01-1125-CD
IN RE: BRANDON SHIMMEL etal

BRANDON SHIMMEL, a minor, by his Parent and natural guardian, KATHY SHIMMEL,	:	IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PA
Petitioner	:	No. 01-1125-CD

RULE RETURNABLE

AND NOW, this 16th day of July, 2001, a Rule is hereby granted to show cause why the within Petition for Court Approval of Settlement of a Minor's Claim should not be granted.

This rule is returnable on the 10th day of September, 2001, at 9:00 a.m./~~p.m.~~ in Courtroom No. 1 at the Clearfield County Courthouse in Clearfield, Pennsylvania.

BY THE COURT:

FILED

JUL 17 2001
9:10 12cc atty Harrington
William A. Shaw
Prothonotary

BRANDON SHIMMEL, a minor, by his Parent and natural guardian, KATHY SHIMMEL,	:	IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PA
Petitioner	:	No. 01-1125-CD

PROPOSED ORDER

AND NOW, this _____ day of _____, 2001, upon consideration of the within Petition, it is hereby ORDERED, ADJUDGED, and DECREED that the claims of KATHY SHIMMEL, parent and natural guardian of the Minor, BRANDON SHIMMEL, shall be, and the same are hereby compromised and settled on the following terms:

1. Payment to Kathy Shimmel, as parent and natural guardian of Brandon Shimmel of a lump sum of Two Thousand Two Hundred and Fifty Dollars ($2,250.00) by Benjamin Shimmel and Progressive Insurance, with said funds to be deposited by Kathy Shimmel into an interest-bearing account on behalf of Brandon Shimmel, said funds not to be withdrawn until Brandon Shimmel reaches the age of majority on NOVEMBER 21, 2009;

2. Payment to Kathy Shimmel, individually, of a lump sum of Two Hundred Fifty Dollars ($250.00) for reimbursement of out of pocket expenses;

3. Record costs and attorneys fees of Pfaff, McIntyre, Dugas, Hartye & Schmitt, will be paid by Progressive Insurance Company; and

4. Petitioner is hereby granted leave to execute a Release for the benefit of Benjamin Shimmel and Progressive Insurance Company.

BY THE COURT:

_____ J.

BRANDON SHIMMEL, a minor, by his Parent and natural guardian, KATHY SHIMMEL,	:	IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PA
Petitioner	:	No. 01-1125-CD

FILED

JUL 12 2001

William A. Shaw
Prothonotary

PETITION FOR APPROVAL OF SETTLEMENT OF A MINOR'S CLAIM

AND NOW, comes Petitioner, Kathy Shimmel, parent and natural guardian of the Minor, Brandon Shimmel, and file the within Petition for Approval of Settlement of a Minor's Claim, saying as follows:

1. Your Petitioner is an adult individual residing at 37 Country Place, DuBois, Clearfield County, Pennsylvania.

2. Your Petitioner is the parent and natural guardian of Brandon Shimmel, born on November 21, 1991, who resides with the Petitioner at the address listed above.

3. On or about February 3, 2000, Brandon Shimmel was a passenger in a vehicle driven by her father, Benjamin Shimmel when Mr. Shimmel lost control of the vehicle, crossing the center line of SR 4011 in Brady Township an impacting a vehicle driven by Charles DuPree.

4. At the time of the accident, Benjamin Shimmel was insured by Progressive Insurance Company, Policy of Insurance No. 65556785-0.

5. In the said accident, the Minor, Brandon Shimmel, received personal injuries in the nature of a laceration to the right forehead area.

6. On the date of said accident, Minor, Brandon Shimmel, was seen at the emergency room of the DuBois Regional Medical Center, where he was diagnosed with a laceration of the right forehead injury. He was then transferred to Children's Hospital

in Pittsburgh where he received stitches to the hairline, was admitted overnight and released the following day. (A copy of all medical treatment records and bills are attached hereto as Exhibit A and incorporated by reference.)

7. Brandon Shimmel has been discharged from medical care by Dr. Siar and does not anticipate any future medical treatment.

8. All medical bills have been paid either by Progressive Insurance Company or the Department of Public Welfare. There is no lien being asserted by the Department of Public Welfare. (Attached as Exhibit B is a copy of correspondence from the Department of Public Welfare dated December 28, 2000 confirming that no lien is being asserted.)

9. Your Petitioner has negotiated a settlement with Benjamin Shimmel and Progressive Insurance Company for the benefit of minor, Brandon Shimmel, the terms of which are as follows:

1. Payment to Kathy Shimmel, as parent and natural guardian of Brandon Shimmel of a lump sum of Two Thousand Two Hundred and Fifty Dollars ($2,250.00) by Benjamin Shimmel and Progressive Insurance, with said funds to be deposited by Kathy Shimmel into an interest-bearing account on behalf of Brandon Shimmel, said funds not to be withdrawn until Brandon Shimmel reaches the age of majority on NOVEMBER 21, 2009;

2. Payment to Kathy Shimmel, individually, of a lump sum of Two Hundred Fifty Dollars ($250.00) for reimbursement of out of pocket expenses;

3. Record costs and attorneys fees of Pfaff, McIntyre, Dugas, Hartye & Schmitt, will be paid by Progressive Insurance Company; and

4. Petitioner is hereby granted leave to execute a Release for the benefit of Benjamin Shimmel and Progressive Insurance Company;

5. Execution of a Release for the benefit of Benjamin Shimmel and Progressive Insurance Company. (A copy of the release is attached hereto, marked as Exhibit C and incorporated by reference.)

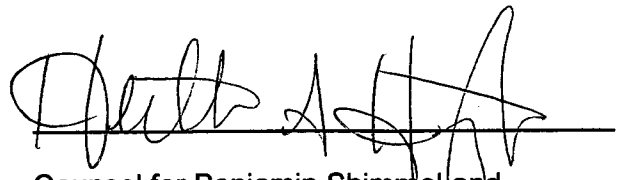
10. Petitioner, Kathy Shimmel, parent and natural guardian

of the Minor, Brandon Shimmel, has read and understand the statements in this Petition and agrees to accept the settlement set forth hereinabove in full and complete satisfaction of any and all claims against Benjamin Shimmel and Progressive Insurance Company for any personal injuries sustained by Minor, Brandon Shimmel, on or about February 3, 2000.

11. Petitioner understands and agrees that Benjamin Shimmel and Progressive Insurance Company deny any and all liability, and that the proposed settlement is not an admission of liability, but under the facts and circumstances pertaining hereto, the settlement offer is the best that can be obtained, and for and on behalf of Minor, Brandon Shimmel, should be accepted.

WHEREFORE, Petitioner, Kathy Shimmel, parent and natural guardian of Minor, Brandon Shimmel, respectfully request that this Honorable Court enter an Order approving the compromise and settlement of the claim on her behalf as parent and natural guardian of Minor, Brandon Shimmel, upon the terms set forth hereinabove, with distribution to be made in accordance therewith.

Respectfully submitted,



Counsel for Benjamin Shimmel and
Progressive Insurance Company

Heather A. Harrington, Esquire
PA ID No. 62977
PFAFF, McINTYRE, DUGAS, HARTYE
& SCHMITT
P.O. Box 533
Hollidaysburg PA 16648
(814) 696-3581

Brandon Shimmel

PROGRESSIVE

One Monroeville Center
3824 Northern Pike, Suite 510
Monroeville PA 15146-2121
Telephone: 412 380-5230
Facsimile: 412 374-8025
http://www.progressive.com

AUTHORIZATION TO OBTAIN HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL PRIOR, CURRENT, AND FUTURE INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PENNSYLVANIA NO-FAULT MOTOR VEHICLE INSURANCE ACT.

NAME (PLEASE PRINT) Brandon Michael Shimmel

SIGNATURE Benjamin L Shimmel FATHER
If a minor, parent or guardian shall sign and indicate relationship

DATE 2-11-2000

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE OR DEFRAUD ANY INSURER WHO FILES AN APPLICATION OR CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION SHALL, UPON CONVICTION, BE SUBJECT TO IMPRISONMENT FOR UP TO SEVEN YEARS AND PAYMENT OF A FINE UP TO $15,000.

AUTHORIZATION TO OBTAIN WORK LOSS AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PENNSYLVANIA NO-FAULT MOTOR VEHICLE INSURANCE ACT.

NAME (PLEASE PRINT)

SIGNATURE PROGRESSIVE
If a minor, parent or guardian shall sign and indicate relationship

DATE FEB 14 2000

WPA - PIP
RECEIVED

SOCIAL SECURITY#

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE OR DEFRAUD ANY INSURER WHO FILES AN APPLICATION OR CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION SHALL, UPON CONVICTION, BE SUBJECT TO IMPRISONMENT FOR UP TO SEVEN YEARS AND PAYMENT OF A FINE UP TO $15,000.

CLAIM# 004222491-SAE REPRESENTATIVE: Stephanie A. Evancho

EXHIBIT
A

PROGRESSIVE

One Monroeville Center
3824 Northern Pike, Suite 510
Monroeville, PA 15146-2121
Telephone: 412 380-5230
Facsimile: 412 374-8025
progressive.com

September 7, 2000

Benjamin L. Shimmel
for Brandon Shimmel
37 Country Place
DuBois, PA 15801

RE: OUR INSURED: Benjamin L. Shimmel
INJURED PARTY: Brandon Shimmel
OUR CLAIM #: 004222491 SAE
DATE OF LOSS: 02/03/00
MAXIMUM MEDICAL COVERAGE: $5,000.00

Dear Mr. Shimmel:

Please be advised that we have paid the maximum amount for first party medical benefits under this policy. Medical expenses are now your responsibility or any group insurance you may have for Brandon.

If you have any questions, please contact me at the above listed number.

Sincerely,

Stephanie Evancho
Medical Claims Representative
Progressive Northern Insurance Company
412/380-5266

cc: University of Pittsburgh Physicians

jg

DUBOIS REGIONAL MEDICAL CENTER
100 Hospital Ave, DuBois, PA 15801

SHIMMEL,BRANDON M *ER Unit # 000372635
37 COUNTRY PLACE
DUBOIS PA 15801-0000 Age 8Y Acct # D0003400477

Date:02/03/00 Time:1828

WENGER,FRED G

SIAR,W J
P.O. BOX 348
DUBOIS PA 15801

Chk-in #	Order	Exam	
383968	0004	41003	XR-CHEST , 2 VIEWS Ord Diag: 959.1-TRUNK INJURY NOS
383968	0004	43013	XR-PELVIS AP Ord Diag: 919.0-trauma

CHEST - PA AND LATERAL:

The lungs are well-aerated. No infiltrate or consolidation is seen. The cardiomediastinal silhouette is normal. There is no pleural effusion or pneumothorax seen.

IMPRESSION: NO ACTIVE PULMONARY PATHOLOGY.

PELVIS:

A frontal view of the pelvis shows a large amount of fecal material within the rectum. The visualized osseous structures are intact. There is normal relationship of the hip joints.

IMPRESSION: THERE IS A LARGE AMOUNT OF FECAL MATERIAL IN THE RECTUM.
THE FINDINGS ARE OTHERWISE UNREMARKABLE.

