Example Inc. Credit Union

999-99-99-99 16769 3 C 001 11 S 66 002
ALEJANDRO ROSALEZ
400 KOZEY LIGHT, WEBERBURGH, HI 29922

Your consolidated statement

For 04/04/2022

Contact us

example.com

(858) LLL-0101 or
(858) 555-0101

Do more with digital banking

Bank without having to leave home. Check your account balances, make transfers, pay bills and deposit checks with your mobile device. If you are not enrolled in digital banking, it only lakes a minute Gel started today at example.com/U.

Example Bank, Member FDIC. To learn more, visit **example.com/ABCXYZ**.

If you are traveling outside of the USA and have concerns about accessing your account while you are traveling, please contact your Branch Banker or call us at 858-LLL-0101.

Summary of your accounts

ACCOUNT NAME	ACCOUNT NUMBER	BALANCE ($)	DETAILS ON
CHECKING	**003525801543**	**5,657.47**	**page 1**
Total checking and money market savings accounts		$5,657.47	
SAVINGS	**352580154336**	**53,578.24**	**page 3**
Total savings accounts		$53,578.24	

Checking and money market savings accounts

■ **CHECKING** 003525801543

Account summary

Your previous balance as of 04/04/2022	$41,982.42
Checks	- 1,177.33
Other withdrawals, debits and service charges	- 567.18
Deposits, credits and interest	+ 3,124.75
Your new balance as of 06/17/2020	= $5,657.47

Average Posted Balance in Statement Cycle $65,360.07

Checks

DATE	CHECK #	AMOUNT ($)	DATE	CHECK #	AMOUNT ($)	DATE	CHECK #	AMOUNT ($)
05/26	**1401**	**450.00**	**06/05**	***965025**	**101.39**	**06/09**	**985026**	**150.00**

* indicates a skip in sequential check numbers above this item

Total checks = $701.39

Other withdrawals, debits and service charges can be found in full statement

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
11-2234-10190

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe, John	M X / F	Doe, Jane
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse X / Child / Other	7. INSURED'S ADDRESS (No., Street)
123 Any Street		123 Any Street
CITY: Any City / STATE: CA	8. PATIENT STATUS: Single / Married X / Other; Employed / Full-Time Student / Part-Time Student	CITY: Any City / STATE: CA
ZIP CODE: 92127 / TELEPHONE (Include Area Code): (858) 555-0100		ZIP CODE: 92127 / TELEPHONE (INCLUDE AREA CODE): (858) 555-0100
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: G4683A
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / X NO	a. INSURED'S DATE OF BIRTH MM DD YY: 06 12 65 / SEX M / F X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M / F	b. AUTO ACCIDENT? YES / X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Group Insur of Amer.
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / X NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Jdoe DATE: 01-15-2021

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: JaneDoe

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
10 11 21	10 11 21	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
Self		
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES / NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. R11.0 3. R19.7		
2. K59.00 4. K92.1		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 11 21		11		90801			170.00					1234567890
2 10 11 21		11		90805			140.00					1234567890
3 10 11 21		11		90812			93.00					1234567890
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
555-88-9999 X		X YES / NO	$ 405.00	$	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
MtJackson 10/11/21 SIGNED DATE	Mateo Jackson PhD 9876 Healthcare Ave Any Town, CA 92126	Mateo Jackson PhD 9876 Healthcare Ave (920) 555-0101 Any Town, CA 92126 PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

Not a Memorial Hospital
Of Collier
Reg: PN/S/11011, Non-Profit
Contact: (999)-(888)-(1234)

Physician Hospital Discharge Summary

Provider: Mateo Jackson, Phd

Patient: John Doe **Provider's Pt ID:** 00988277891 **Patient Gender:** Male

Attachment Control Number: XA/7B/00338763

Visit (Encounter)

Admitted: 07-Sep-2020 **Discharged:** 08-Sep-2020

Discharged to: Home with support services

Assessment

Reported Symptoms / History of present illness:

35 yo M c/o stomach problems since 2 montsh ago. Patient reports epigastric abdominal pain non-radiating. Pain is described as gnawing and burning, intermitent lasting 1-2 hours, and gotten progressively worse. Antacids used to alleviate pain but not anymore; nothing exhacerbates pain. Pain unrelated to daytime or to meals. Patient denies constipation or diarrhea. Patient denies blood in stool but have noticed them darker. Patient also reports nausea. Denies recent illness or fever. He also reports fatigue since 2 weeks ago and bloating after eating.
Patient ID: NARH-36640
ROS: Negative except for above findings
Meds: Motrin once/week. Tums previously.
PMHx: Back pain and muscle spasms. No Hx of surgery. NKDA.
FHx: Uncle has a bleeding ulcer.
Social Hx: Smokes since 15 yo, 1/2-1 PPD. No recent EtOH use. Denies illicit drug use. Works on high elevation construction. Fast food diet. Exercises 3-4 times/week but stopped 2 weeks ago.

Discharge

Discharge Studies Summary:

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

VS/3S/Q990-7550/1090001004290

Attending Provider Notes

Provider: Dr Mateo Jackson, PhD

Patient: John Doe

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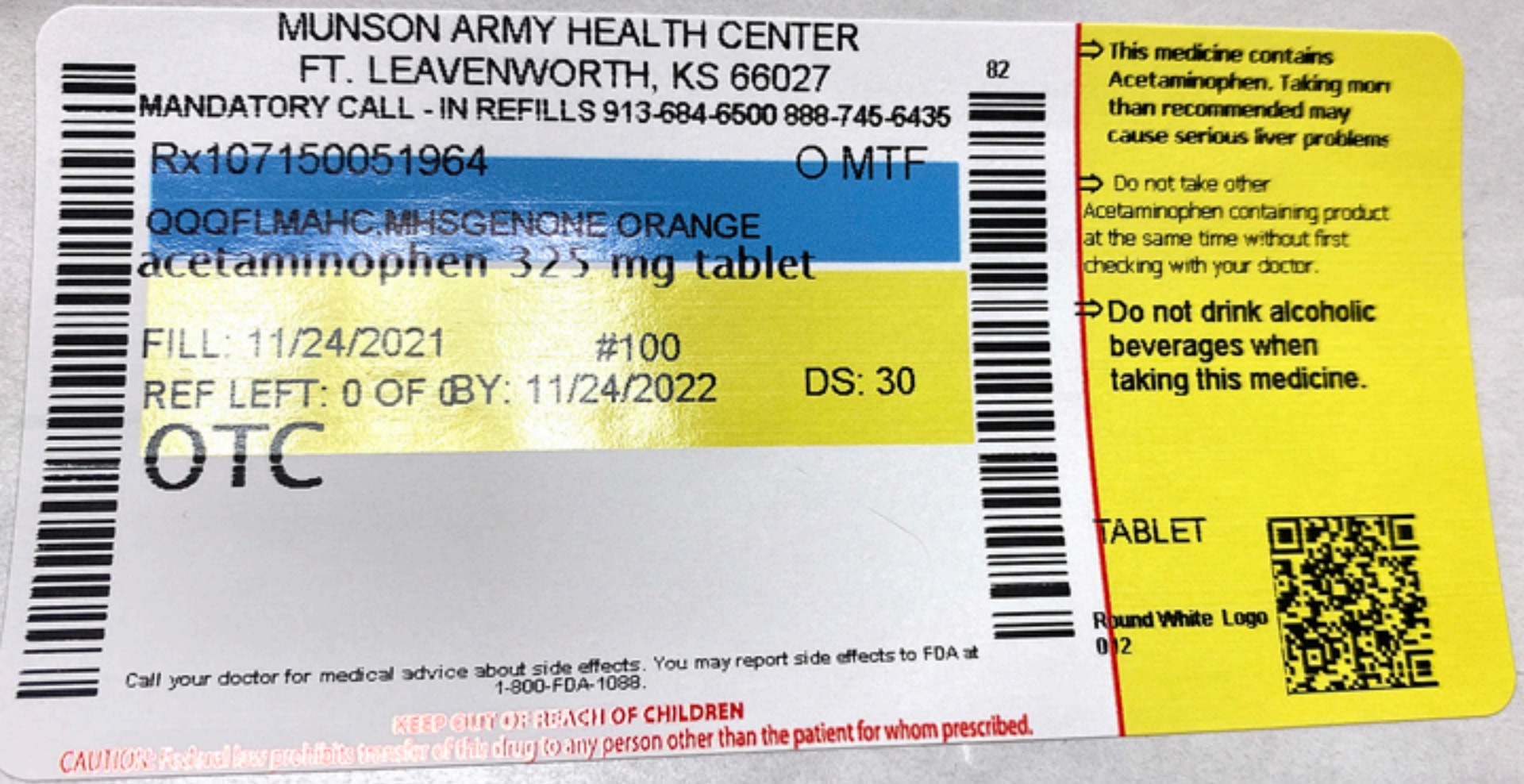
35 yo M c/o stomach problems since last 2 months. Patient reports epigastric abdominal pain non-radiating. Pain is described as gnawing and burning, intermittent lasting 1-2 hours, and gotten progressively worse. Antacids used to alleviate pain but not anymore; nothing exacerbates pain. Pain unrelated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

