</b>	06/08/1958		

<b>Phone Number</b>	<b>Phone Type</b>
580-369-8158	Cell Phone
580-369-8555	Cell Phone

<b>Name</b>	TRICARE FOR LIFE/WPS	<b>Coverage Plan</b>
<b>Policy Number</b>	442581883	<b>Group Name</b>
<b>Address</b>	PO BOX 7890	<b>Group Number</b>
<b>City, State, Zip</b>	MADISON, WI 53707-7890	<b>Employment Status</b>
<b>Country</b>		<b>Employer Name</b>
<b>Phone</b>	1-866-773-0404	<b>Location</b>
<b>Fax</b>		<b>Copay</b> <b>Deductible</b> <b>Coinsurance</b>
<b>Email</b>		<b>Eligibility Status</b> Received <b>Status Date</b> 08/11/25

<b>Release Info</b>	Yes	<b>Exp Info Date</b>
---------------------	-----	----------------------

<b>Assign Benefits</b>	Yes
------------------------	-----

<b>Subscriber</b>	COKER,LLOYD D	<b>Birth Sex</b>	M
<b>Pat Rel to Subs</b>	Self	<b>Soc Sec Num</b>	442-58-1883
<b>Address</b>	171445 N 2770 RD	<b>Marital Status</b>	Married
<b>City, State, Zip</b>	DUNCAN, OK 73533	<b>Race</b>	White
<b>Country</b>	United States	<b>Citizenship</b>	United States
		<b>Language</b>	English

Email REFUSED  
 Birthdate 06/08/1958

Phone Number Phone Type  
 580-369-8158 Cell Phone  
 580-369-8555 Cell Phone

Occurrence Codes	Date	Time	Accident State
DSI 11 - Onset of Symptom-OP Ther	08/11/25		

**Physicians****Other Physicians/Association**

Primary Care None, Physician

Admitting

Attending Watkins, Kayla Michele

Family

Emergency

Reg Date/Time 08/11/25 07:21

Discharge Date/Time 08/11/25 10:45

Requested Accom

Discharge Disposition Home/Assisted Living - 01

Room Rate Accom

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

Facility Directory

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit SCREENING

Last Hospitalization

From Date:

Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
----------	------	------	-----	--------

**Diagnosis Codes**

Eff Date	Num	Code	Name	POA
----------	-----	------	------	-----

**Procedure Codes**

Num	Code	Name	Date	Surgeon/Assisting
-----	------	------	------	-------------------

MR:  
COKER, LLOYD D  
FN# D00048154181 67  
M# MR00194581  
DOB: 06/08/1958 REG DT: 09/11/25  
ATT DR: "Watkins, Kayla Michele FN: 

### Duncan Anesthesia Associates, Inc.

#### ANESTHESIA CHARGE LIST

1/1/2023

BILLING OFFICE USE  
POS 21  
POS 22

Provider: WNT  
Surgeon: K. Watkins,

Anesthesia: General SAB MAC Epidural Bier Other TIVA  
 Procedure: Cervical CPT: 00812 ICD10: 212.11 Modifier: \_\_\_\_\_  
 CPT: \_\_\_\_\_ ICD10: \_\_\_\_\_ Modifier: \_\_\_\_\_  
 CPT: \_\_\_\_\_ ICD10: \_\_\_\_\_ Modifier: \_\_\_\_\_

Measure Codes	

#### Diagnosis:

MUST BE DOCUMENTED	Base Units	SPECIAL PROCEDURES
MEASURE #424 TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9	<u>3</u> Time Units: <u>l</u>	<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64415 (8 units) <input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units)
MEASURE #404 SMOKER IF NO SKIP TO NEXT MEASURE Elective Procedure Instructed to abstain Abstained	<u>O YES <input checked="" type="checkbox"/> NO</u>  <u>TOTAL UNITS:</u> <input checked="" type="checkbox"/>	<input type="checkbox"/> ABG7 PAIN ASSESSMENT <input type="checkbox"/> LUCID <input type="checkbox"/> NON COMMUNICATE <input type="checkbox"/> PACU <input type="checkbox"/> OICU <u>PAIN LEVEL</u> <u>OUT OF 10</u> <u>SCG &amp; DEPRESSION ASSESS.</u> <input type="checkbox"/> YES <input type="checkbox"/> QNO <input type="checkbox"/> REQUIRED <u>DX:</u> <u> </u> <u>Q ASA SCORE:</u> <u>2</u> <u>REQUIRED</u>
MEASURE #430 Inhalation Anes Recvd	<u>O Yes <input checked="" type="checkbox"/> No</u>	<input type="checkbox"/> Art Line 36620 (3 units) <input type="checkbox"/> PICC Placement 36569 (6 units) MEASURE #76 <input type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input type="checkbox"/> Adductor Canal Block 64447 (8 units) <input type="checkbox"/> Intubation Emergency 31500 (5 units) <input type="checkbox"/> iPack Block 64999 (7 units)
IF NO SKIP TO NEXT MEASURE 3 Pt Risk Factors PONV Therapy	<u>O Yes <input checked="" type="checkbox"/> No</u> <u>O Yes <input checked="" type="checkbox"/> No</u>	

**Patient** TONJA LYNN WOOTHTAKEWAHBITTY - D00048216139**Other Names****Med Rec Number** MR00212140**Reg Status**

DEP SDC

WOOTHTAKEWAHBIT,TONJA LYNN

**EMR Number** T00216692**Soc Sec Num**

444-88-2211

**Birthdate** 09/28/1981**Age** 43      **Birth Sex** F**VIP****VIP Comment****Patient Address****Patient Employer**

630 W OREGON ST

COMPLETE HOME HEALTH

1 SW 11th St Suite 120

TEMPLE, OK 73568

United States

LAWTON, OK 73502

**E-Mail** TONJALUNA62@GMAIL.COM

580-351-6565

**Conf Comm Address****Occupation** PART**Employer Status** Full-Time**Phone Number****Phone Type**

580-360-8290

Cell Phone

**Marital Status** Divorced**Country of Origin****Religion**

In School

**Affiliation**

Registered Voter

**Language** English

Veteran Status

**Interpreter Needed**

Organ Donor

**Education Level**

Marketing Comm

**Citizenship****Privacy Notice Date** 05/01/23**Place of Birth****Physical Handicaps****Ethnicity / Additional Ethnicities****Race / Additional Races**