NIA CODE: CHEST/PELVIS - N

/READ BY/ GEORGE M KOSCO,
/Released By/ GEORGE M KOSCO,

02/09/00 1201
RAW

Complete Duplicate

A

372635 0003400477 02/03/00
SHIMMEL,BRANDON M
206-72-7057 M 8Y 11/21/91
MCANDREW,JOSEPH
SIAR,W J

DuBois Regional Medical Center — Making the difference for life

EMERGENCY DEPARTMENT RECORD

Time: 1715 ☐ Emergent ☒ Urgent ☐ Nonurgent

CONDITION ON ARRIVAL: ☐ Poor ☐ Fair ☒ Satisfactory ☐ DOA

CHIEF COMPLAINT: restrained passenger rear seat involved in MVA headache and belly pain / guarding

Brandon Shimmel 8 y/o 16220

VITAL SIGNS	Temp	Pulse	Resp	BP	O_2 Sat	WT
	96.8	62	16	128/73		(36)

ALLERGIES: BEES

CURRENT MEDS: ☐ See attached list none current

IMMUNIZATIONS: ☐ DNA ☒ UP TO DATE LAST TT/TD:

VISUAL ACUITY ☒ DNA | OD | OS | OU | ☐ CORRECTED ☐ UNCORRECTED

PT. PREGNANT? ☒ DNA ☐ YES ☐ NO ☐ UNSURE ☐ HYSTERECTOMY ☐ TUBAL LIGATION
LMP

TRIAGE TO ☒ Registration ☐ Room 7 Triage Nurse:

Primary Nurse: Vicki Packer RN

CHECK THE REQUESTED STUDIES

☒ CBC	☐ Cardiac enzymes	☒ UA	☐ C&S
☐ Lytes	☐ CKMB	☐ UC	☐ Wet Mount
☒ BUN	☐ CPK, Trip, Myo	☐ RSS	☐ RSV
☐ Creatinine	☐ Troponin I	☐ Throat C&S	☐ Triage Drug Screen
☐ Blood Sugar	☐ Digoxin level	☒ Blood C&S	☐ Coma Panel
☐ Amylase	☐ Cholesterol	☐ Type and Screen	☐ 9598
☐ PT/PTT	☐ Monospot	☐ Type and Cross	☐ 89591
☐ Basic Met Prof.	☐ Pregnancy	☐ Type and Cross	☐ 87342
☐ Hepatic Prof.	☐ ETOH	☐ Chlamydia	☐ 7851
☐ Compre profile	☐ Magnesium	☐ GC	☐ C8495

C8191

EKG: ☐ EKG: Provisional Reading: ☐ Repeat

CARDIO: ☐ ABG ☐ on O_2 ☐ on Room Air
☐ Proventil ☐ Repeat ☐ Repeat
☐ Proventil Atrovent ☐ Repeat ☐ Repeat
☐ Vaponephrine ☐ Repeat ☐ Repeat
☐ Other ☐ Repeat ☐ Repeat
☐ Peak Flows ☐

X-RAY + SPECIAL: ☐ Chest ☐ Portable Chest ☐ Port Lat C Spine ☐ C Spine ☐ LS Spine ☐ ABD Series
☐ Chest ☒ pelvis
☐ CT ☐ Enhanced ☐ Unenhanced

PROGRESSIVE

PHYSICIAN REPORT

Dictated

EXAM TIME: 1715

FEB 11 2000

WPA/ PIP RECEIVED 2/14

DX: (Multiple Trauma) / Blunt Abdominal Injury

ORDERS:
1) Irrigate Wound
2) LET Gel →
3) IV NSS @ KVO
4) ...

(Nadler) Trauma Eval

DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS

Condition On Discharge: ☐ Satisfactory ☐ Fair ☐ Poor Time: 1935 WITH: ☐ self ☐ family ☐ other

☐ Admitted Room No: ☐ Physician Notified/Time: ☐ Sent Home ☐ Return to work ☐ Deceased ☐ Transferred

NOTIFIED: ☐ Relative ☐ Police ☐ Coroner ☐ Poison Center

For follow-up care please see: ☐ Personal physician ☐ Occupational medicine ☐ ER if worse or not improving

FOLLOW INSTRUCTIONS ON ☐ HEAD INJURY ☐ CULTURE ☐ STREP SCREEN ☐ LAB TEST ☐ X-RAY/EKG'S ☐ SPRAINS, STRAINS AND CONTUSIONS ☐ NOSEBLEEDS ☐ U.R.I. ☐ WOUND CARE AND BURN CARE ☐ GASTROENTERITIS AND/OR ABDOMINAL PAIN ☐ ALLERGY INJ. ☐ URINARY INFECTIONS ☐ CARE OF CHILD AND FEVER ☐ ANIMAL BITES ☐ CASTS ☐ EYE CARE ☐ TETANUS INJECTION ☐ MEDICATION ALERT ☐ MEDICATION USE

OTHER INSTRUCTION: Transfer to Childrens Hospital Dr Nadler

☐ No Work or School Date:
☐ No Physical Education ☐ Until Released by Physician
☐ Light Work Only

Method of Validating Knowledge: ☐ Verbalization ☐ Return Demo ☐ Other:

PATIENT/ RESPONSIBLE PARTY | NURSE'S SIGNATURE Vicki Packer RN | PHYSICIAN'S SIGNATURE

I hereby acknowledge receipt of these instructions, have read them and understand them. I further understand that I have had emergency treatment and that I may be released before all of my medical conditions/test results are known or treated. I will arrange for follow-up care. DuBois Regional Medical Center-DuBois, PA 15801

Rev. 10/98

CODING/INSURANCE COPY

Children's Hospital of Pittsburgh

EMERGENCY ROOM
FRONT SHEET CONTINUATION PAGE/ CONSULTANT'S NOTES

FORM NO. 809 (4/99)

DATE: (Month, Day, Year) 2 103 00

PATIENT NAME Shumwel, Brandon

UNIT NUMBER 6491692

BIRTHDATE

PLASTICS

1

Xyo unr BSP - restrained. Vehicle c significant front end damage. ø LOC. Transferred here from OSH 2° episode of tachycardia. On arrival A|B|C intact. 2° survey revealed 2 Head LAC.

PMH - constipation

PSH: ESO Bx as infant

All: NKDA

meds: Lactulose
Miralax

PE: TH laying in Bed in NAD. A+O

HEENT- (hairline) 2 x 2cm forehead lac c soft tissue defects from hairline to upper 1/3 of forehead. ø sensory deficits. CN II, CN VII. Depth to periosteum. After thorough washout c NS

A/P - 2 forehead lacs unr sutured ø under sterile conditions after sedation per ED staff. Continuous stitches c 5-0 Vicryl used to approximate lac edges. Bacitracin applied. ø Complications. Remove stitches 5-7 days.

PHYSICIAN'S SIGNATURE:

MEDICAL RECORDS CHART FORM
FORM NO. 6230-251 (REV. 9/89)

Children's Hospital of Pittsburgh

INPATIENT PROGRESS NOTES

Form No. 231 (9/89) Item No: 35130520

8000895822 IONT 649692
SHIMMEL ,BRANDON
11/21/91 M W S 02/03/
FORD, HENRI M.D. C
37 COUNTRY PLACE
DUBOIS PA
15801 SRG
SHIMMEL ,BENJAMIN L
814-371-2931
UNKNOWN

ADDRESSOGRAPH AREA

DATE Mo-Day-Yr	PLEASE COMPLETE FULL DATE INCLUDING THE YEAR FOR EACH ENTRY ON PAGE.

Children's HOSPITAL OF PITTSBURGH

PEDIATRIC SURGERY

1011233135 EMRG 649692
SHIMMEL ,BRANDON
11/21/91 M W S 02/03/00
GARCIA, SYLVIA M.D. CAT
37 COUNTRY PLACE
DUBOIS PA
15801 MED
SHIMMEL ,BENJAMIN L
814-371-2931
UNKNOWN

Date	Critical Care Time
2/3/00	

Type of Service	Location
	ED

HISTORY

Attending Surg—
0 Ht + R as above from backseat passenger restrained in lapbelt in car involved in MVC. ō LOC. Pt now c/o abd pain. Sch – 2nd grade FMHx – Neg
PMHx – Constipation

EXAM

PE – Abd – ⊕ lap belt sign ⇒ superficial abrasion. soft, ND. ⊕ tenderness in hypogastrium
Rectal – nl tone, guaiac neg stool

AXR – ō FA Ap Pelvis ō FX CXR Ø

PLAN

A/P – S/P MVC c̄ lap belt sign + abd tenderness – will obtain CT Abd/pelvis + R/O mesenteric bowel injury

Signature: [signature] ☐ GC ☐ NR

IMPORTANT

PEDIATRIC SURGERY

MEDICAL RECORDS COPY

PLEASE USE REVERSE SIDE

Children's Hospital of Pittsburgh

EMERGENCY ROOM
FRONT SHEET CONTINUATION PAGE/ CONSULTANT'S NOTES

FORM NO. 809 (4/99)

DATE: (Month, Day, Year) 2 10 3 00

PATIENT NAME Shemmel, Brandon

UNIT NUMBER 6491692

BIRTHDATE

PLASTICS

Yo was BSP - restrained. Vehicle c significant front end damage. ø LOC. Transferred here from OSH 2° episode of tachycardia. On arrival A/B/C intact 2° survey revealed 2 Head LAC.

PMH - constipation
PSH: Eso Bx as infant

All: NKDA
meds: Lactulose
Miralax

PE: PT laying on Bed on NAD. A+O

HEENT- (hairline) 2 x 2cm forehead lac c soft tissue defects from hairline to upper 1/3 of forehead. ø sensory deficits CN II, CN III. Depth to periosteum. After thorough wash out c. NS

A/P - 2 forehead lacs were sutured ø under sterile conditions after sedation per ED staff. Continuous stitches c 5-0 Vicryl used to approximate lac edges. Bacitracin applied. ø Complications. Remove stitches 5-7 days.

PHYSICIAN'S SIGNATURE:

MEDICAL RECORDS CHART FORM
FORM NO. 6230-251 (REV. 9/89)

DATE Mo-Day-Yr | PLEASE COMPLETE FULL DATE INCLUDING THE YEAR FOR EACH ENTRY ON PAGE.

MASTER PLATE BACKER
FORMS 214; 214-A; 231; 231-A REV. 5.76

PLAN EXAM HISTORY

Children's HOSPITAL OF PITTSBURGH

PEDIATRIC SURGERY

Date	Critical Care Time
2/4/00	

Type of Service	Location
	10 20 A

SHIMMEL ,BRANDON
11/21/91 M W S 02/03/00
CAT
FORD, HENRI M.D.
37 COUNTRY PLACE
DUBOIS PA
15801 SRG
SHIMMEL ,BENJAMIN L
14-371-2931
UNKNOWN
649642

PTD #1
Doing well
No fevers VSS

H/C Note

Cardiac Reg
Lung Clear
Abd Soft NTBS
2 Colostomies

A/P Clears → discharge
D/C home later today

Signature:

GC NR

MEDICAL RECORDS COPY

PEDIATRIC SURGERY

Children's Hospital of Pittsburgh

8000896822 IONT 649692
SHIMMEL ,BRANDON
1/21/91 M W S 02/03/
FORD, HENRI M.D.
37 COUNTRY PLACE
DUBOIS PA
15801 SRG
ADDRESSOGRAPH AREA
SHIMMEL ,BENJAMIN L
814-371-2931
UNKNOWN

INPATIENT PROGRESS NOTES

Form No. 231 (9/89) Item No: 35130520

DATE Mo-Day-Yr	PLEASE COMPLETE FULL DATE INCLUDING THE YEAR FOR EACH ENTRY ON PAGE.
	Plastic Surgery —
2/4/00	Pt Alert, Cooperative & c/o forehead lacs well approximated & drainage & S/S infection sensation intact to lt forehead in all areas Pt able to raise eyebrows & compress forehead & difficulty. Pt. to D/C Home today. Bacitracin to suture lines Plan: PCP for suture removal in 5-7d.

4744

IMPORTANT
EACH ENTRY MUST BE FOLLOWED IMMEDIATELY BELOW BY SIGNATURE.

