KAYLA SHIMMEL, a minor, by her Parent and natural guardian, KATHY SHIMMEL,

Petitioner

: IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PA

: No. 01-1126-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
09:10/2cc atty Harrington
William A. Shaw
Prothonotary
GK

KAYLA SHIMMEL, a minor, by her Parent and natural guardian, KATHY SHIMMEL,	:	IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PA
Petitioner	:	No. 01-1126-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, KAYLA 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 Kayla Shimmel of a lump sum of Four Thousand Seven Hundred and Fifty Dollars ($ 4,750.00) by Benjamin Shimmel and Progressive Insurance, with said funds to be deposited by Kathy Shimmel into an interest-bearing account on behalf of Kayla Shimmel, said funds not to be withdrawn until Kayla Shimmel reaches the age of majority on NOVEMBER 2, 2008;

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.

KAYLA SHIMMEL, a minor, by her Parent and natural guardian, KATHY SHIMMEL,	:	IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PA
Petitioner	:	No. 01-1136-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, Kayla 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 Kayla Shimmel, born on November 2, 1990, who resides with the Petitioner at the address listed above.

3. On or about February 3, 2000, Kayla 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, Kayla Shimmel, received personal injuries in the nature of lacerations to her left cheek and chin, minor contusion to the kidneys and minor concussion.

6. On the date of said accident, Minor, Kayla Shimmel, was seen at the

emergency room of the DuBois Regional Medical Center, where she was diagnosed with facial lacerations, microscopic hematuria and was admitted for an overnight stay. (A copy of the entire set of treatment records and medical bills from DuBois Regional Medical Center is attached hereto as Exhibit A and incorporated by reference.)

7. Kayla 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 by Progressive Insurance Company

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

1. Payment to Kathy Shimmel, as parent and natural guardian of Kayla Shimmel of a lump sum of Four Thousand Seven Hundred and Fifty Dollars ($ 4,750.00) by Benjamin Shimmel and Progressive Insurance, with said funds to be deposited by Kathy Shimmel into an interest-bearing account on behalf of Kayla Shimmel, said funds not to be withdrawn until Kayla Shimmel reaches the age of majority on NOVEMBER 2, 2008;

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 B and incorporated by reference.)

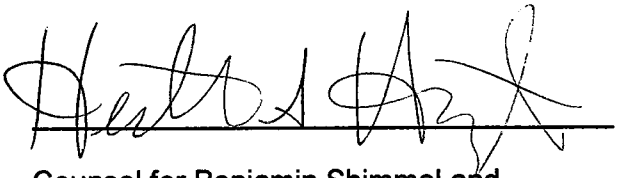
10. Petitioner, Kathy Shimmel, parent and natural guardian of the Minor, Kayla Shimmel, has read and understand the statements in this Petition and agrees to accept the settlement set forth hereinabove in full and complete satisfaction of any and all claims against Benjamin Shimmel and Progressive Insurance

Company for any personal injuries sustained by Minor, Kayla 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, Kayla Shimmel, should be accepted.

WHEREFORE, Petitioner, Kathy Shimmel, parent and natural guardian of Minor, Kayla 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, Kayla 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

Kayla 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) Kayla Marie Shimmel

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

DATE

SOCIAL SECURITY#

PROGRESSIVE
FEB 14 2000
WPA - PIP
RECEIVED

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

#3

DISCHARGE SUMMARY
DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

11/02/1990
PATIENT NAME: SHIMMEL, KAYLA M 0003400471 - 000350366

ADMISSION DATE: 02/03/2000 DISCHARGE DATE: 02/04/2000

HISTORY OF PRESENT ILLNESS: This 9-year-old girl was in the passenger seat in the front of an automobile, restrained with a seat belt, when it was hit head-on with a truck. She was brought to the Emergency Room by ambulance. The patient had multiple small facial lacerations and abrasions. She had a contusion of her right frontal temporal area and had microscopic hematuria. She had amnesia of the event and was admitted for observation. The CT of the head was all right.