Hispanic or Latino

Other Race

**Personal Contacts****Primary Contact****Relationship** Sibling

LUNA,MELISSA

TEMPLE, OK 73568

United States

**Phone Number****Phone Type**

580-360-8298

Cell Phone

**Guarantor****Guarantor Employer**

GN00171164

**Relationship** Self

COMPLETE HOME HEALTH

WOOTHTAKEWAHBITTY,TONJA LYNN

1 SW 11th St Suite 120

630 W OREGON ST

LAWTON, OK 73502

TEMPLE, OK 73568

580-351-6565

United States

**Occupation** PART**Email** TONJALUNA62@GMAIL.COM**Emp Status** Full-Time**Phone Number****Phone Type**

580-360-8290 Cell Phone

**Financial Class****Financial Class** Medicaid**Standard Insurance Order**    **Medicare Part B Order**    **Medicare Part D Order**

MEDICAID

SELF PAY

**Insurances**

Name	MEDICAID	Coverage Plan
Policy Number	B38151349	Group Name
Address	PO BOX 18430	Group Number
City, State, Zip	OKLAHOMA CITY, OK 73154	Employment Status
Country		Employer Name
Phone	800-522-0310	Location
Fax		Copay      Deductible      Coinsurance
Email		Eligibility Status Received      Status Date 08/11/25

<b>Release Info</b>	Yes	<b>Exp Info Date</b>
<b>Assign Benefits</b>	Yes	

<b>Subscriber</b>	WOOTHTAKEWAHBITTY, TONJA LYNN	<b>Birth Sex</b>	F
<b>Pat Rel to Subs</b>	Self	<b>Soc Sec Num</b>	444-88-2211
<b>Address</b>	630 W OREGON ST	<b>Marital Status</b>	Divorced
City, State, Zip	TEMPLE, OK 73568	<b>Race</b>	Other Race
Country	United States	<b>Citizenship</b>	United States
Email	TONJALUNA62@GMAIL.COM	<b>Language</b>	English
Birthdate	09/28/1981		

<b>Phone Number</b>	<b>Phone Type</b>
580-360-8290	Cell Phone

<b>Occurrence Codes</b>	<b>Date</b>	<b>Time</b>	<b>Accident State</b>
DSI	11 - Onset of Symptom-OP Ther	08/11/25	

**Physicians****Other Physicians/Association**

<b>Primary Care</b>	Piontek, Raven Jeaneene	Hallford, Steven Michael
---------------------	-------------------------	--------------------------

**Admitting****Attending** Watkins, Kayla Michele**Family****Emergency**

<b>Reg Date/Time</b>	08/11/25 09:43	<b>Discharge Date/Time</b>	08/11/25 13:15
<b>Requested Accom</b>		<b>Discharge Disposition</b>	Home/Assisted Living - 01

**Room Rate Accom****Room/Bed****Service****Location** Ambulatory Care Unit**Admit Priority** Elective**Admit Source** Physician Referral**Newborn Admit Src****Entry Code**

**Facility Directory**

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit Other specified diseases of gallbladder, Right upp

Last Hospitalization

From Date:

Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

<b>Eff Date</b>	<b>Code</b>	<b>Name</b>	<b>Alt</b>	<b>Source</b>
08/11/25	K82.8	Other specified diseases of gallbladder	No	SUR
08/11/25	R10.11	Right upper quadrant pain	No	SUR
08/11/25	R10.12	Left upper quadrant pain	No	SUR
<b>Diagnosis Codes</b>				
<b>Eff Date</b>	<b>Num</b>	<b>Code</b>	<b>Name</b>	<b>POA</b>
07/31/25 -	1	K82.8	Other specified diseases of ga	
07/31/25 -	2	R10.11	Right upper quadrant pain	
07/31/25 -	3	R10.12	Left upper quadrant pain	
<b>Procedure Codes</b>				
<b>Num</b>	<b>Code</b>	<b>Name</b>	<b>Date</b>	<b>Surgeon/Assisting</b>

MR: WOOTHAKEWABBITTY, TONJA  
 FN# D00048216139 43  
 MR# MR00212140  
 DOB: 09/28/1981 REG DT: 08/11/25  
 ATT DR: Watkins, Kayla Michele  
 FN: 

**Duncan Anesthesia Associates, Inc.**  
**ANESTHESIA CHARGE LIST**

1/1/2023

BILLING OFFICE USE  
POS 21  
POS 22

**Provider:** 8-11-25  
**Surgeon:** SLT  
**Anesthesia:** General Lap Chse  
**Procedure:** SAB MAC Epidural Bier Other TIVA  
**CPT:** 790 **ICD10:** K82.8 **Modifier:** \_\_\_\_\_  
**CPT:** \_\_\_\_\_ **ICD10:** R10.11 **Modifier:** \_\_\_\_\_  
**CPT:** \_\_\_\_\_ **ICD10:** R10.12 **Modifier:** \_\_\_\_\_  
**CPT:** \_\_\_\_\_ **ICD10:** \_\_\_\_\_ **Modifier:** \_\_\_\_\_

**Diagnosis:**

MUST BE DOCUMENTED	Base Units:	SPECIAL PROCEDURES
<b>MEASURE #424</b> <input checked="" type="checkbox"/> TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9	<u>7</u>	<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64415 (8 units) <input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units)
<b>IF NO SKIP TO NEXT MEASURE</b> <input checked="" type="checkbox"/> Elective Procedure <input checked="" type="checkbox"/> Instructed to abstain <input checked="" type="checkbox"/> Abstained <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<u>1</u>	<b>SPECIAL PROCEDURES:</b> _____
<b>MEASURE #430</b> <input checked="" type="checkbox"/> Inhalation Anes Recvd <b>IF NO SKIP TO NEXT MEASURE</b> <input checked="" type="checkbox"/> 3 Pt Risk Factors <input checked="" type="checkbox"/> PONV Therapy	<b>TOTAL UNITS:</b> <u>1</u>	<b>ABG7 PAIN ASSESSMENT</b> <input type="checkbox"/> LUCID <input type="checkbox"/> NON COMMUNICATE <input checked="" type="checkbox"/> PACU <input type="checkbox"/> OICU <u>PAIN LEVEL</u> <u>SCG 8 DEPRESSION ASSESS.</u> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> ONO <u>DX:</u> <u>dx</u> <u>med</u> <input type="checkbox"/> REQUIRED <input type="checkbox"/> ASA SCORE <u>2</u> REQUIRED



JENNER,TERRY LYNN  
400 TAYLOR ST  
APT 6  
RYAN, OK 73565  
United States  
[Email](#)