PLEASE USE REVERSE SIDE

PROGRESSIVE INSURANCE
ONE MONROEVILLE CENTER
3824 NORTHERN PIKE, SUITE 510
MONROEVILLE PA 15146

C980
CLINIC-OFFICE 0895-02 00957
CLIENT FORM #: 4

APPROVED OMB-0938-0008

SBF# 2328

HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐ — PICA ☐☐☐

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
☐ (Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☒ (ID)	004222491SAE
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BRANDON	3. PATIENT'S BIRTH DATE MM DD YY: 11 21 1991 SEX: M ☒ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BRANDON	
5. PATIENT'S ADDRESS (No., Street): 37 COUNTRY PLACE	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street): 37 COUNTRY PLACE	
CITY: DUBOIS STATE: PA	8. PATIENT STATUS: Single ☒ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐
CITY: DUBOIS STATE: PA	
ZIP CODE: 15801 TELEPHONE (Include Area Code): (814)371-2931	
ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814)371-2931	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NO OTHER INSURANCE	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO
a. INSURED'S DATE OF BIRTH MM DD YY: 11 21 1991 SEX: M ☐ F ☐	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐	b. AUTO ACCIDENT? ☒ YES ☐ NO PLACE (State): PA
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: PROGRESSIVE INSURANCE	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO (If yes, return to and complete item 9 a-d.)	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 06/25/00

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY (ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)) 02 03 00	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: HENRI R FORD	17a. I.D. NUMBER OF REFERRING PHYSICIAN: F51856	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 03 00 TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES: 0.00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 854.01 2. 959.01 3. E81.21 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER: 004222491JAE

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 02 03 00	21	01	99221	GC	1,2,3	8500	1				
2			INITIAL HOSPITAL CAR								
3											
4											
5											
6											

PER ATTACHED

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
232919472 ☐ ☒	67954880	☒ YES ☐ NO	$ 8500	$ 000	$ 8500

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 # (412) 647-7600
HENRI R FORD MD	CHP INPT	UNIV OF PITTSBURGH PHYSICIANS
SIGNED 06/25/00 DATE	ONE CHILDRENS PLAC	PO BOX 371980
	PITTSBURGH PA 15214	PITTSBURGH PA 15250-7980
		PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

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

PLEASE PRINT OR TYPE

06/26/2000

MED. CHART 649692

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

2519 P

PROGRESSIVE INSURANCE
ONE MONROEVILLE CENTER
3824 NORTHERN PIKE, SUITE 510
MONROEVILLE PA 15146

C980
CLINIC-OFFICE 0895-02
CLIENT FORM #: 4

APPROVED OMB-0938-0008
00928

HEALTH INSURANCE CLAIM FORM

SBF# 2328

CARRIER

PICA ☐☐☐ PICA ☐☐☐

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 004222491SAE

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BRANDON

3. PATIENT'S BIRTH DATE MM DD YY: 11 21 1991 SEX M ☒ F ☐

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

5. PATIENT'S ADDRESS (No., Street): 37 COUNTRY PLACE

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

7. INSURED'S ADDRESS (No., Street): 37 COUNTRY PLACE

CITY: DUBOIS STATE: PA

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

CITY: DUBOIS STATE: PA

ZIP CODE: 15801 TELEPHONE (Include Area Code): (814) 371-2931

ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814) 371-2931

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NO OTHER INSURANCE

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: 11 21 1991 SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): PA

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: PROGRESSIVE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

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 SIGNATURE ON FILE DATE 06/25/00

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 02 03 00 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DANIEL H HECHTMAN

17a. I.D. NUMBER OF REFERRING PHYSICIAN: G15130

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 03 00 TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES: 0.00

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

1. 854.01
2. 959.01
3. E81.21
4. ____

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 004222491JAE

PHYSICIAN OR SUPPLIER INFORMATION

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 02 04 00		21	01	99238	GC	1,2,3	8500	1				
				HOSPITAL DISCHARGE D								
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 232919472 ☐ ☒

26. PATIENT'S ACCOUNT NO.: 67954900

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

28. TOTAL CHARGE: $ 8500

29. AMOUNT PAID: $ 000

30. BALANCE DUE: $ 8500

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.)

DANIEL H HECHTMAN MD

SIGNED 06/25/00 DATE

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

CHP INPT
ONE CHILDRENS PLAC
PITTSBURGH PA 15214

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (412) 647-9600

UNIV OF PITTSBURGH PHYSICIANS
PO BOX 371980
PITTSBURGH PA 15250-7980

PIN# GRP#

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

PLEASE PRINT OR TYPE

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

2520 P

MED. CHART 649692

06/26/2000

PROGRESSIVE INSURANCE
ONE MONROEVILLE CENTER
3824 NORTHERN PIKE, SUITE 510
MONROEVILLE PA 15146

3/6/00

C980
CLINIC-OFFICE 0895-02 0058
CLIENT FORM #: 4

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

SBF# 2328

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
004222491SAF -2

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
SHIMMEL, BRANDON

3. PATIENT'S BIRTH DATE MM DD YY: 11 21 1991 **SEX** M X F

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

5. PATIENT'S ADDRESS (No., Street)
37 COUNTRY PLACE

6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)
37 COUNTRY PLACE

CITY: DUBOIS STATE: PA

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

CITY: DUBOIS STATE: PA

ZIP CODE: 15801 TELEPHONE (Include Area Code): (814) 371-2931

ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814) 371-2931

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
NO OTHER INSURANCE

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 11 21 1991 SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
CLAIM: Benjamin Sinclair

b. AUTO ACCIDENT? YES X NO PLACE (State) PA

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: PROGRESSIVE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME
DOL: 2/3/00 MOI: CAR

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X 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.
NOT TRAUMA TRAUMA
SIGNED SIGNATURE ON FILE DATE 2/3/00

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY: 02 03 00 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 03 00 TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X $ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. L 959.01
2. L 959.1
3. E81.21
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
004222491JAF

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 02 03 00		23	01	99284		1,2,3	225 00	1				
				EMERGENCY DEPT VISIT								
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN
232919472

26. PATIENT'S ACCOUNT NO.
67571010

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

28. TOTAL CHARGE $ 225 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 225 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.)
MANANDA S BHENDE MD
SIGNED 06/23/00 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
CHP EMERG RM
ONE CHILDRENS PLAC
PITTSBURGH PA 15213

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (412) 647-9600
UNIV OF PITTSBURGH PHYSICIANS
PO BOX 371980
PITTSBURGH PA 15250-7980
PIN# GRP#

PATIENT AND INSURED INFORMATION

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

PLEASE PRINT OR TYPE

MED. CHART 649692

06/23/2000

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

1466 P

PROGRESSIVE INSURANCE
ONE MONROEVILLE CENTER
3824 NORTHERN PIKE, SUITE 510
MONROEVILLE PA 15146

316100

C980
CLINIC-OFFICE 0895-02
CLIENT FORM #: 4

APPROVED OMB-0938-0008
00590

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

SBF# 2328

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 004222491SAE

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BRANDON

3. PATIENT'S BIRTH DATE MM DD YY: 11 21 1991 SEX M ☒ F ☐

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

5. PATIENT'S ADDRESS (No., Street): 37 COUNTRY PLACE

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

7. INSURED'S ADDRESS (No., Street): 37 COUNTRY PLACE

CITY: DUBOIS STATE: PA

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

CITY: DUBOIS STATE: PA

ZIP CODE: 15801 TELEPHONE (Include Area Code): (814) 371-2931

ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814) 371-2931

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NO OTHER INSURANCE

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: 11 21 1991 SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): PA

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: PROGRESSIVE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes,* return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

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 SIGNATURE ON FILE DATE 06/23/00

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 02 03 00 ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 03 00 TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES 0.00

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

1. 959 01
2. 873 42
3. E81 21
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 004222491JAE

PHYSICIAN OR SUPPLIER INFORMATION

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 02 03 00		23	01	99283		1,2,3	16200	1				
				EMERGENCY DEPT VISIT								
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 232919472 ☐ ☒

26. PATIENT'S ACCOUNT NO.: 67571030

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

28. TOTAL CHARGE: $ 16200

29. AMOUNT PAID: $ 000

30. BALANCE DUE: $ 16200

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.)

SYLVIA GARCIA MD

SIGNED 06/23/00 DATE

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

CHP EMERG RM
ONE CHILDRENS PLAC
PITTSBURGH PA 15213

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (412) 647-9600

UNIV OF PITTSBURGH PHYSICIANS
PO BOX 371980
PITTSBURGH PA 15250-7980

PIN# GRP#

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

PLEASE PRINT OR TYPE

06/23/2000

MED. CHART 649692

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

1467 P

PS2L PRVDR

PROGRESSIVE

EXPLANATION OF REVIEW
PROVIDER COPY

ONE MONROEVILLE CENTER, SUITE 510
MONROEVILLE, PA 15146
(412) 380-5230

PATIENT NAME:	PATIENT ID#:	INTERNAL CONTROL#:	DATE PROCESSED:
BRANDON M SHIMMEL	0042224910200	06002454020600	09/01/00

PROVIDER TAX ID:
232919472

PROVIDER:
UNIVERSITY OF PITTSBURGH PHYS.
PO BOX 371980
PITTSBURGH PA 15250

PAYOR: PROGRESSIVE INSURANCE
POLICY#:
CLAIM#: 004222491-02
REP ID#: SAE EXT 5266
PATIENT ACCT#:
DATE OF INJURY: 02/03/00
MISC INFO: BILL #9
POLICY HOLDERS NAME: BRANDON M SHIMMEL

DATE OF SERVICE	PROC CODE	DESCRIPTION OF SERVICE	BILLED CHARGE	FS/UCR	PAID AMOUNT	REASON CODE
02/03/00	99284	EMERG DEPT VST-EVL/MGMT	225.00	0.00	0.00	
02/03/00	99283	EMERG DEPT VST-EVL/MGMT	162.00	0.00	0.00	
		TOTALS:	387.00	0.00	0.00	

DIAGNOSIS CODES:

959.01 OTHER AND UNSPECIFIED INJURY TO FACE AND NECK, HEAD INJURY, UNSPECIFIED
959.1 OTHER AND UNSPECIFIED INJURY TO TRUNK
E812.1 OTHER MOTOR VEHICLE TRAFFIC ACCIDENT INVOLVING COLLISION WITH MOTOR VEHICLE INJURING PASSENGER IN MOTO

*-(D) THIS ITEM WAS PREVIOUSLY SUBMITTED AND REVIEWED WITH NOTIFICATION OF DECISION ISSUED TO PAYOR/PROVIDER (DUPLICATE INVOICE). (X801)

TOTAL AMOUNT PAID: **********
0.00
****

THE ABOVE EXPLANATION IS WHAT PROGRESSIVE HAS DETERMINED TO BE THE APPROPRIATE REIMBURSEMENT AMOUNT FOR THIS BILL. IF YOU HAVE ANY QUESTIONS ABOUT THIS OR ANY OTHER PART OF YOUR REIMBURSEMENT, PLEASE CALL US AT THE NUMBER LISTED ABOVE. (Y101)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. (Y102)

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 655567850

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BRANDON M

3. PATIENT'S BIRTH DATE MM DD YY: 11 21 1991 | SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BENJAMIN LEROY

5. PATIENT'S ADDRESS (No., Street): 37 COUNTRY PLACE

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

7. INSURED'S ADDRESS (No., Street): 37 COUNTRY PLACE

CITY: DUBOIS | STATE: PA

8. PATIENT STATUS: Single [X] | Married | Other

CITY: DUBOIS | STATE: PA

ZIP CODE: 15801-0000 | TELEPHONE (Include Area Code): (814) 371-2931

Employed | Full-Time Student [X] | Part-Time Student

ZIP CODE: 15801-0000 | TELEPHONE (INCLUDE AREA CODE): (814) 371-2931

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: 999999

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY: CLAIM #03 1967 | SEX M [X] F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? [X] YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: NI: EL CAM Benjamin Shimmel

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: BILL#: PROGRESSIVE AUTO INS SAC

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? TOTAL CHARGE 300.00 (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: SIGNATURE ON FILE DATE: 02/08/2000