HOSPITAL COURSE: On admission, the patient had multiple small lacerations over the face and chin with contusion of the right frontal temporal area. The examination otherwise was unremarkable. Neurologically, the patient appeared appropriate. She did have some temporary loss of memory of the incident. However, by the next morning, she was remembering it. Her H&H remained stable. The examination at the time of discharge was unremarkable. She had a sonogram of the abdomen and urinary tract as well as urinalysis at the time of discharge, but the results were not back at the time of this dictation.

DISCHARGE DIAGNOSES:
Multiple lacerations and contusions.
Contusion of the kidneys.

DISCHARGE INSTRUCTIONS: The patient will be followed in my office in one week or sooner.

D: 02/04/2000 9:12 A
T: 02/04/2000 11:17 A WJS/mrr
DOCUMENT NO: 123323
Job/Tape ID: 008186

W John Siar, M.D.

cc: W John Siar, M.D.

Chart Copy

9/2/98SAG

PROGRESS RECORD

DuBois Regional Medical Center

Making the difference for life.

350366 9Y PED 4120-01 I/P
SHIMMEL,KAYLA M
SIAR,W J
11/02/90 F 02/03/00
183-72-2977 0003400471

Date	Record progress of case, complications, change, instructions to patient
2/3/00	Pt admitted after being in a motor vehicle accident. Has microscopic hematuria and facial lacerations.
2/4/00	Alert. Abd soft + non tender. Will get Surgeon eval abd + plans discharge

H:\SHARING\MIS FORMS. HW-73 MIS.doc
9/2/98SAG

PROGRESS RECORD

DuBois Regional Medical Center

Making the difference for life.

350366 9Y PED 4120-01 I/P
SHIMMEL,KAYLA M
SIAR,W J
11/02/90 F 02/03/00
183-72-2977 0003400471

Date	Record progress of case, complications, c[illegible] instructions to patient [illegible] ischarge,
2/4/00	Kayla may Go home (Be Discharged) with her
12pm	Grandmother, Dorothy Shimmel.
	Permission Given By Benjamin Shimmel (Father)
	Jennifer Giuffreda
	Christie Hess RN.

HISTORY AND PHYSICAL EXAMINATION
DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

11/02/1990
SHIMMEL, KAYLA M 0003400471 - 000350366 4120

HISTORY OF PRESENT ILLNESS: This 9-year-old girl was in the passenger seat in the front of an automobile, restrained with a seat belt, when it was hit head-on with a truck. She was brought to the Emergency Room by ambulance. The patient had multiple small facial lacerations and abrasions. She had a contusion of her right frontal temporal area and had microscopic hematuria. She had amnesia of the event and was admitted for observation. The CT of the head was all right.

PAST MEDICAL HISTORY: The patient was 2 months premature.

FAMILY HISTORY: Paternal grandfather has hypertension.

ALLERGIES: NONE KNOWN.

SOCIAL HISTORY: The patient lives with her parents.

REVIEW OF SYSTEMS: Other than the problems mentioned above, unremarkable.

PHYSICAL EXAMINATION

GENERAL: The patient is an alert, well-nourished, well-developed, 9-year-old girl in no obvious distress. SKIN: Multiple small lacerations over the face with some abrasions and contusions of the right frontal temporal area. HEENT: Sclera and conjunctiva clear. Pupils equal, round, and react. Red reflex present. Ears, nose, and throat unremarkable. Tympanic membranes normal. Pharynx benign. NECK: Supple. CHEST: Symmetrical. LUNGS: Clear. HEART: No murmur. Regular rhythm. ABDOMEN: Soft. No organomegaly, masses, or guarding. BACK: Normal. GENITALIA: Normal female. Peripheral pulses normal. NEUROMUSCULAR: Appropriate for age.

ASSESSMENT:
Multiple small lacerations and contusions.
Mild concussion.
Probable contusion of the kidneys.