ROS: Negative except for above findings
Meds: Motrin once/week. Tums previously.
PMHx: Back pain and muscle spasms. No Hx of surgery.
NKDA.
FHx: Uncle has a bleeding ulcer.
Social Hx: Smokes since 15 yo, 1/2-1 PPD. No recent EtOH use. Denies illicit drug use. Works on high elevation construction. Fast food diet. Exercises 3-4 times/week but stopped 2 weeks ago.


UNITED STATES
DRIVER LICENSE
EXPIRES 09/21/2034
DL 6383736743891101
CLASS C
END NONE
LN DOE
FN JOHN
123 ANY STREET
ANY CITY, CA 92127
DOB 09/21/1970
SSN ON FILE
DONOR
SEX M
HAIR BLK
EYES BLU
HGT 5'11"
WGT 185LB
US 11/05/2001266737RP/AMER/19


MUNSON ARMY HEALTH CENTER
FT. LEAVENWORTH, KS 66027
MANDATORY CALL - IN REFILLS 913-684-6500 888-745-6435
82
Rx107150051964
O MTF
QQQFLMAHC,MHSGENONE ORANGE
acetaminophen 325 mg tablet
FILL: 11/24/2021
#100
REF LEFT: 0 OF 0
BY: 11/24/2022
DS: 30
OTC
This medicine contains Acetaminophen. Taking more than recommended may cause serious liver problems
Do not take other Acetaminophen containing product at the same time without first checking with your doctor.
Do not drink alcoholic beverages when taking this medicine.
TABLET
Round White Logo
012
Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.
KEEP OUT OF REACH OF CHILDREN
CAUTION: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed.

Performance Health

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

[-LB]

Remittance Advice

Forwarding Service Requested

J67F
SCRANTON QUINCY CLINIC COMPANY LLC
PO BOX 27944
BELFAST ME 04915-2031

[2,742]

Customer Service

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

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

Claim#: 1270082
Patient: Patients One
Patient #:

Member:
Member ID: 87533XXXX

CLAIM DETAIL

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

Patient's Responsibility: $0.00

Claim Summary

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

Payment Details

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

Additional Information

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

Important Information

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

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

Your Rights and Protections Against Surprise Medical Bills

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

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

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

Group Insurance of America | Community Plan

Health Plan (80840) 911-87726-04

Member ID: 11-2234-10190 Group Number: AAAAA

Member:

JOHN DOE

PCP Name: **MATEO JACKSON, PhD**

PCP Phone: **(920)-555-0101**

Payer ID: 87726

InsurRX

Rx Bin: 610494
Rx Grp: AAAAA
Rx PCN: 00000

0501

Administered by Amer. Insurance Community Plan, Inc.

MEDICAID PLAN OF XXXX

Not-A Real Hospital of Washington

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

MEDICAL INSURANCE INVOICE

Invoice # 23-AUK9909 Date: April 1, 2022

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

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

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

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

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

Hospital Name
Address

Surgical Pathology Report

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

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

Clinical History: Large Gastric Mass

Specimen: Gastric Mucosa

Diagnosis

Stomach, Partial Gastrectomy:

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

Gross Description

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

Microscopic Description

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

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

Comment

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