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

SIGNED: SIGNATURE ON FILE

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: WENGER, FRED G

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E52919

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 03 2000 TO 02 03 2000

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

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

1. 9591
2. 87342
3. 7850
4. E8495

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02032000	02032000	23		99291		1	300 00	1				568816GY8
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 25-1490707 | SSN | EIN [X]

26. PATIENT'S ACCOUNT NO.: 0003400477

27. ACCEPT ASSIGNMENT? (For govt. claims see back) [X] YES | NO

28. TOTAL CHARGE: $ 30000

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 30000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: WENGER, FRED DATE: 02/08/2000

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

DUBOIS REG MED CTR
PO BOX 447
DUBOIS PA 15801

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

DUBOIS REG MED CTR
PO BOX 447
DUBOIS PA 15801

PIN# | GRP# 402465

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

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS

PROGRESSIVE INSURANCE
ONE MONROEVILLE CENTER
3824 NORTHERN PIKE, SUITE 510
MONROEVILLE PA 15146

C980
CLINIC-OFFICE 0895-02
CLIENT FORM #: 4

APPROVED OMB-0938-0008 003

SBF# 2328

PICA 0600175210

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 004222491SAE

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BRANDON

3. PATIENT'S BIRTH DATE: 11 21 1991 SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 37 COUNTRY PLACE

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

7. INSURED'S ADDRESS (No., Street): 37 COUNTRY PLACE

CITY: DUBOIS STATE: PA

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

CITY: DUBOIS STATE: PA

ZIP CODE: 15801 TELEPHONE (Include Area Code): (814) 371-2931

ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814) 371-2931

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NO OTHER INSURANCE

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO X

a. INSURED'S DATE OF BIRTH: 11 21 1991 SEX: M F

CLAIM#: 004222491-02

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F

b. AUTO ACCIDENT? YES X NO PLACE (State): PA

b. EMPLOYER'S NAME OR SCHOOL NAME

NI: Benjamin Shimmel

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: PROGRESSIVE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.

DOL 2500 MCR 557 SAE

TOTAL CHARGES $ 85.00

NOT TRAUMA TRAUMA

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 SIGNATURE ON FILE DATE 04/07/00

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 SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 02 03 00

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: HENRI R FORD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: F51856

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 03 00 TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X $ CHARGES: 0.00

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

1. 854.01
2. 959.01
3. E81.21
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 004222491JAE

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 02 03 00		21	01	99221	GC	1,2,3	8500	1				
				INITIAL HOSPITAL CAR								
2												
3												
4												
5												
6												

SEE ATTACHED

PAID

25. FEDERAL TAX I.D. NUMBER: 232919472 SSN EIN: EIN X

26. PATIENT'S ACCOUNT NO.: 4842616

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

28. TOTAL CHARGE: $ 8500

29. AMOUNT PAID: $ 000

30. BALANCE DUE: $ 8500

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.)

HENRI R FORD MD

SIGNED 04/07/00 DATE

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

CHP INPT
ONE CHILDRENS PLAC
PITTSBURGH PA 15214

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (412) 647-9600

UNIV OF PITTSBURGH PHYSICIANS
PO BOX 371980
PITTSBURGH PA 15250-7980

PIN# GRP#

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

PAGE 1

PLEASE PRINT OR TYPE

MED. CHART 649692

04/07/2000

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

924 P

PROGRESSIVE INSURANCE
ONE MONROEVILLE CENTER
3824 NORTHERN PIKE, SUITE 510
MONROEVILLE PA 15146

C980
CLINIC-OFFICE 0895-02 0039
CLIENT FORM #: 4

APPROVED OMB-0938-0008

SBF# 2328

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 004222491SAE

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BRANDON

3. PATIENT'S BIRTH DATE MM DD YY: 11 21 1991 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 37 COUNTRY PLACE

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 37 COUNTRY PLACE

CITY: DUBOIS STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: DUBOIS STATE: PA

ZIP CODE: 15801 TELEPHONE (Include Area Code): (814)371-2931

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814) 371-2931

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NO OTHER INSURANCE

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 11 21 1991 SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): PA

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: PROGRESSIVE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *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 SIGNATURE ON FILE DATE 04/07/00

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 02 03 00 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DANIEL H HECHTMAN

17a. I.D. NUMBER OF REFERRING PHYSICIAN: G15130

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 03 00 TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0.00

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

1. 854.01
2. 959.01
3. E81.21
4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 004222491JAE

PHYSICIAN OR SUPPLIER INFORMATION

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 02 04 00		21	01	99238	GC	1,2,3	85.00	1				
				HOSPITAL DISCHARGE D								
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 232919472 [X]

26. PATIENT'S ACCOUNT NO.: 4842617

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

28. TOTAL CHARGE: $ 85.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 85.00

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.)

DANIEL H HECHTMAN MD

SIGNED 04/07/00 DATE

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

CHP INPT
ONE CHILDRENS PLAC
PITTSBURGH PA 15214

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (412) 647-9600

UNIV OF PITTSBURGH PHYSICIANS
PO BOX 371980
PITTSBURGH PA 15250-7980

PIN# GRP#

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

PAGE 1

PLEASE PRINT OR TYPE 04/07/2000

MED. CHART 649692

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

927 P

PROGRESSIVE AUTO INS
PROGRESSIVE AUTO INS
1 MONROEVILLE SUT510
MONROEVILLE PA 15146

CLINIC-OFFICE 089502 00001
CLIENT FORM #: UPMC1

SBF# 2328

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 004222491SA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BRANDON

3. PATIENT'S BIRTH DATE (MM DD YY): 11 21 1991 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BENJAMIN L

5. PATIENT'S ADDRESS (No., Street): 37 COUNTRY PLACE

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 37 COUNTRY PLACE

CITY: DUBOIS | STATE: PA

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

CITY: DUBOIS | STATE: PA

ZIP CODE: 15801 | TELEPHONE (Include Area Code): (814) 371-2931

ZIP CODE: 15801 | TELEPHONE (INCLUDE AREA CODE): (814) 371-2931

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): SHIMMEL BRANDON

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 4101457564

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY): SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY): 11 21 1991 SEX: M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: PROGRESSIVE AUTO INS

d. INSURANCE PLAN NAME OR PROGRAM NAME: FAMILY CARE NETWORK

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 SIGNATURE ON FILE DATE 03/07/00

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 SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES 0.00

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

1. 959.01
2. 959.1
3. E81.21
4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 00		23	01	99284		1,2,3	225 00	1				
				EMERGENCY DEPT VISIT								
2												
3												
4												
5												
6												

3/25/00

PAYMENT CANNOT BE CONSIDERED UNTIL RECORDS ARE RECEIVED

25. FEDERAL TAX I.D. NUMBER: 232919472 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 4092039

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

28. TOTAL CHARGE: $ 225 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 225 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.)

MANANDA S BHENDE MD

SIGNED 03/07/00 DATE

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

CHP EMERG RM
ONE CHILDRENS PLAC
PITTSBURGH PA 15213

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (412) 647-5600

UNIV OF PITTSBURGH PHYSICIANS
PO BOX 371980
PITTSBURGH PA 15250-7980

PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

PAGE 1 03/07/2000

CD P ** 1 51 46 21 41 99 ** MED. CHART 649692

PLEASE PRINT OR TYPE

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

3566CP

PROGRESSIVE AUTO INS
PROGRESSIVE AUTO INS
1 MONROEVILLE SUT510
MONROEVILLE PA 15146

CLIENT FORM #: UPMC1

SBF# 2328

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 004222491SA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BRANDON

3. PATIENT'S BIRTH DATE: 11 21 1991 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BENJAMIN L

5. PATIENT'S ADDRESS (No., Street): 37 COUNTRY PLACE

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 37 COUNTRY PLACE

CITY: DUBOIS STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: DUBOIS STATE: PA

ZIP CODE: 15801 TELEPHONE (Include Area Code): (814) 371-2931

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814) 371-2931

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): SHIMMEL BRANDON

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 4101457564

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH SEX

b. OTHER INSURED'S DATE OF BIRTH: 11 21 1991 SEX: M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: PROGRESSIVE AUTO INS

d. INSURANCE PLAN NAME OR PROGRAM NAME: FAMILY CARE NETWORK

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 SIGNATURE ON FILE DATE 03/07/00

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0.00

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

1. 959 01
2. L873 42
3. E81 21
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 00		23	01	99283		1,2,3	162 00	1				
				EMERGENCY DEPT VISIT								
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 232919472 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 4092040

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

28. TOTAL CHARGE: $ 162 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 162 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.)

SYLVIA GARCIA MD

SIGNED 03/07/00 DATE

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

CHP EMERG RM
ONE CHILDRENS PLAC
PITTSBURGH PA 15213

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (412) 647-9600

UNIV OF PITTSBURGH PHYSICIANS
PO BOX 371980
PITTSBURGH PA 15250-7980

PIN# GRP#

CARRIER

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 OWCP-1500 FORM RRB-1500
3567CP

APPROVED OMB-0938-0008

PROGRESSIVE- STATE COLLEGE
100 SCENERY DR SUITE B

STATE COLLEGE, PA 16801

00-4222491

HEALTH INSURANCE CLAIM FORM

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 206727057

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BRANDON M

3. PATIENT'S BIRTH DATE: MM 12 DD 91 YY; SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SHIMMEL BRANDON M

5. PATIENT'S ADDRESS (No., Street): 37 COUNTRY PLACE

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

7. INSURED'S ADDRESS (No., Street): 37 COUNTRY PLACE

CITY: DUBOIS — STATE: PA

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

CITY: DUBOIS — STATE: PA

ZIP CODE: 15801 — TELEPHONE (Include Area Code): (814) 371-2931

ZIP CODE: 15801 — TELEPHONE (INCLUDE AREA CODE): (814) 371-2931

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: 206727057

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES NO X

a. INSURED'S DATE OF BIRTH: MM DD YY; SEX: M F

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY; SEX: M F

b. AUTO ACCIDENT? X YES 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: PROGRESSIVE- STATE COLLEGE

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.

CLAIM#: 00422491
NI: Benjamin Shimmel
BILL#: 6
DOL: 2/3/00 MCR: STE
TOTAL CHARGE $ 1776
NOT TRAUMA
TRAUMA

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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: SIGNATURE ON FILE — DATE: 02/03/00

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: SIGNATURE ON FILE

14. DATE OF CURRENT: MM 02 DD 03 YY 00 — 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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

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

1. 789 0 Abdominal Pain
2. E819 9 Motor Vehicle Acci
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 00	02 03 00	41	9	A0360 Base Charge	1,2	320 00	1				
2 02 03 00	02 03 00	41	9	A0380 BLS MILEAGE	1,2	742 50	99				
3 02 03 00	02 03 00	41	9	A0380	1,2	7 50	1				
4 02 03 00	02 03 00	41	9	A0422 Oxygen Administration	1,2	55 00	1				
5 02 03 00	02 03 00	41	9	A0370 ALS EMERGENCY - BS	1,2	445 00	1				
6 02 03 00	02 03 00	41	9	A0390 ALS MILEAGE - ALS	1,2	36 00	4				

PAID

25. FEDERAL TAX I.D. NUMBER: 25-1638713 — SSN — EIN X

26. PATIENT'S ACCOUNT NO.: 0001132#A

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

28. TOTAL CHARGE $ CONTINUED ON NEXT PAGE

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
KATHLEEN SCHAFFER
04/20/00
SIGNED — DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
FROM:
DUBOIS REG MEDICAL CTR -
TO:
CHILDREN'S HOSPITAL

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
AM SERV LIMITED
P.O. BOX 8
INDIANA, PA. 15701
1-888-463-348
PIN# — GRP#

PATIENT AND INSURED INFORMATION

SIGNATURE OF PHYSICIAN OR SUPPLIER INFORMATION

PLEASE PRINT OR TYPE

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
WHCFA-1500-2-N-90 (3-95)