D: 02/04/2000 9:12 A
T: 02/04/2000 10:57 A WJS/mrr
DOCUMENT NO: 123321
Job/Tape ID: 008186

W John Siar, M.D.

cc: W John Siar, M.D.

Chart Copy

35036 003400471 02/ 0
SHIMN AYLA M
183-72-..7 F 9Y 11/02/90
MCANDREW,JOSEPH
SIAR,W J

DuBois Regional Medical Center 17

EMERGENCY PHYSICIAN RECORD

MVA (5)

TIME SEEN: 1745 ROOM: #10 __ EMS Arrival
HISTORIAN: ✓patient __spouse __paramedics
__HX / __EXAM LIMITED BY:

HPI chief complaint: MVA *Injury to:* a lot

occurred: ✓just PTA

position in vehicle: driver passenger *front back*

context: ✓-car collision overturned vehicle
single-car accident (*lost control / fell asleep / unknown cause*)
Head on

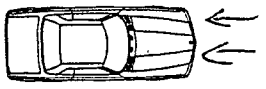
location of pain/injuries:
head face mouth
neck chest abdomen
back *upper mid- lower*
radiating to (R / L) thigh / leg

–right–		–left–	
shldr	hip	shldr	hip
arm	thigh	arm	thigh
elbow	knee	elbow	knee
f-arm	leg	f-arm	leg
wrist	ankle	wrist	ankle
hand	foot	hand	foot

severity of pain:
mild
moderate
severe

associated symptoms:
? lost consciousness / dazed
• *duration:*
remembers:
impact *coming to hospital*
__seizure

site of impact:
"P" = primary "S" = secondary



force low mod high
direct glancing

restraints:
none lap / shoulder
doesn't recall
car seat
air bag deployed
thrown from vehicle
ambulated at scene
long extrication

ROS ☐all systems neg excpt as markd
✓loss feeling / power arms/legs
__headache
__double vision / hearing loss
__trouble breathing / chest pain
__nausea / vomiting
✓loss of bladder function
✓skin laceration
__recent fever / illness

SOCIAL HISTORY __recent ETOH __smoker __drug abuse

PAST HISTORY ✓negative

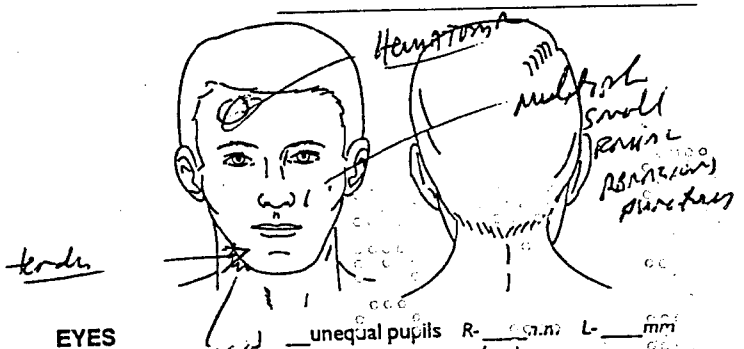
Meds- __none / __see nurses note
Allergies- ✓NKDA / __see nurses note

☐ Nurses note reviewed ☒ Tetanus immun. UTD ☐ Vital signs reviewed

PHYSICAL EXAM ✓Alert __Lethargic __Anxious
Distress- ✓NAD __mild __moderate __severe
Other- __c-collar (PTA / in ED) __back-board __IV __splint

HEAD
__no evidence of trauma
__see diagram
__Battle's sign / Raccoon Eyes

NECK
✓non-tender
✓painless ROM
✓trachea midline
__see diagram
__vertebral point-tenderness
__muscle spasm / decreased ROM
__pain on movement of neck



EYES
✓PERRL
✓EOMI
__unequal pupils R-___mm L-___mm
__EOM entrapment / palsy
__subconjunctival hemorrhage
__pale conjunctivae