**Phone Number** 817-991-5434    **Phone Type** Cell Phone

**Financial Class**

**Financial Class** Medicare Advantage

**Standard Insurance Order**

AETNA MEDICARE 60054  
SELF PAY

**Medicare Part B Order****Medicare Part D Order**

<b>Insurances</b>			
<b>Name</b>	AETNA MEDICARE 60054	<b>Coverage Plan</b>	000003OK
<b>Policy Number</b>	101933416600	<b>Group Name</b>	
<b>Address</b>	PO BOX 981106	<b>Group Number</b>	000003OK
<b>City, State, Zip</b>	EL PASO, TX 79998-1106	<b>Employment Status</b>	
<b>Country</b>	US	<b>Employer Name</b>	RETIRED
<b>Phone</b>	800-624-0756	<b>Location</b>	
<b>Fax</b>		<b>Copay</b>	<b>Deductible</b>
<b>Email</b>		<b>Eligibility Status</b>	Received <b>Status Date</b> 08/11/25

**Release Info** Yes    **Exp Info Date**  
**Assign Benefits** Yes

<b>Subscriber</b>	JENNER,TERRY LYNN	<b>Birth Sex</b>	F
<b>Pat Rel to Subs</b>	Self	<b>Soc Sec Num</b>	451-76-3903
<b>Address</b>	400 TAYLOR ST	<b>Marital Status</b>	Widowed
	APT 6	<b>Race</b>	White
<b>City, State, Zip</b>	RYAN, OK 73565	<b>Citizenship</b>	United States
<b>Country</b>	United States	<b>Language</b>	English
<b>Email</b>			

**Birthdate** 12/10/1946

**Phone Number** 817-991-5434    **Phone Type** Cell Phone

**Authorization Number****Referral Number**

<b>Eff Date</b>	<b>Exp Date</b>	<b>Referral Type</b>	<b>Status</b>	<b>Referred By</b> <b>Referred To</b>
-----------------	-----------------	----------------------	---------------	---------------------------------------

<b>Occurrence Codes</b>	<b>Date</b>	<b>Time</b>	<b>Accident State</b>
DSI	11 - Onset of Symptom-OP Ther	08/11/25	

**Physicians**

**Primary Care** Gillispie,Allon F  
**Admitting**  
**Attending** Miller,Byron Ronald

**Other Physicians/Association**

Roberson,Matthew Wayne

Family

Emergency

Reg Date/Time 08/11/25 10:17

Discharge Date/Time 08/11/25 13:50

Requested Accom

Discharge Disposition Home/Assisted Living - 01

Room Rate Accom

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

Facility Directory

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit Age-related nuclear cataract, left eye 1

Last Hospitalization From Date: Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source	
08/11/25	H25.12	Age-related nuclear cataract, left eye	No	SUR	
<b>Diagnosis Codes</b>					
Eff Date	Num	Code	Name	POA	
08/06/25 -	1	H25.12	Age-related nuclear cataract,	<b>Procedure Codes</b>	
<b>Surgeon/Assisting</b>					
Num	Code	Name	Date	Surgeon/Assisting	

MR: **JENNER, TERRY LYNN**  
 FN# **D00048240162** REG DT: **08/11/25**  
 MR# **MR00213719**  
 DOB: **12/10/1946** ATT DR: **Miller, Byron Ronald**  
 FN: 

**Duncan Anesthesia Associates, Inc.**  
**ANESTHESIA CHARGE LIST**

1/1/2023

*8/11/25*  
*Hoover, Q*  
*M.16*

Provider: \_\_\_\_\_  
Surgeon: \_\_\_\_\_

Anesthesia: General SAB MAC

Procedure: *Cathartos & Irc* CPT: *00142* ICD10: *H25.1* Modifier: \_\_\_\_\_  
CPT: \_\_\_\_\_ ICD10: \_\_\_\_\_  
CPT: \_\_\_\_\_ ICD10: \_\_\_\_\_  
CPT: \_\_\_\_\_ ICD10: \_\_\_\_\_

**Diagnosis:**

**MUST BE DOCUMENTED**

Base Units: 2  
Time Units: 1

**MEASURE #424**  
TEMP 30 MINUTES BEFORE OR 15 MINS  
AFTER ANESTHESIA END TIME  
TEMP GREATER OR EQUAL 95.9

**MEASURE #404**

YES  NO

**IF NO SKIP TO NEXT MEASURE**  
Elective Procedure  Yes  No  
Instructed to abstain  Yes  No  
Abstained  Yes  No

**MEASURE #430**

Inhalation Anes Recvd  Yes  No

**IF NO SKIP TO NEXT MEASURE**  
3 Pt Risk Factors  Yes  No  
PONV Therapy  Yes  No

**BILLING OFFICE USE**  
POS 21 POS 22

SURGERY	BLOCK PROCEDURE
START: <u>/247</u>	START: _____
STOP: <u>/32/</u>	STOP: _____
TOTAL: <u>34</u>	TOTAL: _____

Measure Codes	
ICD10: <i>H25.1</i>	Modifier: _____
ICD10: _____	Modifier: _____
ICD10: _____	Modifier: _____
ICD10: _____	Modifier: _____

SPECIAL PROCEDURES	
<input type="radio"/>	Femoral Single 64447 (8 units)
<input type="radio"/>	Brachial Plexus Single 64415 (8 units)
<input type="radio"/>	Lumbar Epidural Continuous 62319 (8 units)
<input type="radio"/>	Thoracic Epidural Continuous 62318 (8 units)
<input type="radio"/>	Lumbar Puncture 622270 (8 units)
<input type="radio"/>	Sciatic Single 64445 (7 units)
<input type="radio"/>	Ultrasound 76942-26 (2 units)
<input type="radio"/>	Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units)
<input type="radio"/>	Epidural Steroid 62322 (8 units)
<input type="radio"/>	Daily Epidural Mgmt 01996 (3 units)
<input type="radio"/>	Art Line 36620 (3 units)
<input type="radio"/>	PIICC Placement 36569 (6 units) <b>MEASURE #76</b>
<input type="radio"/>	Lumbar Blood Patch 62273 (8 units)
<input type="radio"/>	Adductor Canal Block 64447 (8 units)
<input type="radio"/>	Intubation Emergency 31500 (5 units)
<input type="radio"/>	iPack Block 64999 (7 units)

Patient ASHLEY ANKA UNWIN - D00048127138

Other Names

Med Rec Number MR00218095      Reg Status DEP SDC  
 EMR Number T00224498      Soc Sec Num 543-39-9736  
 Birthdate 01/26/1990  
 Age 35      Birth Sex F  
 VIP  
 VIP Comment