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

APPROVED OMB-0938-0008

PROGRESSIVE- STATE COLLEGE
100 SCENERY DR SUITE B
STATE COLLEGE, PA 16801

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare#) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) X (ID)	206727057
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SHIMMEL, BRANDON M	3. PATIENT'S BIRTH DATE MM 11 DD 21 YY 91 SEX M X F 4. INSURED'S NAME (Last Name, First Name, Middle Initial) SHIMMEL BRANDON M
5. PATIENT'S ADDRESS (No., Street) 37 COUNTRY PLACE	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other 7. INSURED'S ADDRESS (No., Street) 37 COUNTRY PLACE
CITY DUBOIS	STATE PA
8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student	CITY DUBOIS STATE PA
ZIP CODE 15801	TELEPHONE (Include Area Code) (814)371-2931
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 206727057
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 SEX M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? X YES 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 PROGRESSIVE- STATE COLLEGE
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 SIGNATURE ON FILE DATE 02/03/00

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM 02 DD 03 YY 00 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 FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 789 0 Abdominal Pain
2. E819 9 Motor Vehicle Acci
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 00	02 03 00	41	9	A0422		1,2	55 00	1				
2 02 03 00	02 03 00	41	9	CARDIAC MONITOR/SUPPLIES Z0224		1,2	85 00	1				
3												
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
25-1638713 X	0001132#A	X YES NO	$ 1746 00	$ 0 00	$ 1746 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 #
KATHLEEN SCHAFFER 04/20/00 SIGNED DATE	FROM: DUBOIS REG MEDICAL CTR - TO: CHILDREN'S HOSPITAL	AM SERV LIMITED P.O. BOX 8 INDIANA, PA. 15701 1-888-436-348 PIN# GRP#

PLEASE PRINT OR TYPE

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
WHCFA-1500-2-N-90 (3-95)

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

PS2L PRVDR

PROGRESSIVE

EXPLANATION OF REVIEW
PROVIDER COPY

ONE MONROEVILLE CENTER, SUITE 510
MONROEVILLE, PA 15146
(412) 380-5230

PATIENT NAME:
BRANDON M SHIMMEL

PATIENT ID#:
0042224910100

INTERNAL CONTROL#:
06001432000700

DATE PROCESSED:
05/22/00

PROVIDER TAX ID:
251638713

PROVIDER:
AMBULANCE SERVICE LTD
PO BOX 8
INDIANA PA 15701

PAYOR: PROGRESSIVE INSURANCE
POLICY#:
CLAIM#: 004222491-01
REP ID#: SAE X5266
PATIENT ACCT#:
DATE OF INJURY: 02/03/00
MISC INFO: 6
POLICY HOLDERS NAME: BRANDON M SHIMMEL

DATE OF SERVICE	PROC CODE	DESCRIPTION OF SERVICE	BILLED CHARGE	FS/UCR	PAID AMOUNT	REASON CODE
02/03/00	A0380	BLS MILEAGE, PER MILE	742.50	694.98	694.98	1
02/03/00	A0370	AMBULANCE SERVICE; ALS	445.00	445.00	445.00	
02/03/00	A0360	AMBULANCE SERVICE;BLS	320.00	320.00	320.00	
02/03/00	Z0224	AMBULANCE SERVICE	85.00	77.00	77.00	1
02/03/00	A0422	AMBULANCE OXYGEN SUPPLIE	55.00	42.10	42.10	1
02/03/00	A0422	AMBULANCE OXYGEN SUPPLIE	55.00	42.10	42.10	1
02/03/00	A0390	ALS MILEAGE,PER MILE	36.00	26.20	26.20	1
02/03/00	A0380	BLS MILEAGE, PER MILE	7.50	7.02	7.02	1
		TOTALS:	1,746.00	1,654.40	1,654.40	

DIAGNOSIS CODES:

789.0 ABDOMINAL PAIN
E819.9 MOTOR VEHICLE TRAFFIC ACCIDENT OF UNSPECIFIED NATURE INJURING UNSPECIFIED PERSON

1-THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY ALLOWANCE. (Z560)

TOTAL AMOUNT PAID: **********
1,654.40
****

THE ABOVE EXPLANATION IS WHAT PROGRESSIVE HAS DETERMINED TO BE THE APPROPRIATE REIMBURSEMENT AMOUNT FOR THIS BILL. IF YOU HAVE ANY QUESTIONS ABOUT THIS OR ANY OTHER PART OF YOUR REIMBURSEMENT, PLEASE CALL US AT THE NUMBER LISTED ABOVE. (Y101)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. (Y102)

JUN-21-2000 20:07 P.02

APPROVED OMB NO. 0938-0279

CHILDREN S HOSPITAL OF PI
PO BOX 360001
PITTSBURGH PA 15251 6001
888 873 0698

3 PATIENT CONTROL NO.: 8000896822

4 TYPE OF BILL: 111

5 FED. TAX NO.: 25-0402510

6 STATEMENT COVERS PERIOD: FROM 020300 THROUGH 020400

7 COV D.: 1

12 PATIENT NAME: SHIMMEL BRANDON M

13 PATIENT ADDRESS: 37 COUNTRY PLACE DUBOIS PA 15801

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	31
11211991	M	S	020300	22	1	1	14	01	649692	446

32 OCCURRENCE CODE	DATE
01	020300

38
BENJAMIN L SHIMMEL
37 COUNTRY PLACE
DUBOIS PA 15801

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	A3	418092	ZZ	297094	01	55000
b	45	9900				
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	123	PEDS/2BED	550.00	020300	1	55000		
2	230	NURSING INCREM		020300	1	39200		
3	250	PHARMACY		020300	3	4792		
4	270	MED-SUR SUPPLIES		020300	26	38300		
5	300	LABORATORY		020300	5	18800		
6	305	LAB/HEMATOLOGY		020300	2	11100		
7	352	CT SCAN/BODY		020300	1	165200		
8	370	ANESTHESIA		020300	1	5100		
9	450	EMERG ROOM		020300	1	48700		
10	460	PULMONARY FUNC		020300	1	8900		
11	636	DRUG/DETAIL CODE		020300	2	23000		
12								
13	001	TOTAL CHARGES				418092		

SAE

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	PROGRESSIVE AUTO INS		Y	Y		418092	
B	MEDICAL ASST OF PA	110533312	Y	Y			
C							

DUE FROM PATIENT

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	SHIMMEL BENJAMIN L	03	004222491SAE	SHIMMEL	
B	SHIMMEL BENJAMIN L	03	4101457564		
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A		9	SHIMMEL	DUBOIS PA 15801
B	0350050467	9	SHIMMEL	DUBOIS PA 15801
C				

67 PRIN. DIAG. CD.	68 OTHER DIAG. CODES	69	76 ADM. DIAG. CD.	77 E-CODE	78
95901	87342	7850	85401	E8121	446

80 PRINCIPAL PROCEDURE CODE	DATE
8659	020300

82 ATTENDING PHYS. ID: OTH000 FORD HENRI MD

83 OTHER PHYS. ID: OTH000 FORD HENRI MD

84 REMARKS
PROGRESSIVE AUTO INS
1 MONROEVILLE SUT510
MONROEVILLE PA 15146

85 PROVIDER REPRESENTATIVE: X

86 DATE: 020800

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450 PAYER COPY

TOTAL P.02

Direct inquiries regarding this review to:

004222491

Med Path
3191 Trewigtown Road
Colmar, PA 18915
Phone (215) 996-9100 • Fax (215) 996-0887

A bill audit, fee schedule
and claims processing service

SHIMMEL, BRANDON

CHILDRENS HOSP OF PITT
PO BOX 60001
PITTSBURGH, PA 15251

CLAIM NO: 004222491
COVERED INDIVIDUAL: SHIMMEL, BRANDON
POLICY HOLDER:

PROVIDER: CHILDRENS HOSP OF PITT
TAX ID/PROVIDER NO: 39-3302
PATIENT NO: 80000896822

PAYOR: PROGRESSIVE COMPANIES
MONROEVILLE, PA
ACCIDENT DATE: 02/03/00
MEDLOGIX ID: 067640A -002A
CALCULATION DATE: 06/22/00

EXPLANATION OF BENEFITS

DIAGNOSES: 1) 959.01 HEAD INJURY NOS
2) 873.42 OPEN WOUND OF FOREHEAD
3) 785.0 TACHYCARDIA NOS

DATE OF SERVICE: 02/03/00

THE MED BOX

Total Billed Amount.....:	4,180.92
Calculated Amount.....:	2,401.87
Carrier's Responsibility....:	
TOTAL AMOUNT DUE.....:	2,401.87

Inpatient
PA Automobile

ITEMIZED CHARGES

DATE	SERVICE	DIAGS	UNITS	CHARGE	PAYMENT TYPE	REDUCTION	AMT DUE	STATUS
02/03/00	PDR 1		1.00	550.00	Per Diem	14.10	535.90	
	INPT ROUTINE SERVICE COST PER DIEM							
02/03/00	1		1.00	392.00	RCC	78.40	313.60	
	UNSPECIFIED REVENUE CENTER (80%)							
02/03/00	250 1		1.00	47.92	RCC	15.35	32.57	
	DRUGS CHARGED TO PATIENTS/PHARM							
02/03/00	270 1		1.00	383.00	RCC	86.48	296.52	
	MED SUPPLIES CHARGED TO PATIENTS							
02/03/00	300 1		1.00	188.00	RCC	122.44	65.56	
	LABORATORY							
02/03/00	300 1		1.00	111.00	RCC	72.29	38.71	
	LABORATORY							
02/03/00	350 1		1.00	1,652.00	RCC	1,123.46	528.54	
	CAT SCAN							
02/03/00	370 1		1.00	51.00	RCC	36.67	14.33	
	ANESTHESIOLOGY							
02/03/00	450 1		1.00	487.00	RCC	156.19	330.81	
	EMERGENCY							

THE ABOVE SERVICES HAVE BEEN COMPUTED TO CONFORM TO PENNA HOUSE BILL 121 AUTO INSURANCE REFORM LAW, "ACT 6", AS AMENDED NOVEMBER 30, 1991. ALL CALCULATIONS REPRESENT 110% OF THE APPLICABLE MEDICARE FEE SCHEDULE, RECOMMENDED FEE, DRG AMOUNT, 80% OF U&C; OR PROVIDER CHARGES, AS IN ACCORDANCE WITH SECTION 69.43.