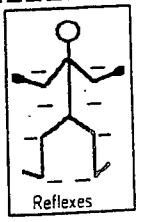
ENT
__nml external inspection
✓no dental injury
__hemotympanum
__TM obscured by wax
__clotted nasal blood
__dental injury / malocclusion

RESP & CVS
✓chest non-tender
✓breath sounds nml
✓heart sounds nml
__see diagram (on reverse)
__decreased breath sounds
__wheezing / rales
__splinting / paradoxical movements
__tachycardia

ABDOMEN
✓non-tender
✓no organomegaly
__see diagram (on reverse)
__rebound tenderness
__mass / organomegaly
__guarding

GENITAL / RECTAL
__nml genital exam
__nml vaginal exam
__nml rectal exam
__heme neg. stool
__perineal hematoma
__blood at urethral meatus
__decreased rectal tone

NEURO / PSYCH
✓oriented x3
✓mood & affect
✓CN'S nml as tested
✓sensation & motor nml
__confusion / disorientation
__EOM palsy / anisocoria
__facial asymmetry
__unsteady / ataxic gait
__sensory / motor deficit

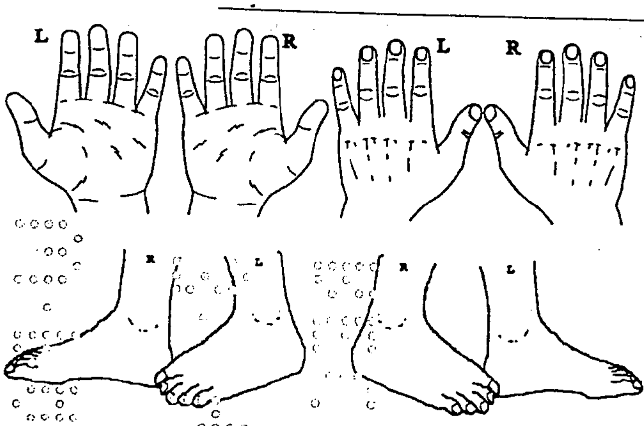

Reflexes

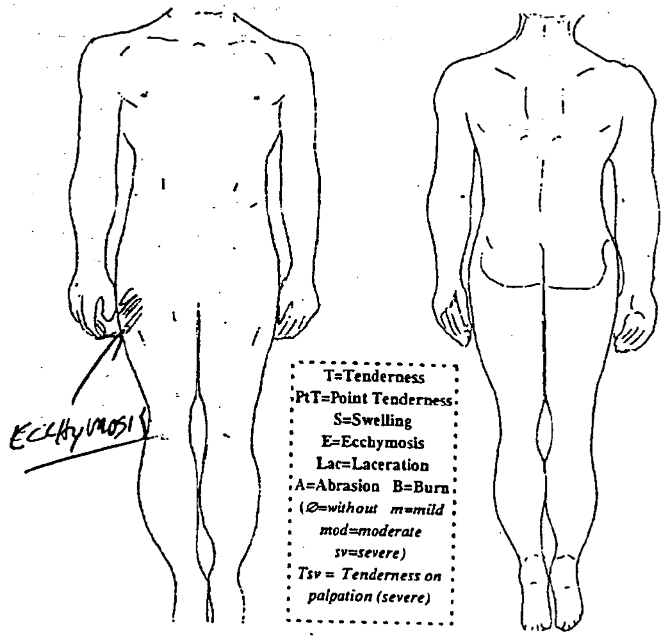
350366 00 0471 02/03/00
SHIMMEL,KA . M
183-72-2977 F 9Y 11/02/90
MCANDREW,JOSEPH
SIAR,W J

SKIN
__intact
__warm, dry
__see diagram
__crepitus / diaphoresis

BACK
__no CVA tenderness
__no vertebral tenderness
__see diagram
__vertebral point-tenderness
__CVA tenderness
__muscle spasm / limited ROM