## Patient Address

## Patient Employer

1801 TERRACE DR                                  ELK CROSSING NURSING AND REHAB  
 DUNCAN, OK 73533                                  811 W ELK AVE  
 United States                                        DUNCAN, OK 73533

## E-Mail

## Conf Comm Address

580-475-0750

Occupation CNA

Employer Status Full-Time

Phone Number      Phone Type  
 503-881-5151      Cell Phone

Marital Status Single    Country of Origin  
 Religion    In School  
 Affiliation    Registered Voter  
 Language English    Veteran Status  
 Interpreter Needed    Organ Donor  
 Education Level     Marketing Comm  
 Citizenship     Privacy Notice Date 03/07/24  
 Place of Birth

Physical Handicaps

Ethnicity / Additional Ethnicities  
 Non Hispanic or Latino

Race / Additional Races  
 White

## Personal Contacts

Person to Notify      Relationship Mother  
 UNWIN,DEBORAH  
 1801 TERRACE DR

DUNCAN, OK 73533  
 United States

Phone Number      Phone Type  
 503-798-5783      Cell Phone

Guarantor

GN00181610      Relationship Self  
 UNWIN,ASHLEY ANKA  
 1801 TERRACE DR  
 DUNCAN, OK 73533  
 United States  
 Email

## Guarantor Employer

ELK CROSSING NURSING AND REHAB  
 811 W ELK AVE  
 DUNCAN, OK 73533  
 580-475-0750  
 Occupation CNA  
 Emp Status Full-Time

Phone Number      Phone Type

503-881-5151 Cell Phone

**Financial Class****Financial Class** Medicaid**Standard Insurance Order**OKLAHOMA COMPLETE HEALTH  
SELF PAY**Medicare Part B Order****Medicare Part D Order****Insurances**

Name	OKLAHOMA COMPLETE HEALTH	Coverage Plan
Policy Number	B38328426	Group Name
Address	PO BOX 8001	Group Number
	ATTN CLAIM DEPARTMENT	Employment Status
City, State, Zip	FARMINGTON, MO 63640-8001	Employer Name
Country		Location
Phone	833-752-1664	Copay      Deductible      Coinsurance
Fax		Eligibility Status Received      Status Date 08/11/25
Email		

Release Info	Yes	Exp Info Date
Assign Benefits	Yes	

Subscriber	UNWIN,ASHLEY ANKA	Birth Sex	F
Pat Rel to Subs	Self	Soc Sec Num	543-39-9736
Address	1801 TERRACE DR	Marital Status	Single
City, State, Zip	DUNCAN, OK 73533	Race	White
Country	United States	Citizenship	United States
Email		Language	English
Birthdate	01/26/1990		

Phone Number	Phone Type
503-881-5151	Cell Phone

**Accident Data**

Type	Within 24 Hours
Date/Time	Accident Comments
Place of Accident	Description
Police Involved	
Nature of Injury	
Originally Treated at	

Occurrence Codes	Date	Time	Accident State
DSI      11 - Onset of Symptom-OP Ther	08/11/25		

**Physicians****Other Physicians/Association**

Primary Care Bardshier,Tonya L

Admitting

Attending Watkins,Kayla Michele

Family

Emergency

Reg Date/Time 08/11/25 11:23

Discharge Date/Time 08/11/25 15:45

Requested Accom

Discharge Disposition Home/Assisted Living - 01

## Room Rate Accom

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

Facility Directory Yes

Clergy Visit Yes

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit IRREDUCIBLE UMBILICAL HERNIA

Last Hospitalization

From Date:

Thru Date:

## ICD10 Codes

## Reason for Visit Diagnoses

Eff Date	Code	Name	Alt	Source
08/11/25	K42.0	Umbilical hernia with obstruction, witho	No	SUR
Diagnosis Codes				
Eff Date	Num	Code	Name	POA
07/10/25 -	1	K42.0	Umbilical hernia with obstruct	
Procedure Codes				
Num	Code	Name	Date	Surgeon/Assisting

MR:   
UNWIN,ASHLEY ANKA  
FN# D00048127138 35  
MR# MR00213095

35

DOB: 01/26/1990 REG DT: 08/11/25  
ATT DR: Watkins, Kayla Michele

FN: 

1/1/2023

Duncan Anesthesia Associates, Inc.  
ANESTHESIA CHARGE LIST

BILLING OFFICE USE  
POS 21  
POS 22

Provider: Surgeon:  
W.N.R  
K.Watkins

SURGERY		BLOCK PROCEDURE	
START:	1251	START:	
STOP:	1352	STOP:	
TOTAL:	57A	TOTAL:	

Anesthesia:  General SAB MAC Epidural Bier Other TVA

Procedure: L Ankle C Unbilical CPT: 00840 ICD10: K42.0 Modifier:  
Hernia repair CPT: ICD10: Modifier:  
CPT: ICD10: Modifier:

Measure Codes	

Diagnosis:

MUST BE DOCUMENTED	Base Units:	SPECIAL PROCEDURES
	<u>6</u>	<input type="radio"/> Femoral Single 64447 (8 units)
MEASURE #424 <input checked="" type="radio"/> TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9	<u>4</u>	<input type="radio"/> Brachial Plexus Single 64415 (8 units) <input type="radio"/> Lumbar Epidural Continuous 62319 (8 units) <input type="radio"/> Thoracic Epidural Continuous 62318 (8 units) <input type="radio"/> Lumbar Puncture 62270 (8 units) <input type="radio"/> Sciatic Single 64445 (7 units) <input type="radio"/> Ultrasound 76942-26 (2 units) <input type="radio"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units)
MEASURE #404		<input type="radio"/> Epidural Steroid 62322 (8 units) <input type="radio"/> Daily Epidural Mgmt 01996 (3 units)
SMOKER	<input type="radio"/> YES <input checked="" type="radio"/> NO	<input type="radio"/> ABG7 PAIN ASSESSMENT <input checked="" type="radio"/> LUCID <input type="radio"/> NON COMMUNICATE <input type="radio"/> PACU <input type="radio"/> OICU <input checked="" type="radio"/> OUT OF 10 PAIN LEVEL <u>C</u> SCG 8 DEPRESSION ASSESS.
IF NO SKIP TO NEXT MEASURE	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> YES <input type="radio"/> NO DX: <u> </u> REQUIRED <input checked="" type="radio"/> ASA SCORE <u>2</u> REQUIRED
Elective Procedure	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Inhalation Anes Recvd <input checked="" type="radio"/> Yes <input type="radio"/> No MEASURE #430 Inhalation Anes Recvd <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> MEASURE #76 NON COMMUNICATE PACU OICU OUT OF 10 PAIN LEVEL <u>C</u> SCG 8 DEPRESSION ASSESS.
Instructed to abstain	<input type="radio"/> Yes <input type="radio"/> No	
Abstained	<input type="radio"/> Yes <input type="radio"/> No	
IF NO SKIP TO NEXT MEASURE		
3 Pt Risk Factors	<input type="radio"/> Yes <input type="radio"/> No	
PoNV Therapy	<input type="radio"/> Yes <input type="radio"/> No	
		<input type="radio"/> iPack Block 64999 (7 units)