Direct inquiries regarding this review to:

Med Path
3191 Trewigtown Road
Colmar, PA 18915
Phone (215) 996-9100 · Fax (215) 996-0887

CLAIM NO: 004222491
COVERED INDIVIDUAL: SHIMMEL, BRANDON
PAYOR: PROGRESSIVE COMPANIES
MONROEVILLE, PA

ITEMIZED CHARGES

DATE	SERVICE	DIAGS	UNITS	CHARGE	PAYMENT TYPE	REDUCTION	AMT DUE	STATUS		
02/03/00	460	1	1.00	89.00	RCC	0.00	89.00			
	PULMONARY FUNCTION									
02/03/00	250	1	1.00	230.00	RCC				73.67	156.33
	DRUGS CHARGED TO PATIENTS/PHARM									
	Totals:			4,180.92					1,779.05	2,401.87

THE ABOVE SERVICES HAVE BEEN COMPUTED TO CONFORM TO PENNA HOUSE BILL 121 AUTO INSURANCE REFORM LAW, "ACT 6", AS AMENDED NOVEMBER 30, 1991. ALL CALCULATIONS REPRESENT 110% OF THE APPLICABLE MEDICARE FEE SCHEDULE, RECOMMENDED FEE, DRG AMOUNT, 80% OF U&C; OR PROVIDER CHARGES, AS IN ACCORDANCE WITH SECTION 69.43.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PROGRESSIVE AUTO INS
100 SCENERY DRIVE
SUITE B
STATE COLLEGE PA 16801

#4 NT
SAE 5246
DOV 2/3/00

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 655567356 0

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
SHIMMEL BRANDON M	11 21 91 / M X	SHIMMEL BENJAMIN

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
37 COUNTRY PLACE	Self / Spouse / Child X / Other	37 COUNTRY PLACE

CITY	STATE	8. PATIENT STATUS	CITY	STATE
DUBOIS	PA	Single X / Married / Other	DUBOIS	PA

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (INCLUDE AREA CODE)
15801	(814) 371 2931	Employed / Full-Time Student / Part-Time Student	15801	(814) 371 2931

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
		CIATM 000222491 -N-
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / NO X	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 01 02 67 / M X / F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES / NO X PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME: DAD FICAM
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / NO X	c. INSURANCE PLAN NAME OR PROGRAM NAME: PROGRESSIVE AUTO INS
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO X *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: SIGNATURE ON FILE DATE: 022400

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: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES / NO X — $ CHARGES: 30 00

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. 873.8 3.	
2. E810.1 4.	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 02 10 00 02 10 00	3	35	99212	1 2	30 00	1				
2										
3										
4										
5										
6										

DAY IN 3/25

DAY OUT

PAID

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES / NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
25 1428819	6499 2	X	30 00	0 00	30 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 #
W JOHN SIAR MD	SIAR OFFICE PO BOX 348	GAPMAY AREA MEDICAL ASSOC INC 701 SUNFLOWER DRIVE
SIGNED: 022400 DATE	DUBOIS PA 15801	DUBOIS PA 15801 371 1771
		PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PS2L PRVDR

PROGRESSIVE

EXPLANATION OF REVIEW
PROVIDER COPY

ONE MONROEVILLE CENTER, SUITE 510
MONROEVILLE, PA 15146
(412) 380-5230

PATIENT NAME:	PATIENT ID#:	INTERNAL CONTROL#:	DATE PROCESSED:
BRANDON M SHIMMEL	0042224910200	06000952662200	04/05/00

PROVIDER TAX ID:
251428819

PROVIDER:
GATEWAY AREA MEDICAL ASSO
PO BOX 348
DU BOIS PA 15801

PAYOR: PROGRESSIVE INSURANCE
POLICY#:
CLAIM#: 004222491-02
REP ID#: SAE X5266
PATIENT ACCT#:
DATE OF INJURY: 02/03/00
MISC INFO:
POLICY HOLDERS NAME: BENJAMIN M SHIMMEL

DATE OF SERVICE	PROC CODE	DESCRIPTION OF SERVICE	BILLED CHARGE	FS/UCR	PAID AMOUNT	REASON CODE
02/10/00	99212	EST OUTPT L2 PROB FOC H&	30.00	30.00	30.00	
		TOTALS:	30.00	30.00	30.00	

DIAGNOSIS CODES:

873.8 OTHER AND UNSPECIFIED OPEN WOUND OF HEAD WITHOUT MENTION OF COMPLICATION
E819.1 MOTOR VEHICLE TRAFFIC ACCIDENT OF UNSPECIFIED NATURE INJURING PASSENGER IN MOTOR VEHICLE OTHER THAN MO

TOTAL AMOUNT PAID: **********
30.00
****

THE ABOVE EXPLANATION IS WHAT PROGRESSIVE HAS DETERMINED TO BE THE APPROPRIATE REIMBURSEMENT AMOUNT FOR THIS BILL. IF YOU HAVE ANY QUESTIONS ABOUT THIS OR ANY OTHER PART OF YOUR REIMBURSEMENT, PLEASE CALL US AT THE NUMBER LISTED ABOVE. (Y101)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. (Y102)

PROGRESSIVE AUTO INS
PROGRESSIVE AUTO INS
1 MONROEVILLE SUT510
MONROEVILLE PA 15146

C980
CLINIC-OFFICE 089502 00001
CLIENT FORM #: UPMC1

#3

SAE 004222491 SBF# 2328

HEALTH INSURANCE CLAIM FORM

APPROVED OMB-0938-0008

CARRIER

PICA ☐☐☐ PICA ☐☐☐

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 004222491SAE - N-8

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BRANDON

3. PATIENT'S BIRTH DATE: MM 11 DD 21 YY 1991 SEX M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BENJAMIN L

5. PATIENT'S ADDRESS (No., Street): 37 COUNTRY PLACE

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

7. INSURED'S ADDRESS (No., Street): 37 COUNTRY PLACE

CITY: DUBOIS — STATE: PA

8. PATIENT STATUS: Single ☒ Married ☐ Other ☐

CITY: DUBOIS — STATE: PA

ZIP CODE: 15801 — TELEPHONE (Include Area Code): (814) 371-2931

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: 15801 — TELEPHONE (INCLUDE AREA CODE): (814) 371-2931

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): SHIMMEL BRANDON

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 4101457564

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH: MM 11 DD 21 YY 1991 SEX M ☒ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: PROGRESSIVE AUTO INS

d. INSURANCE PLAN NAME OR PROGRAM NAME: FAMILY CARE NETWORK

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☒ YES ☐ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 02/22/00

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: HOLLY W DAVIS

17a. I.D. NUMBER OF REFERRING PHYSICIAN: C30103

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 03 00 TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES 0.00

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

1. 922.2 3. ___.__

2. ___.__ 4. ___.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PAID

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 02 03 00		21	04	74160	26 GC	1	254 00	1				
				CT SCAN OF ABDOMEN C								
2												
3												
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
232919472	☐ ☒	3744810	☒ YES ☐ NO	$ 254 00	$ 0 00	$ 254 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.)

MANUEL P MEZA MD

SIGNED 02/22/00 DATE

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

CHP INPT
ONE CHILDRENS PLAC
PITTSBURGH PA 15214

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (412) 647-9600

UNIV OF PITTSBURGH PHYSICIANS
PO BOX 371980
PITTSBURGH PA 15250-7980

PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

#2 SAE

APPROVED OMB-0938-0008

PROGRESSIVE INS
1 MONROEVILLE CENTER
3824 NORTHERN PIKE SUITE 510
MONROEVILLE PA 15146

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA ☐ PICA ☐

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 004222491SAE - N - 8

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Shimmel Brandon M	11 21 1991 M ☒ F ☐	Shimmel Benjamin L
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
37 Country Place	Self ☐ Spouse ☐ Child ☒ Other ☐	37 Country Place
CITY / STATE	8. PATIENT STATUS	CITY / STATE
DuBois PA	Single ☒ Married ☐ Other ☐	DuBois PA
ZIP CODE / TELEPHONE (Include Area Code)	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
15801 (814) 371-2931		15801 (814) 371-2931
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
Brandon M Shimmel		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
41014577564		11 21 1991 M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	b. AUTO ACCIDENT? ☒ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
M ☐ F ☐		Elcam
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
Elcam		
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.
DEPARTMENT OF PUBLIC WELFARE	******	

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.
Signature On File 021100
SIGNED _____ DATE _____

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

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
02 03 00	PROGRESSIVE	
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
Fred G Wenger D O	FEB 17 2000	
19. RESERVED FOR LOCAL USE	WPA - PIP RECEIVED	20. OUTSIDE LAB? ☐ YES ☒ NO / $ CHARGES 0 00
		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		23. PRIOR AUTHORIZATION NUMBER
1. 9591 9591	3.	
2. 9596	4.	

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 02 03 00	2	4	71020	26	1	30 00	1				
2 02 03 00	2	4	72170	26	2	33 00	1				
3											
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
25-1715230 ☐ ☐	shimbr395407	☒ YES ☐ NO	$ 63 00	$ 0 00	$ 63 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 # (814) 371-2484
G Kosco MD	DuBois Reg Medical Ctr DuBois, PA 15801 DU390086	DuBois Radiologists Inc. PO Box 1106 DuBois PA 15801
SIGNED 25-1715230 DATE 021100		PIN# GRP# 25-1715230

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

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

Explanation of Reimbursement

Progressive Insurance

Claim Information

Claim Number:	004222491-08	Region:	W PA PIP
Policyholder:	SHIMMEL , BENJAMIN LEROY	Office:	MONROEVILL
Claimant:	SHIMMEL, BRANDON	Claim Rep:	SAE0005
Date of Loss:	02/03/2000	Party:	First
Updated:	03/06/2000	Bill No:	2
		Audited:	03/06/2000

Provider Information

DUBOIS RADIOLOGISTS INC
P.O BOX 1106
DUBOIS, PA 15801

Place of Service ZIP:	15801
Jurisdiction State:	PA
Payee EIN:	25-1715230
Specialty:	30 - RADIOLOGY, DIAGNOSTIC MD OR DO
Patient Account Number:	

Diagnosis

Seq#	ICD-9	Description
1	959.1	OTHER AND UNSPECIFIED INJURY TO TRUNK
2	959.6	OTHER AND UNSPECIFIED INJURY TO HIP AND THIGH

Item Detail

Item	Date	POS	CPT-Mod	Description	Units	Charge	PAID AMOUNT	Reason Code
1	02/03/00	22	71020-26	X-RAY, CHEST, TWO VIEWS, FRONTAL/LATERAL		30.00	12.40	FA97P
2	02/03/00	22	72170-26	X-RAY EXAM, PELVIS, AP ONLY		33.00	9.66	FA97P
				Totals for Bill		63.00	22.06	

Reason Code Description

Reason Code - Item	Description
FA97P -	Charge exceeds 110% of the Medicare prevailing charge or 110% of the fee schedule, whichever has been determined to be applicable by Medicare.

Applicable for Pennsylvania only: For your protection, Pennsylvania requires the following to appear on this form: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

APPROVED OMB NO. 0938-0279

0003400477 1

DUBOIS REG MED CTR PO BOX 447 DUBOIS PA 15801 (814) 371-2200	2	3 PATIENT CONTROL NO. 0003400477	4 TYPE OF BILL 131
	5 FED. TAX NO. 25-1490707	6 STATEMENT COVERS PERIOD FROM 02/03/0002 THROUGH 03/08/0000	7 COV D. 8 N-C D. 9 C-I D. 10 L-R D. 11

12 PATIENT NAME: SHIMMEL, BRANDON M

13 PATIENT ADDRESS: 37 COUNTRY PLACE DUBOIS PA 15801

#1 NT. SAME

14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 26 27 28 29 30 31
11211991	M	S	020300	17	2	1	19	02	000372435	

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37 A B C
a												Rec. 2-3-00
b												

SHIMMEL, BENJAMIN LEROY — NI
37 COUNTRY PLACE
DUBOIS PA 15801
(814) 371-2931

38 CODE	38 VALUE CODES AMOUNT	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a							
b			004272491-N-8				
c							
d							

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	258	IV SOLUTIONS			1	2000		
2	270	SUPPLIES			7	1500		
3	300	SPECIMEN COLLECTION - CH	G0001		1	500		
4	305	CBC & DIFF	85025		1	4200		
5	307	URINALYSIS ROUTINE	81000		1	2100		
6	320	XR-PELVIS AP	72170		1	10100		
7	324	XR-CHEST, 2 VIEWS	71020		1	10700		
8	450	CRITICAL CARE E/M 1ST HO	99291		1	35000		
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	TOTAL CHARGES				66100		

DAY IN 3/1/00
DAY OUT 3/6

361.55

PROGRESS
FEB 11 2000
WPA - PIP RECEIVED

Auth rcvd 2/14

50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A PROGRESSIVE AUTO INS	390086	Y	Y	PAID	66100	
B						
C						

DUE FROM PATIENT

57	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	SHIMMEL, BENJAMIN LEROY	03	655567850		999999
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A		1	ELCAM	
B				
C				

67 PRIN. DIAG. CD.	68 CODE	69 CODE	OTHER DIAG. CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
959.1	87342	7850	E8191					9598	E8495	

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE	82 ATTENDING PHYS. ID
9						E52919 WENGER FRED

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

OTHER PHYS. ID

	84 REMARKS
a	
b	
c	
d	

REPRESENTATIVE 86 DATE 020900

THIS BILL AND ARE MADE A PART HEREOF.