EXTREMITIES
__atraumatic
__pelvis stable
__hips non-tender
__no pedal edema
__nml ROM
__see diagram
__bony point-tenderness
__painful / unable to bear weight
__pulse deficit
Joint Exam:
__limited ROM / ligaments laxity / joint effusion





XRAYS ☐ Interp. by me ☐ Reviewed by me ☐ Discsd w/radiologist

C-Spine *D-Spine* *LS-Spine*
__nml / NAD
__no fracture
__nml alignment
__soft tissues nml
__reversal / straightening of cerv. lordosis
__DJD / spondylosis / spurring
Portable

CXR
__nml / NAD
__no infiltrates
__nml heart size
__nml mediastinum
__rib fracture
__infiltrate / atelectasis

OTHER ☐ See separate report
~~Rt hip Cty. CT Head - nl~~

Wound Description/Repair
length_______ **cm** **location**_______
__superficial __SQ __muscle __linear __^stellate __^irregular
__clean __contaminated *moderately / *heavily*
distal NVT: __neuro & vascular status intact __no tendon injury
anesthesia: __local __digital block _______cc
__lidoc 1% 2% epi / bicarb __marcaine .25% .5% __LET
prep:
__sterile saline irrigation
__irrigated/washed w/ saline **extensively*
__explored
__^debrided / undermined **extensively*
__foreign material removed *minimal moderate ^extensive*
repair: *Wound closed with: dermabond / steri-strips*
SKIN- #_____ _____-0 nylon / prolene / staples
*SUBCU- #_____ _____-0 vicryl / chromic
*may indicate intermediate repair ^may indicate intermediate or complex repair

PROGRESS:

__Discussed with Dr. Siar
will see patient in: office / ED / hospital
__Counseled patient / family regarding:
lab results diagnosis need for follow-up
__Rx given __Admit orders written

__CRIT CARE- *30-74 min* *75-104 min* ______ *min*
__Prior records ordered
__Additional history from: *family caretaker paramedics*

CLINICAL IMPRESSION: MVA

contusion				sprain / strain
head		wrist	R / L	neck dorsal lumbar
face		hand	R / L	
chest		hip	R / L	
abdomen		thigh	R / L	**concussion**
back		knee	R / L	*with LOC w/o LOC*
shoulder	R / L	leg	R / L	
arm	R / L	ankle	R / L	**laceration**
elbow	R / L	foot	R / L	
forearm	R / L			

(1) Concussion (2) Facial Abrasions
(3) Rt hip contusion (4)

DISPOSITION- ☐ home ☒ admitted ☐ transferred
CONDITION- ☐ unchanged ☐ improved ☐ stable

[signature] MD / DO
Joseph E. McAndrew, MD
DEA #BM3871...
PA Lic. #MD051828L

MVA - 17

BOIS REGIONAL MEDICAL CEN
100 Hospital Ave., DuBois, PA 15801

SHIMMEL,KAYLA M PED-4120-01 Unit # 000350366
37 COUNTRY PLACE
DUBOIS PA 15801 Age 9Y Acct # D0003400471

Date:02/03/00 Time:1902

MCANDREW,JOSEPH

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

Chk-in #	Order	Exam	
383971	0001	40005	XR-MANDIBLE COMPLETE Ord Diag: 919.0-trauma
383971	0001	44015	XR-HIP UNI 2 VIEWS*R Ord Diag: 919.0-trauma
383975	0002	43023	XR-SPINE SINGLE VIEW Ord Diag: 919.0-trauma

LATERAL CERVICAL SPINE - SINGLE VIEW:

The heights and the alignment of the cervical vertebral bodies are normal. The intervertebral disc spaces are normally preserved. The pedicles, the transverse processes, and the posterior spinous processes are intact. The neural foramina are patent throughout with no evidence of bony encroachment. The posterior facet joints are normal. The relationship of the occiput to C1 and C1 to C2 is preserved. No abnormal soft tissue mass is present.

IMPRESSION: NORMAL CERVICAL SPINE.

MANDIBLE - FOUR VIEWS:

The bones are intact. The joint relationships are normally maintained. The soft tissues are unremarkable.