Patient Shylone Kelly - D00048247803

Other Names

Med Rec Number MR00226277      Reg Status DEP SDC  
 EMR Number T00234165      Soc Sec Num 447-74-5165  
 Birthdate 01/17/1978  
 Age 47      Birth Sex M  
 VIP  
 VIP Comment

## Patient Address

## Patient Employer

104 SW Timber Lane      UNKNOWN

INDIAHOMA, OK 73552  
United States

## E-Mail

Conf Comm Address

Phone Number      Phone Type  
 580-350-7308      Cell Phone

Marital Status	Country of Origin
Religion	In School
Affiliation	Registered Voter
Language English	Veteran Status
Interpreter Needed	Organ Donor
Education Level	Marketing Comm
Citizenship	Privacy Notice Date 06/11/25
Place of Birth	

## Physical Handicaps

Ethnicity / Additional Ethnicities      Race / Additional Races  
 Non Hispanic or Latino      White

## Personal Contacts

Emergency Contact      Relationship Sister  
 Washburn,Donna

Phone Number      Phone Type  
 580-350-7308      Cell Phone

## Guarantor

## Guarantor Employer

GN00195613      Relationship Self      UNKNOWN  
 Kelly,Shylone  
 104 SW Timber Lane  
 INDIAHOMA, OK 73552  
 United States  
 Email

Phone Number      Phone Type

580-350-7308 Cell Phone

**Financial Class****Financial Class** Medicare**Standard Insurance Order**    **Medicare Part B Order**    **Medicare Part D Order**

MEDICARE

MEDICAID

SELF PAY

**Insurances**

Name	MEDICARE	Coverage Plan
Policy Number	8QF1TP9GR16	Group Name
Address	PO BOX 3114	Group Number
	ATTN: PART A CLAIMS	Employment Status
City, State, Zip	MECHANICSBURG, PA 17055-1829	Employer Name
Country	US	Location
Phone	855-252-8782	Copay      Deductible      Coinsurance
Fax		Eligibility Status Received      Status Date 08/08/25
Email		

Release Info	Yes	Exp Info Date
--------------	-----	---------------

Assign Benefits	Yes
-----------------	-----

Subscriber	Kelly, Shylone	Birth Sex	M
Pat Rel to Subs	Self	Soc Sec Num	447-74-5165
Address	104 SW Timber Lane	Marital Status	
City, State, Zip	INDIAHOMA, OK 73552	Race	White
Country	United States	Citizenship	United States
Email		Language	English
Birthdate	01/17/1978		

Phone Number	Phone Type
580-350-7308	Cell Phone

Name	MEDICAID	Coverage Plan
Policy Number	002122811	Group Name
Address	PO BOX 18430	Group Number
City, State, Zip	OKLAHOMA CITY, OK 73154	Employment Status
Country		Employer Name
Phone	800-522-0310	Location
Fax		Copay      Deductible      Coinsurance
Email		Eligibility Status Received      Status Date 08/08/25

Release Info	Yes	Exp Info Date
--------------	-----	---------------

Assign Benefits	Yes
-----------------	-----

Subscriber	Kelly, Shylone	Birth Sex	M
Pat Rel to Subs	Self	Soc Sec Num	447-74-5165
Address	104 SW Timber Lane	Marital Status	
City, State, Zip	INDIAHOMA, OK 73552	Race	White
Country	United States	Citizenship	United States
Email		Language	English

Birthdate 01/17/1978

Phone Number 580-350-7308  
 Phone Type Cell Phone

Occurrence Codes	Date	Time	Accident State
DSI 11 - Onset of Symptom-OP Ther	08/11/25		

**Physicians****Other Physicians/Association**

Primary Care Miller,Douglas Che

Admitting

Attending Miller,Douglas Che

Family

Emergency

Reg Date/Time 08/11/25 08:05

Discharge Date/Time 08/11/25 11:10

Requested Accom

Discharge Disposition Home/Assisted Living - 01

Room Rate Accom

Room/Bed

Service

Location Cardiac Cath Lab

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

Facility Directory

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit Venous insufficiency (chronic) (peripheral)

Last Hospitalization

From Date:

Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
----------	------	------	-----	--------

08/11/25	R60.0	Localized edema	No	SUR
08/11/25	I87.2	Venous insufficiency (chronic) (peripher	No	SUR
08/11/25	I83.813	Varicose veins of bilateral lower extrem	No	SUR

**Diagnosis Codes**

Eff Date	Num	Code	Name	POA
08/07/25 -	1	R60.0	Localized edema	
08/07/25 -	2	I87.2	Venous insufficiency (chronic)	
08/07/25 -	3	I83.813	Varicose veins of bilateral lo	

**Procedure Codes**

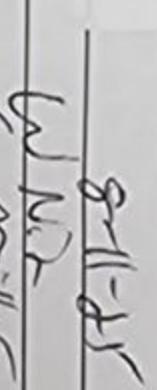
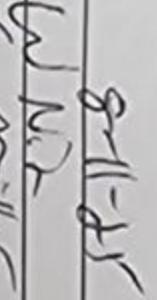
Num	Code	Name	Date	Surgeon/Assisting
-----	------	------	------	-------------------

MR:   
 Kelly, Shylone  
 FN# D00048247803 47  
 MR# MR00226277  
 DOB: 01/17/1978 REG DT: 08/11/25  
 ATT DR: Miller, Douglas Che  
 FN: 

**Duncan Anesthesia Associates, Inc.**  
**ANESTHESIA CHARGE LIST**

1/1/2023

13  
39  
BILLING OFFICE USE  
POS 21  
POS 22

Provider:   
 Surgeon: 