D0003400477 2 FINAL

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 655567850
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BRANDON M	3. PATIENT'S BIRTH DATE MM DD YY: 11 21 1991 SEX M [X] F [ ]		4. INSURED'S NAME (Last Name, First Name, Middle Initial): SHIMMEL, BENJAMIN LEROY
5. PATIENT'S ADDRESS (No., Street): 37 COUNTRY PLACE	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]		7. INSURED'S ADDRESS (No., Street): 37 COUNTRY PLACE
CITY: DUBOIS STATE: PA	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]		CITY: DUBOIS STATE: PA
ZIP CODE: 15801-0000 TELEPHONE (Include Area Code): (814) 371-2931	Employed [X] Full-Time Student [ ] Part-Time Student [ ]		ZIP CODE: 15801-0000 TELEPHONE (INCLUDE AREA CODE): (814) 371-2931
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: 999999
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]		a. INSURED'S DATE OF BIRTH MM DD YY: 01 03 1967 SEX M [X] F [ ]
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: ELCAM
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]		c. INSURANCE PLAN NAME OR PROGRAM NAME: PROGRESSIVE AUTO INS
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 02/08/2000

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: WENGER, FRED G	17a. I.D. NUMBER OF REFERRING PHYSICIAN: E52919	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 03 2000 TO MM DD YY 02 03 2000
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 9591 2. 87342 3. 7850 4. E8495		22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

PROGRF
FEB 11 2000
WPA - PIP RECEIVED

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 02 03 2000	02 03 2000	23		99291		1	300 00	1				568816GY8
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 25-1490707	26. PATIENT'S ACCOUNT NO.: 0003400477	27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 300 00
29. AMOUNT PAID: $ 0 00	30. BALANCE DUE: $ 300 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.) SIGNED WENGER, FRED DATE 02/08/2000	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office): DUBOIS REG MED CTR, PO BOX 447, DUBOIS PA 15801	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: DUBOIS REG MED CTR, PO BOX 447, DUBOIS PA 15801 PIN# GRP# 402465

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

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS

Direct inquiries regarding this review to:

004222491

Med Path
3191 Trewigtown Road
Colmar, PA 18915
Phone (215) 996-9100 · Fax (215) 996-0687

A bill audit, fee schedule
and claims processing service

CLAIM NO: 004222491
COVERED INDIVIDUAL: SHIMMEL, BRANDON
POLICY HOLDER:

SHIMMEL, BRANDON

PROVIDER: DUBOIS REGIONAL MEDICAL CE
TAX ID/PROVIDER NO: 39-0086
PATIENT NO: 0003400477

DUBOIS REGIONAL MEDICAL CENT
100 HOSPITAL AVE
DUBOIS, PA 15801

PAYOR: PROGRESSIVE COMPANIES, MON
ACCIDENT DATE: 02/03/00

MEDLOGIX ID: 067640A -001A
CALCULATION DATE: 03/31/00

EXPLANATION OF BENEFITS

DATE OF SERVICE: 02/03/00

DIAGNOSES:
1) 959.1 TRUNK INJURY NOS
2) 873.42 OPEN WOUND OF FOREHEAD
3) 785.0 TACHYCARDIA NOS
4) E819.1 TRAFFIC ACC NOS-PASNGR

THE MED BOX

Total Billed Amount.....:	661.00
Calculated Amount.....:	301.55
Carrier's Responsibility....:	
TOTAL AMOUNT DUE.....:	301.55

Outpatient
PA Automobile

ITEMIZED CHARGES

DATE	SERVICE	DIAGS	UNITS	CHARGE	PAYMENT TYPE	REDUCTION	AMT DUE	STATUS
02/03/00	250	1	1.00	20.00	RCC	10.89	9.11	
	DRUGS CHARGED TO PATIENTS/PHARM							
02/03/00	270	1	1.00	15.00	RCC	7.13	7.87	
	MED SUPPLIES CHARGED TO PATIENTS							
02/03/00	G0001	1	1.00	5.00	State Fee	1.70	3.30	
	ROUTINE VENIPUNCTURE FOR COLLECTION OF SPECIMEN(S)							
02/03/00	85025	1	1.00	42.00	State Fee	30.19	11.81	
	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)							
02/03/00	81000	1	1.00	21.00	State Fee	16.19	4.81	
	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, prote							

THE ABOVE SERVICES HAVE BEEN COMPUTED TO CONFORM TO PENNA HOUSE BILL 1621 AUTO INSURANCE REFORM LAW, "ACT 6", AS AMENDED NOVEMBER 30, 1991. ALL CALCULATIONS REPRESENT 110% OF THE APPLICABLE MEDICARE FEE SCHEDULE, RECOMMENDED FEE, DRG AMOUNT, 80% OF UCC; OR PROVIDER CHARGES, AS IN ACCORDANCE WITH SECTION 65.43.

Direct inquiries regarding this review to: 004222491

Med Path
3191 Trewigtown Road
Colman, PA 18915
Phone (215) 996-9100 • Fax (215) 996-0887

A bill audit, fee schedule and claims processing service

CLAIM NO: 004222491
COVERED INDIVIDUAL: SHIMMEL, BRANDON
PAYOR: PROGRESSIVE COMPANIES, MONROEVILLE, PA

ITEMIZED CHARGES

DATE	SERVICE	DIAGS	UNITS	CHARGE	PAYMENT TYPE	REDUCTION	AMT DUE	STATUS
02/03/00	72170	320	1 1.00	101.00	Blended Rate	70.29	30.71	
	Radiologic examination, pelvis; anteroposterior only							
	Payment Blended using Radiology/Imaging Ratios from 320 RADIOLOGY - DIAGNOSTIC							
02/03/00	71020	320	1 1.00	107.00	Blended Rate	72.72	34.28	
	Radiologic examination, chest, two views, frontal and lateral;							
	Payment Blended using Radiology/Imaging Ratios from 320 RADIOLOGY - DIAGNOSTIC							
02/03/00		450	1 1.00	350.00	RCC	150.34	199.66	
	EMERGENCY							
			Totals:	661.00		393.45	301.55	

THE ABOVE SERVICES HAVE BEEN COMPUTED TO CONFORM TO PENN HOUSE BILL 121 AUTO INSURANCE REFORM LAW, "ACT 6", AS AMENDED NOVEMBER 30, 1991. ALL CALCULATIONS REPRESENT 110% OF THE APPLICABLE MEDICARE FEE SCHEDULE, RECOMMENDED FEE, DRG AMOUNT, 80% OF U&C; OR PROVIDER CHARGES, AS IN ACCORDANCE WITH SECTION 83.43.

Explanation of Reimbursement

Progressive Insurance

Claim Information

Claim Number:	004222491-08	Region:	W PA PIP
Policyholder:	SHIMMEL , BENJAMIN LEROY	Office:	MONROEVILL
Claimant:	SHIMMEL, BRANDON	Claim Rep:	SAE0005
Date of Loss:	02/03/2000	Party:	First
Updated:	03/06/2000	Bill No:	1
		Audited:	03/06/2000

Provider Information

DUBOIS REGIONAL MEDICAL CENTER
PO BOX 447
DUBOIS, PA 15801

Place of Service ZIP:	15801
Jurisdiction State:	PA
Payee EIN:	25-1490707
Specialty:	00 - HOSPITAL, ECF, ETC
Patient Account Number:	

Diagnosis

Seq#	ICD-9	Description
1	959.1	OTHER AND UNSPECIFIED INJURY TO TRUNK
2	873.42	OPEN WOUND OF FOREHEAD, UNCOMPLICATED
3	785.0	TACHYCARDIA, UNSPECIFIED
4	E819.1	MOTOR VEHICLE TRAFFIC ACCIDENT OF UNSPECIFIED NATURE INJURING PASSENGER IN MOTOR VEHICLE OTHER THAN MOTORCYCLE
5	959.8	OTHER AND UNSPECIFIED INJURY TO OTHER SPECIFIED SITES, INCLUDING MULTIPLE
6	E849.5	STREET AND HIGHWAY ACCIDENTS

Item Detail

Item	Date	POS	CPT-Mod	Description	Units	Charge	PAID AMOUNT	Reason Code
1	02/03/00	22	ER100	HOSPITAL ER		661.00	301.55	EX201
				Totals for Bill		661.00	301.55	

Reason Code Description

Reason Code - Item	Description
EX201 -	MEDPATH RECOMMENDED ALLOWANCE

Applicable for Pennsylvania only: For your protection, Pennsylvania requires the following to appear on this form: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DUBOIS REGIONAL MEDICAL CENTER
Wed Feb 09, 2000 12:01 pm
Single Test Report

Pat Name: SHIMMEL,BRANDON M
Unit #/Acct #: 000372635/D0003400477
Loc: ER 02/03/00
Phys-Service: WENGER,FRED G - *EMERGENCY ROOM

In: 02/03/00 1905
Out: 02/03/00 1918
Coll Time: 02/03/00 1903
Order Phys: WENGER,FRED G

URINALYSIS ROUTINE

Spec: Urine Clean Catch
Techs: VER T01447*

[D0003400477/1115480]

*STAT*STAT*STAT*

Result Name	Result
Color:	YELLOW
Clarity:	CLEAR
Glucose(mg/dl):	500 mg/dL
Bili,Ua:	NEGATIVE
Ketone, Ua(mg/dl):	15 mg/dL
Specific Gravity:	1.025
Blood, Occult:	NEGATIVE
pH(pH Units):	6.5
Protein(mg/L):	NEGATIVE
Urobilinogen(EU/dl):	0.2 E.U./dL
Nitrites:	NEGATIVE
Leukocytes:	NEGATIVE
WBCs(/HPF):	0
RBCs(/HPF):	0
Epithelial Cells(/LPF):	0
Order Comment:	BED 9

End of Report - 02/09/00 12:01pm

Jose Costa M.D./Gregory Suslow M.D.

Single Test Report

SHIMMEL,BRANDON M
000372635/D0003400477
ER 02/03/00
(M-11/21/91)
Dr. WENGER,FRED G

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF FINANCIAL OPERATIONS
TPL SECTION - CASUALTY UNIT
PO BOX 8486
HARRISBURG, PA 17105-8486

December 28, 2000

PROGRESSIVE INSURANCE COMPANY
MICHELLE SMEAL CLAIMS ADJUSTER
100 SCENERY DRIVE STE B
STATE COLLEGE PA 16801

RE: BRANDON SHIMMEL
CIS: 4101457564
Incident Date: 2/3/00

Dear Ms. Smeal,

This is in response to our telephone conversation on December 28, 2000, where you stated that first party benefits have been exhausted. The Department of Public Welfare has no medical assistance lien for this incident.

If you have any questions, please feel free to contact me.

Sincerely,

Karen H. Peterson

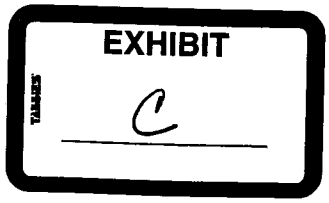
Karen H. Peterson
Claims Investigation Agent
(717) 772-6615

EXHIBIT
B

FULL AND FINAL RELEASE

KNOW ALL MEN BY THESE PRESENTS, that I, Kathy Shimmel, individually and as parent and natural guardian of Brandon Shimmel, being of full legal age and of sound mind, for and in consideration of the sum of TWO THOUSAND FIVE HUNDRED AND 00/100 DOLLARS ($2,500.00), lawful money of the United States of America to me in hand paid by BENJAMIN SHIMMEL and PROGRESSIVE INSURANCE COMPANY the receipt whereof is hereby acknowledged, do hereby release and forever discharge, and by these presents do for myself, my heirs, successors and assigns, release and forever discharge the said BENJAMIN SHIMMEL and PROGRESSIVE INSURANCE COMPANY their heirs, successors, assigns and all other persons, firms, corporations from any and all liability, claims, causes of action, damages, costs, expenses or demands of any kind whatsoever in law or in equity, AND, SPECIFICALLY, FROM ANY CLAIMS OR JOINDERS FOR SOLE LIABILITY, CONTRIBUTION, INDEMNITY OR OTHERWISE, which against the said BENJAMIN SHIMMEL and PROGRESSIVE INSURANCE COMPANY I or Brandon Shimmel ever had, now have or which we may have in the future, or which our heirs, executors, successors, assigns hereinafter can or may have by reason of any bodily or personal injury, damages to property and the consequences thereof, known or unknown, foreseen or unforeseen, arising or which may arise as a result of or in any way connected with personal injuries as sustained by Brandon Shimmel on or about February 3, 2000 on Route 4011 in Brady Township, Clearfield County, Pennsylvania.