IMPRESSION: NEGATIVE MANDIBLE.

RIGHT HIP - TWO VIEWS:

The bones are intact. The joint relationships are normally maintained. The soft tissues are unremarkable.

IMPRESSION: NEGATIVE RIGHT HIP.
NIA CODE: ALL - N

/READ BY/ JERJIS T ALAJAJI, Radiologist
/Released By/ JERJIS T ALAJAJI, Radiologist

02/04/00 1217
LLW

Complete

D OIS REGIONAL MEDICAL CENTE
100 Hospital Ave, DuBois, PA 15801

SHIMMEL,KAYLA M PED-4120-01 Unit # 000350366
37 COUNTRY PLACE
DUBOIS PA 15801 Age 9Y Acct # D0003400471

Date:02/03/00 Time:1909

MCANDREW,JOSEPH

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

Chk-in #	Order	Exam	
383970	0001	72724	CT-HEAD UNENHANCED

Ord Diag: 854.00-BRAIN INJURY NEC

CT HEAD SCAN UNENHANCED:

HISTORY: MVA.

Computerized tomographic axial sections of the head were obtained without intravenous contrast enhancement.

The ventricular system is of normal size and shape. The cerebral hemispheres and posterior fossa are normal. There are no abnormal masses. There is no evidence of hemorrhage.

IMPRESSION: NORMAL UNENHANCED CT HEAD SCAN.

NIA CODE: N

/READ BY/ JERJIS T ALAJAJI, Radiologist
/Released By/ JERJIS T ALAJAJI, Radiologist

02/04/00 1217
LLW

Complete

D OIS REGIONAL MEDICAL CENTE
100 Hospital Ave, DuBois, PA 15801

SHIMMEL,KAYLA M PED-4120-01 Unit # 000350366
37 COUNTRY PLACE
DUBOIS PA 15801 Age 9Y Acct # D0003400471

Date:02/04/00 Time:0926

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

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

Chk-in #	Order	Exam	
383985	0006	42100	US-ABDOMEN COMPLETE

Ord Diag: 854.00-BRAIN INJURY NEC

ABDOMINAL SONOGRAM:

History: MVA.

There are no gallstones or gallbladder wall thickening. There is no intra- or extra-hepatic biliary dilatation. The common bile duct measures 2.5 mm. Both kidneys reveal preserved cortical thickness with no hydronephrosis or echogenic stones. The right kidney measures 8.4 x 3.6 cm, and the left kidney measures 9.5 x 3.1 cm. The spleen, the aorta, and the pancreas are unremarkable. The urinary bladder appears unremarkable. There is no fluid in the cul-de-sac.

IMPRESSION: NEGATIVE ABDOMINAL SONOGRAM.

NIA CODE: n

/READ BY/ JERJIS T ALAJAJI, Radiologist
/Released By/ JERJIS T ALAJAJI, Radiologist

02/04/00 1217
LLW

Complete

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

SHIMMEL, KAYLA M
37 COUNTRY PLACE
DUBOIS PA 15801

PED-4120-01 Unit # 000350366
Age 9Y Acct # D0003400471

Date:02/03/00 Time:1902

MCANDREW, JOSEPH

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

Chk-in #	Order	Exam		
383971	0001	40005	XR-MANDIBLE COMPLETE Ord Diag: ~~919.0~~-trauma	959.09
383971	0001	44015	XR-HIP UNI 2 VIEWS ® Ord Diag: ~~919.0~~-trauma	959.6
383975	0002	43023	XR-SPINE SINGLE VIEW Ord Diag: ~~919.0~~-trauma	959.09

LATERAL CERVICAL SPINE - SINGLE VIEW:

The heights and the alignment of the cervical vertebral bodies are normal. The intervertebral disc spaces are normally preserved. The pedicles, the transverse processes, and the posterior spinous processes are intact. The neural foramina are patent throughout with no evidence of bony encroachment. The posterior facet joints are normal. The relationship of the occiput to C1 and C1 to C2 is preserved. No abnormal soft tissue mass is present.