Anesthesia:	General	SAB	MAC	Epidural	Bier	Other	TVA
Procedure:	(R) Greater Saphenous						
		CPT: 01520	ICD10: L87.2	Modifier: _____	START: 0547	BLOCK PROCEDURE	
		CPT:	ICD10: R60.0	Modifier: _____	STOP: 0939	START: _____	
		CPT:	ICD10: L83.613	Modifier: _____	TOTAL: 52	STOP: _____	
		CPT:	ICD10:	Modifier: _____		TOTAL: _____	

**Diagnosis:**

MUST BE DOCUMENTED	Base Units: <u>3</u>	<b>SPECIAL PROCEDURES</b>	
		<input type="checkbox"/> Femoral Single 64447 (8 units)	<input type="checkbox"/> Brachial Plexus Single 64415 (8 units)
<b>MEASURE #424</b> <input checked="" type="checkbox"/> TEMP 30 MINUTES BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9		<input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units)	<input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units)
<b>MEASURE #404</b> <input type="checkbox"/> SMOKER <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<input type="checkbox"/> PS 3 (1 unit) <input type="checkbox"/> PS 4 (2 units) <input type="checkbox"/> PS 5 (3 units) <input type="checkbox"/> Age: 99100 [<1 or >70] (1 unit) <input type="checkbox"/> Emergency: 99140 (2 units)	<input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units)
<b>IF NO SKIP TO NEXT MEASURE</b> <input type="checkbox"/> Elective Procedure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Instructed to abstain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Abstained <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Epidural Steroid 62322 (8 units) <input type="checkbox"/> Daily Epidural Mgmt 01996 (3 units)	<input type="checkbox"/> Art Line 36620 (3 units) <input type="checkbox"/> PICC Placement 36569 (6 units) <b>MEASURE #76</b>
<b>IF NO SKIP TO NEXT MEASURE</b> <input type="checkbox"/> 3 Pt Risk Factors <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PONV Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> SCG 8 DEPRESSION ASSESS. <input checked="" type="checkbox"/> YES <input type="checkbox"/> ONO <input type="checkbox"/> REQUIRED <input type="checkbox"/> DX _____ <input type="checkbox"/> ASA SCORE <u>7</u> REQUIRED	<input type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input type="checkbox"/> Adductor Canal Block 64447 (8 units) <input type="checkbox"/> Intubation Emergency 31500 (5 units) <input type="checkbox"/> iPack Block 64999 (7 units)

Patient JACK MICHAEL BAKER - D00048251912

Other Names

Med Rec Number MR00226345

Reg Status

DEP SDC

EMR Number T00234246

Soc Sec Num

440-74-6855

Birthdate 06/23/1977

Age 48 Birth Sex M

VIP

VIP Comment

## Patient Address

## Patient Employer

13494 NE KLEEMAN RD

ELGIN PUBLIC SCHOOL

HWY 17 AND MIGHTY OWL AVE

ELGIN, OK 73538

ELGIN, OK 73538

United States

E-Mail JBAKER@ELGIN.NET

580-492-3663

Conf Comm Address

Occupation TEACHER

Employer Status Full-Time

Phone Number

Phone Type

405-996-0165

Cell Phone

Marital Status Married

Country of Origin

Religion

In School

Affiliation

Registered Voter

Language English

Veteran Status

Interpreter Needed

Organ Donor

Education Level

Marketing Comm

Citizenship

Privacy Notice Date 06/16/25

Place of Birth

## Physical Handicaps

Ethnicity / Additional Ethnicities

Race / Additional Races

Non Hispanic or Latino

White

## Personal Contacts

Next of Kin

Relationship Child

BAKER,JACK JR

13494 NE KLEEMAN RD

ELGIN, OK 73538

United States

Phone Number

Phone Type

580-678-7119

Cell Phone

Person to Notify

Relationship Spouse

BAKER,REBECCA

13494 NE KLEEMAN RD

ELGIN, OK 73538

United States

Phone Number

Phone Type

405-996-0166

Cell Phone

## Guarantor

## Guarantor Employer

GN00195726

Relationship Self

ELGIN PUBLIC SCHOOL

BAKER,JACK MICHAEL

13494 NE KLEEMAN RD

HWY 17 AND MIGHTY OWL AVE

ELGIN, OK 73538

United States

ELGIN, OK 73538

580-492-3663

Occupation TEACHER

Emp Status Full-Time

Email JBAKER@ELGIN.NET

**Phone Number** 405-996-0165      **Phone Type** Cell Phone

**Financial Class****Financial Class** Blue Cross**Standard Insurance Order**BC BS FEDERAL EMPLOYEE PROGRAM  
SELF PAY**Medicare Part B Order****Medicare Part D Order****Insurances****Name** BC BS FEDERAL EMPLOYEE PROGRAM**Coverage Plan** 112**Policy Number** R60603509**Group Name****Address** PO BOX 655924**Group Number** 112**City, State, Zip** DALLAS, TX 75266-5924**Employment Status****Country****Employer Name****Phone** 1-800-722-3130**Location****Fax****Copay**      **Deductible****Email****Coinsurance****Eligibility Status** Received**Status Date** 08/11/25**Release Info** Yes**Exp Info Date****Assign Benefits** Yes**Subscriber** BAKER,REBECCA A**Birth Sex** F**Pat Rel to Subs** Spouse**Soc Sec Num** 445-90-6359**Address** 13494 NE KLEEMAN**Marital Status****City, State, Zip** ELGIN, OK 73538**Race****Country** United States**Citizenship** United States**Email****Language****Birthdate** 03/10/1987

**Phone Number** 405-996-0166      **Phone Type** Cell Phone

**Occurrence Codes****Date****Time****Accident State**

DSI 11 - Onset of Symptom-OP Ther 08/11/25

**Physicians****Primary Care** Whiteman,Angelia Marie

Palmer,Haskell Trace

**Admitting****Attending** Watkins,Kayla Michele**Family****Emergency****Reg Date/Time** 08/11/25 10:07**Discharge Date/Time** 08/11/25 14:20**Requested Accom****Discharge Disposition** Home/Assisted Living - 01**Room Rate Accom**

Room/Bed

Service

Location Ambulatory Care Unit

Admit Priority Elective

Admit Source Physician Referral

Newborn Admit Src

Entry Code

Facility Directory

Clergy Visit

Adm Legal Status

Confidential

Conf Comment

Admit Comment

Dis Comment

Reason for Visit Postprocedural seroma of skin and subcutaneous tis

Last Hospitalization From Date: Thru Date:

**ICD10 Codes****Reason for Visit Diagnoses**

Eff Date	Code	Name	Alt	Source
08/11/25	L76.34	Postprocedural seroma of skin and subcut	No	SUR
<b>Diagnosis Codes</b>				
Eff Date	Num	Code	Name	POA
08/08/25 -	1	L76.34	Postprocedural seroma of skin	
<b>Procedure Codes</b>				
Num	Code	Name	Date	Surgeon/Assisting

MR:  
BAKER, JACK MICHAEL  
FN# D00048251912 48

MR# MR00226345

DOB: 06/23/1977 REG DT: 08/11/25

ATT DR: Watkins, Kaitlyn Michele

FN: 

**Duncan Anesthesia Associates, Inc.**  
**ANESTHESIA CHARGE LIST**

1/1/2023

BILLING OFFICE USE	
POS 21	POS 22

DOS: 8/11/25  
PROVIDER: H.P.  
SURGEON: Watkins

ANESTHESIA: GENERAL SAB MAC EPIDURAL BIER OTHER TIVA  
PROCEDURE: I+D Abdominal Abscess CPT: 00800  
post Hernia Repair CPT: \_\_\_\_\_  
CPT: \_\_\_\_\_  
ICD10: \_\_\_\_\_

SURGERY	BLOCK PROCEDURE
START: 1234	START: _____
STOP: 1323	STOP: _____
TOTAL: 49 min	TOTAL: _____

DIAGNOSIS: Post Surgical Abdominal Abscess

<b>MUST BE DOCUMENTED</b>					
MEASURE #424 TEMP 30 MINS BEFORE OR 15 MINS AFTER ANESTHESIA END TIME TEMP GREATER OR EQUAL 95.9					
MEASURE #404 SMOKER <input type="radio"/> YES <input checked="" type="radio"/> NO IF NO SKIP TO NEXT MEASURE Elective Procedure <input type="radio"/> YES <input type="radio"/> NO Instructed to abstain <input type="radio"/> YES <input type="radio"/> NO Abstained <input type="radio"/> YES <input type="radio"/> NO					
MEASURE #430 Inhalation Anes Recvd <input checked="" type="radio"/> YES <input type="radio"/> NO IF NO SKIP TO NEXT MEASURE 3 Pt Risk Factors <input type="radio"/> YES <input checked="" type="radio"/> NO PONV Therapy <input type="radio"/> YES <input type="radio"/> NO					
Base Units:	<u>4</u>	Time Units:	<u>3</u>	ICD10:	<u>776.34</u>
TOTAL UNITS: <u>4</u>			Modifier: _____		
ABG7 PAIN ASSESSMENT: <input checked="" type="radio"/> LUCID <input checked="" type="radio"/> NON COMMUNICATE <input checked="" type="radio"/> PACU <input checked="" type="radio"/> PAIN LEVEL _____ OUT OF 10 SCG 8 DEPRESSION ASSESS. <input checked="" type="radio"/> YES <input type="radio"/> NO dx: _____			Measure Codes		
IF NO SKIP TO NEXT MEASURE MEASURE #76 PICC Placement 36569 (6 units) Lumbar Blood Patch 62273 (8 units) Adductor Canal Block 64447 (8 units) Intubation Emergency 31500 (5 units) Pack Block 64999 (7 units)					
ASA SCORE <u>3</u> REQUIRED					

Patient DEBORAH TRICHE - D00048144182

Other Names

Med Rec Number MR00226795      Reg Status      DEP SDC  
 EMR Number T00234783      Soc Sec Num      442-66-0679  
 Birthdate 06/10/1959  
 Age 66      Birth Sex F  
 VIP  
 VIP Comment

## Patient Address

## Patient Employer

1802 SE 165TH      RETIRED

LAWTON, OK 73501  
United States

## E-Mail

Conf Comm Address

Phone Number      Phone Type  
 580-284-4727      Cell Phone

Marital Status Married      Country of Origin  
 Religion      In School  
 Affiliation      Registered Voter  
 Language English      Veteran Status  
 Interpreter Needed      Organ Donor  
 Education Level      Marketing Comm  
 Citizenship      Privacy Notice Date 08/11/25  
 Place of Birth

## Physical Handicaps

Ethnicity / Additional Ethnicities      Race / Additional Races  
 Non Hispanic or Latino      White

## Personal Contacts

Person to Notify      Relationship Spouse  
 TRICHE,HERMAN

Phone Number      Phone Type  
 580-284-1999      Cell Phone

## Guarantor

## Guarantor Employer

GN00196617      Relationship Self      RETIRED  
 TRICHE,DEBORAH  
 1802 SE 165TH

LAWTON, OK 73501  
United States  
Email

Phone Number      Phone Type

580-284-4727 Cell Phone

**Financial Class****Financial Class** Champus/VA**Standard Insurance Order** — **Medicare Part B Order** — **Medicare Part D Order** —

CHAMP VA 84146

HUMANA HEALTHY HORIZONS

SELF PAY

**Insurances**

<b>Name</b>	CHAMP VA 84146	<b>Coverage Plan</b>		
<b>Policy Number</b>	442660679	<b>Group Name</b>		
<b>Address</b>	ATTN: CHAMPVA PO BOX 30750	<b>Group Number</b>		
<b>City, State, Zip</b>	TAMPA, FL 33630-3750	<b>Employment Status</b>		
<b>Country</b>		<b>Employer Name</b>		
<b>Phone</b>	1-800-733-8387	<b>Location</b>		
<b>Fax</b>		<b>Copay</b>	<b>Deductible</b>	<b>Coinsurance</b>
<b>Email</b>		<b>Eligibility Status</b>	Received	<b>Status Date</b> 08/11/25

<b>Release Info</b>	Yes	<b>Exp Info Date</b>
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<b>Assign Benefits</b>	Yes
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<b>Subscriber</b>	TRICHE,DEBORAH	<b>Birth Sex</b>	F
<b>Pat Rel to Subs</b>	Self	<b>Soc Sec Num</b>	442-66-0679
<b>Address</b>	1802 SE 165TH	<b>Marital Status</b>	Married
<b>City, State, Zip</b>	LAWTON, OK 73501	<b>Race</b>	White
<b>Country</b>	United States	<b>Citizenship</b>	United States
<b>Email</b>		<b>Language</b>	English
<b>Birthdate</b>	06/10/1959		