It is further understood and agreed that the acceptance of this sum is in full accord and satisfaction of a disputed claim and the payment of this sum is not to be construed as an admission of liability and liability is hereby expressly denied.



It is further understood and agreed that this is a complete release agreement and that there is no written or oral understanding or agreement directly or indirectly connected with this release and settlement that is not incorporated herein.

I hereby declare that I fully understand the terms of this settlement, that the amount stated herein is the sole consideration for this release and that I have voluntarily accepted the said sum for the purpose of making a full and final compromise and settlement of my said claim.

This agreement shall be construed that wherever applicable, the use of the singular number shall include the plural number and the masculine gender shall be construed to include the feminine or neuter gender.

It is further understood and agreed that we are responsible for the payment of any lien or charges against the settlement sum should any person or entity make a claim for payment against any lien or charges against Benjamin Shimmel, Progressive Insurance Company or Pfaff, McIntyre, Dugas, Hartye & Schmitt. I hereby agree to indemnify and hold harmless the aforesaid entities from any and all liens, charges, fees, costs, interests and other sums.

I have read the above, understand the same, and agree to be legally bound by all the terms of this Release agreement.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this _____ day of _____, 2001.

WITNESS:

_____ _____

Kathy Shimmel, individually and as parent and natural guardian of Brandon Shimmel

Kathy Shimmel Soc. Sec. No.:_____

Brandon Shimmel Soc. Sec. No.:_____

STATE OF PENNSYLVANIA)
) ss:
COUNTY OF _____)

On this ____ day of _____, 2001, before me personally appeared _____ to me known, and known to me to be the same persons described in and who executed the above instrument and they severally acknowledged to me that they executed the same.

_____
Notary Public

VERIFICATION

I, **KATHY SHIMMEL**, do hereby verify that I have read the foregoing **PETITION FOR APPROVAL OF SETTLEMENT OF A MINOR'S CLAIM.** The statements therein are correct to the best of my personal knowledge or information and belief.

This statement and verification are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn fabrication to authorities, which provides that if I make knowingly false averments I may be subject to criminal penalties.

Kathy Shimmel

Kathy Shimmel

Date: 6-5-01

FILED

JUL 12 2001

03:57 Cathy Harrington

William A. Shaw
Prothonotary

PD $80.00

4 no cc

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION

BRANDON SHIMMEL, a minor, by his Parent and Natural Guardian, KATHY SHIMMEL	:	No. 01 – 1125 – CD

ORDER

NOW, this 20th day of September, 2001, upon consideration of the within Petition, it is hereby ORDERED, ADJUDGED, AND DECREED that the claims of KATHY SHIMMEL, parent and natural guardian of the minor, BRANDON SHIMMEL, shall be, and the same are hereby compromised and settled on the following terms:

1. Payment to Kathy Shimmel, as parent and natural guardian of Brandon Shimmel of a lump sum of Two Thousand Five Hundred ($2,500.00) by Benjamin Shimmel and Progressive Insurance, with said funds to be deposited by Kathy Shimmel into an interest-bearing account on behalf of Brandon Shimmel, said funds not to be withdrawn until Brandon Shimmel reaches the age of majority on November 21, 2009;

2. Record costs and attorneys fees of Pfaff, McIntyre, Dugas, Hartye & Schmitt, will be paid by Progressive Insurance Company; and

3. Petitioner is hereby granted leave to execute a Release for the benefit of Benjamin Shimmel and Progressive Insurance Company.

By the Court,

President Judge

FILED

SEP 20 2001

William A. Shaw
Prothonotary

FILED

SEP 20 2001

01:35:13 cc atty Harrington

William A. Shaw
Prothonotary

KLD

BRANDON SHIMMEL, a minor, by his Parent and Natural Guardian, KATHY SHIMMEL,	: IN THE COURT OF COMMON PLEAS : OF CLEARFIELD COUNTY, PA
Petitioner	: No. 01-1125-CD

PRAECIPE FOR FILING OF PROOF OF DEPOSIT

TO THE PROTHONOTARY:

Please file the attached Proof of Deposit of proceeds from this Court-approved settlement.

Respectfully submitted,

McINTYRE, DUGAS, HARTYE & SCHMITT

Heather A. Harrington, Esquire
PA. ID. No. 62977
P.O. Box 533
Hollidaysburg, PA 16648
814/696-3581

DEPOSIT BANK

a division of FIRST COMMONWEALTH BANK
Member FDIC
DUBOIS MALL OFFICE
814 371-5002

Certificate of Deposit

NON TRANSFERABLE -- NON NEGOTIABLE
AUTOMATICALLY RENEWABLE

60 - 180 MONTH CERTIFICATE

REPRESENTATIVE	BRANCH	CD TYPE	CERTIFICATE NUMBER	AMOUNT
SLC	042	445	01042000000301	$2,500.00

MATURITY PERIOD	ISSUE DATE	MATURITY DATE
60 MONTH	October 16, 2001	October 16, 2006

INTEREST RATE PAYABLE: **4.120%**

ANNUAL PERCENTAGE YIELD: **4.20 %**

ISSUED TO: CUSTOMER NUMBER: **1042000000301**
BRANDON M SHIMMEL
KATHERINE SHIMMEL GUARDIAN
BY ORDER OF COURT UNTIL 11-21-09

ADDRESS
38 COUNTRY PLACE
DUBOIS PA 15801

TELEPHONE: **814 371-8727**

COPY

INTEREST WILL BE PAID **MONTHLY** AND **ADDED TO THE PRINCIPAL BALANCE**

EARLY WITHDRAWAL PENALTY
IF THE DEPOSIT IS WITHDRAWN BEFORE THE MATURITY DATE, A PENALTY EQUAL TO **365 days** SIMPLE INTEREST WILL BE ASSESSED. ALL PENALTIES ARE ASSESSED AT THE RATE BEING PAID ON THE ACCOUNT AT THE TIME OF WITHDRAWAL. EARLY WITHDRAWAL MAY RESULT IN A REDUCTION IN THE PRINCIPAL AMOUNT ORIGINALLY DEPOSITED. NO PENALTY WILL BE ASSESSED ON WITHDRAWALS RESULTING FROM THE DEATH OR MENTAL INCAPACITY OF A DEPOSITOR.

RENEWABILITY
THE ACCOUNT IS AUTOMATICALLY RENEWABLE. UNLESS WE RECEIVE WRITTEN INSTRUCTIONS TO THE CONTRARY WITHIN TEN (10) CALENDAR DAYS AFTER THE MATURITY DATE, THE ACCOUNT WILL BE RENEWED FOR AN ADDITIONAL **60 MONTH** TERM. THE INTEREST RATE AND ANNUAL PERCENTAGE YIELD FOR THE NEXT MATURITY PERIOD WILL BE WHAT THE BANK IS OFFERING ON REGULAR **60 MONTH** CERTIFICATES AS OF THE MATURITY DATE. RENEWAL WILL BE EFFECTIVE AND INTEREST WILL BE EARNED AS OF THE MATURITY DATE. FUNDS MAY BE WITHDRAWN WITHIN THE TEN (10) CALENDAR DAYS AFTER ANY MATURITY DATE BY SURRENDERING THE CERTIFICATE AND COMPLETING A WRITTEN REQUEST. NO INTEREST WILL BE PAID AFTER THE MATURITY DATE ON FUNDS WITHDRAWN DURING THE TEN (10) DAY PERIOD.

The sum of $2500 dols 00 cts

COPY

CDC_CR.05S December 11, 2000

TAX REPORTING INFORMATION

TAX INFORMATION FOR THIS ACCOUNT WILL BE REPORTED USING THE FOLLOWING TAXPAYER NAME AND TAXPAYER IDENTIFICATION NUMBER:

TAXPAYER NAME: **BRANDON M SHIMMEL**
TAXPAYER IDENTIFICATION NUMBER: **206-72-7057**

DEPOSITOR ACKNOWLEDGEMENTS

BY SIGNING THE BANK'S COPY OF THE CERTIFICATE AT THE TIME THE ACCOUNT WAS OPENED, EACH SIGNER: (1) ACKNOWLEDGED THAT THE *DEPOSIT ACCOUNT AGREEMENT FOR CERTIFICATES OF DEPOSIT*, AND THE *DISCLOSURE OF ACCOUNT TERMS* WERE RECEIVED BEFORE THE ACCOUNT WAS OPENED, **AND** (2) ACKNOWLEDGED THAT THE BANK REFERENCED ABOVE IS A DIVISION OF FIRST COMMONWEALTH BANK, AS ARE THE OTHER DIVISIONS DETAILED IN THE *DEPOSIT ACCOUNT AGREEMENT -- CERTIFICATES OF DEPOSIT*, AND THAT THE DEPOSITS HELD AT EACH FACILITY ARE NOT SEPARATELY INSURED BY THE FDIC, (3) AGREED THAT THE TERMS AND CONDITIONS CONTAINED THEREIN WILL GOVERN THE OPERATION OF THE ACCOUNT, **AND** (4) AUTHORIZED THE BANK TO RECOGNIZE THE SIGNATURES OF ANY 1 OF THE DEPOSITORS TO TRANSACT BUSINESS ON THE ACCOUNT.

BANK SIGNATURE

BANK SIGNATURE ► Sherry L Carney <SEAL> DATE ► 10/16/01

CUSTOMER COPY

FILED NO CC
m 10:52 BH
NOV 07 2001

William A. Shaw
Prothonotary

BRANDON SHIMMEL, a minor, by his Parent and Natural Guardian, KATHY SHIMMEL,	:	IN THE COURT OF COMMON PLEAS
	:	OF CLEARFIELD COUNTY, PA
	:	
	:	No. 01-1125-CD
Petitioner	:	

PRAECIPE TO SETTLE AND DISCONTINUE

TO THE PROTHONOTARY:

Kindly mark the above-captioned matter as settled and discontinued.

Respectfully submitted,

McINTYRE, DUGAS, HARTYE & SCHMITT

Heather A. Harrington, Esquire
PA. ID. No. 62977
P.O. Box 533
Hollidaysburg, PA 16648
814/696-3581

FILED Atty pd.
m 10:52 BL 7.00
NOV 07 2001
Certificate to Atty
William A. Shaw
Prothonotary
NoCC

IN THE COURT OF COMMON PLEAS OF
CLEARFIELD COUNTY, PENNSYLVANIA

COPY

CIVIL DIVISION

In Re:
Brandon Shimmel, a minor by his
Parent and Natural Guardian
Kathy Shimmel

No. 2001-01125-CD

CERTIFICATE OF DISCONTINUATION

Commonwealth of PA
County of Clearfield

I, William A. Shaw, Prothonotary of the Court of Common Pleas in and for the County and Commonwealth aforesaid do hereby certify that the above case was on November 7, 2001, marked:

Settled and Discontinued

Record costs in the sum of $87.00 have been paid in full by Heather A. Harrington, Esq..

IN WITNESS WHEREOF, I have hereunto affixed my hand and seal of this Court at Clearfield, Clearfield County, Pennsylvania this 7th day of November A.D. 2001.

_____
William A. Shaw, Prothonotary