IMPRESSION: NORMAL CERVICAL SPINE.

MANDIBLE - FOUR VIEWS:

The bones are intact. The joint relationships are normally maintained. The soft tissues are unremarkable.

IMPRESSION: NEGATIVE MANDIBLE.

RIGHT HIP - TWO VIEWS:

The bones are intact. The joint relationships are normally maintained. The soft tissues are unremarkable.

IMPRESSION: NEGATIVE RIGHT HIP.
NIA CODE: ALL - N

/READ BY/ JERJIS T ALAJAJI, Radiologist
/Released By/ JERJIS T ALAJAJI, Radiologist

02/04/00 1216
LLW

Complete

PROGRESS
FEB 17 2000
WPA - PI
RECEIVED

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

SHIMMEL,KAYLA M
37 COUNTRY PLACE
DUBOIS PA 15801

PED-4120-01 Unit # 000350366
Age 9Y Acct # D0003400471

Date:02/03/00 Time:1909

MCANDREW,JOSEPH

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

Chk-in #	Order	Exam	
383970	0001	72724	CT-HEAD UNENHANCED

Ord Diag: 854.00-BRAIN INJURY NEC

CT HEAD SCAN UNENHANCED:

HISTORY: MVA.

Computerized tomographic axial sections of the head were obtained without intravenous contrast enhancement.

The ventricular system is of normal size and shape. The cerebral hemispheres and posterior fossa are normal. There are no abnormal masses. There is no evidence of hemorrhage.

IMPRESSION: NORMAL UNENHANCED CT HEAD SCAN.

NIA CODE: N

/READ BY/ JERJIS T ALAJAJI, Radiologist
/Released By/ JERJIS T ALAJAJI, Radiologist

02/04/00 1216
LLW

Complete

AUT

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

SHIMMEL,KAYLA M PED-4120-01 Unit # 000350366
37 COUNTRY PLACE
DUBOIS PA 15801 Age 9Y Acct # D0003400471

Date:02/04/00 Time:0926

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

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

959.1

Chk-in #	Order	Exam	
383985	0006	42100	US-ABDOMEN COMPLETE

Ord Diag: ~~854.00~~ BRAIN INJURY NEC

ABDOMINAL SONOGRAM:

History: MVA.

There are no gallstones or gallbladder wall thickening. There is no intra- or extra-hepatic biliary dilatation. The common bile duct measures 2.5 mm. Both kidneys reveal preserved cortical thickness with no hydronephrosis or echogenic stones. The right kidney measures 8.4 x 3.6 cm, and the left kidney measures 9.5 x 3.1 cm. The spleen, the aorta, and the pancreas are unremarkable. The urinary bladder appears unremarkable. There is no fluid in the cul-de-sac.

IMPRESSION: NEGATIVE ABDOMINAL SONOGRAM.

NIA CODE: n

/READ BY/ JERJIS T ALAJAJI, Radiologist
/Released By/ JERJIS T ALAJAJI, Radiologist

02/04/00 1216
LLW

Complete

PROG

FEB 17 2000

WPA - PI
RECEIVE

DuBois Regional Medical Center

P.O. Box 447, 100 Hospital Avenue
DuBois, PA 15801

STEPHANIE EVANCHO
PROGRESSIVE INSURANCE - MONROEVILLE
3824 NORTHERN PIKE
SUITE 510, 1 MONROEVILLE CENTER
MONROEVILLE, PA 15146-2121

Mar 01 2000

Enclosed please find copies of medical records you requested on KAYLA SHIMMEL.

Among our patients' rights are the right to privacy and the protection of medical records. Each request is carefully reviewed to assure proper disclosure; any re-disclosure without written consent of the person to whom the information pertains, or the authorized representative, is prohibited. Also, the use of the information for other than the stated purpose is prohibited. The American Health Information Management Association recommends that the information be destroyed after the stated need has been fulfilled.