<b>Phone Number</b>	<b>Phone Type</b>
580-284-4727	Cell Phone

<b>Name</b>	HUMANA HEALTHY HORIZONS	<b>Coverage Plan</b>		
<b>Policy Number</b>	H69900028	<b>Group Name</b>		
<b>Address</b>	PO BOX 14601	<b>Group Number</b>		
<b>City, State, Zip</b>	LEXINGTON, KY 40512-4601	<b>Employment Status</b>		
<b>Country</b>		<b>Employer Name</b>		
<b>Phone</b>	855-223-9868	<b>Location</b>		
<b>Fax</b>		<b>Copay</b>	<b>Deductible</b>	<b>Coinsurance</b>
<b>Email</b>		<b>Eligibility Status</b>	Received	<b>Status Date</b> 08/11/25

<b>Release Info</b>	Yes	<b>Exp Info Date</b>
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<b>Assign Benefits</b>	Yes
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<b>Subscriber</b>	TRICHE,DEBORAH	<b>Birth Sex</b>	F
<b>Pat Rel to Subs</b>	Self	<b>Soc Sec Num</b>	442-66-0679
<b>Address</b>	1802 SE 165TH	<b>Marital Status</b>	Married
<b>City, State, Zip</b>	LAWTON, OK 73501	<b>Race</b>	White
<b>Country</b>	United States	<b>Citizenship</b>	United States
<b>Email</b>		<b>Language</b>	English

Birthdate 06/10/1959

Phone Number 580-284-4727  
 Phone Type Cell Phone

Authorization Number	Referral Number			
NO AUTH REQ				
Eff Date	Exp Date	Referral Type	Status	Referred By Referred To

Authorization Number	Referral Number			
Eff Date	Exp Date	Referral Type	Status	Referred By Referred To

Occurrence Codes	Date	Time	Accident State
DSI	11 - Onset of Symptom-OP Ther	08/11/25	

Physicians		Other Physicians/Association	
Primary Care	Aiku,Idorenyin Leslie	Hallford,Steven Michael	
Admitting			
Attending	Watkins,Kayla Michele		
Family			
Emergency			

Reg Date/Time	08/11/25 06:29	Discharge Date/Time	08/11/25 11:35
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Requested Accom		Discharge Disposition	Home/Assisted Living - 01
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Room Rate Accom	
-----------------	--

Room/Bed	
----------	--

Service	
---------	--

Location	Ambulatory Care Unit
----------	----------------------

Admit Priority	Elective
----------------	----------

Admit Source	Physician Referral
--------------	--------------------

Newborn Admit Src	
-------------------	--

Entry Code	
------------	--

Facility Directory	
--------------------	--

Clergy Visit	
--------------	--

Adm Legal Status	
------------------	--

Confidential	
--------------	--

Conf Comment	
--------------	--

Admit Comment	
---------------	--

Dis Comment	
-------------	--

Reason for Visit	Malignant melanoma of other part of trunk
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Last Hospitalization	From Date:	Thru Date:
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#### ICD10 Codes

#### Reason for Visit Diagnoses

Eff Date	Code	Name	Alt	Source
08/11/25	C43.59	Malignant melanoma of other part of trun	No	SUR
		Diagnosis Codes		

Eff Date	Num	Code	Name	POA
07/15/25 -	1	C43.59	Malignant melanoma of other pa	
<b>Procedure Codes</b>				
Num	Code	Name	Date	Surgeon/Assisting

MR:  
TRICHE, DEBORAH  
FN# D00048144182 66  
MR# MR00226795

DOB: 06/10/1959

REG DT: 08/11/25

ATT DR: Watkins, Kayla Michele

FN: 

# Duncan Anesthesia Associates, Inc.

## ANESTHESIA CHARGE LIST

1/1/2023

Provider: SH  
Surgeon:

Procedure: <u>Exc. Melanoma LLL</u>	SAB	MAC	Epidural	Bier	Other	TIVA
<u>Lymphoscintigraphy</u>						
	CPT:	860	CPT:			ICD10: C43,59
	CPT:		CPT:			ICD10:
	CPT:		CPT:			ICD10:
	CPT:		CPT:			ICD10:

SURGERY	BLOCK PROCEDURE
START: <u>841</u>	START: _____
STOP: <u>1005</u>	STOP: _____
TOTAL: <u>1;24</u>	TOTAL: _____

Measure Codes

### Diagnosis:

MUST BE DOCUMENTED	Base Units: <u>4</u>	SPECIAL PROCEDURES
MEASURE #424	Time Units: <u>6</u>	<input type="checkbox"/> Femoral Single 64447 (8 units) <input type="checkbox"/> Brachial Plexus Single 64415 (8 units) <input type="checkbox"/> Lumbar Epidural Continuous 62319 (8 units) <input type="checkbox"/> Thoracic Epidural Continuous 62318 (8 units) <input type="checkbox"/> Lumbar Puncture 62270 (8 units) <input type="checkbox"/> Sciatic Single 64445 (7 units) <input type="checkbox"/> Ultrasound 76942-26 (2 units) <input type="checkbox"/> Nerve Block for Post-op Pain 64450 Hip/64415 Shoulder (5 Units) <input type="checkbox"/> Epidural Steroid 62322 (8 units) <input type="checkbox"/> Daily Epidural Mgmt 01996 (3 units) <input type="checkbox"/> Art Line 36620 (3 units) <input type="checkbox"/> PICC Placement 36569 (6 units) MEASURE #76 <input type="checkbox"/> Lumbar Blood Patch 62273 (8 units) <input type="checkbox"/> Adductor Canal Block 64447 (8 units) <input type="checkbox"/> Intubation Emergency 31500 (5 units) <input type="checkbox"/> iPack Block 64999 (7 units)
IF NO SKIP TO NEXT MEASURE	TOTAL UNITS: <u>10</u>	
Elective Procedure		
Instructed to abstain		
Abstained		
SMOKER	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
SPECIAL PROCEDURES:		
ABG7 PAIN ASSESSMENT	<input type="checkbox"/> LUCID <input type="checkbox"/> NON COMMUNICATE <input type="checkbox"/> PACU —OICU <input type="checkbox"/> PAIN LEVEL OUT OF 10 <input type="checkbox"/> SCG 8 DEPRESSION ASSESS. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ON MED REQUIRED <input type="checkbox"/> DX: <u>WAS</u>	
MEASURE #430	<input type="checkbox"/> Inhalation Anes Recvd <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
IF NO SKIP TO NEXT MEASURE	<input type="checkbox"/> 3 Pt Risk Factors <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> PONV Therapy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	<input type="checkbox"/> ASA SCORE <u>2</u> REQUIRED	