If you have a question regarding this request, please call Medical Records at (814) 375-3484 Monday through Friday, between 7:30 a.m. and 4:00 p.m. EST.

Thank you.

Medical Records Department

02/15 '00 11:01 NO.473 04/04

DuBois Regional Medical Center | P. O. Box 447 | DuBois, Pennsylvania 15801

CONSENT FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize DuBois Regional Medical Center and/or follow-up physician(s) to release the records of: Shimmel, Joyce — 11-2-90
RECEIVED FEB 19, 2000
Patient Name | Date of Birth

Ans'd The information is to be released to (circle one) my employer or the carrier for Worker's Compensation; my automobile insurance carrier; CHAMPUS; CHAMPVA; Veteran's Administration; Federal Black Lung Program for the purpose of claims payment.

For Worker's Comp: Auto
Employer
Contact Person — Date 2-29 Req. # 11947
Address — #PGS 11 Initials
Itemized portion of record and time period of information to be released: ***Records and reports which explain diagnosis, history & physical, treatments and prognosis for this hospitalization or visit.***

If no boxes are marked, existing special records will not be released. This section does not imply t special records do exist.

If applicable, I consent to the release of the following special records:

HIV-related ☐ **Psychiatric** ☐ **Substance Abuse/Chemical Dependency** ☐

I also understand that this consent is revocable, except to the extent that action has been taken in reliar thereon, and that this consent will remain in force for three months in order to effectuate the purposes which it was given.

2-3-00
Date of Signature

Patient's Signature

Signature of Witness

X Benjamin L Shimmel
Signature of Responsible Party, when applicable

Medical Record Number(s): 3503166 DC 2/4/00 Sian P

Billing Number(s): 0003400471 MP

Fee: _____ Amount Received: _____ Date: Michelle

Check No.: _____ Cash Received By: _____

Medical Records Account No. 5300852 – F0078

DS, T.S. H+P, Labs + X-rays

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

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

004222491
S. EVANCHO

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 655567585 0

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

3. PATIENT'S BIRTH DATE: 11 02 00 | SEX: M | F [X]

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

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)

CLAIM#: 004222491-3

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: CLAIM 004222491

a. OTHER INSURED'S POLICY OR GROUP NUMBER

NI: BENJAMIN SHIMMEL

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

a. INSURED'S DATE OF BIRTH: 01 03 67 | SEX: M [X] | F

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

PHL#:

DOL: 2/3/00 MCR: SAT

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

b. EMPLOYER'S NAME OR SCHOOL NAME: DAD FLCAM

c. EMPLOYER'S NAME OR SCHOOL NAME

TOTAL CHARGES: $ 280.00

c. OTHER ACCIDENT? YES | NO [X]

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

d. INSURANCE PLAN NAME OR PROGRAM NAME

NOT TRAUMA TRAUMA SECOND REQUEST 3/20/00

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.

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: 022400 2/20/00

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): 02 03 00

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

PAYMENT CANNOT BE CONSIDERED UNTIL RECORDS ARE RECEIVED

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 02 03 00 TO 02 04 00

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO [X] | $ CHARGES: 250 00

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

1. ~~924 8~~
2. E66 01
3. ~~E819~~ 1
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	1	60	99223		1 2 3	150 00	1				
2 02 04 00	02 04 00	1	60	99238		1 2 3	100 00	1				
3												
4												
5												
6												

PAID

25. FEDERAL TAX I.D. NUMBER: 25 1428819 SSN | EIN [X]

26. PATIENT'S ACCOUNT NO.: 6499 1

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

28. TOTAL CHARGE: $ 250 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 250 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.)

W JOHN SIAR MD

SIGNED 022400 DATE

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

DRMC WEST INPATIENT
PO BOX 447
DUBOIS PA 15801
DU390086

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

GAPRMC/AY AREA MEDICAL ASSOC INC
701 SUNFLOWER DRIVE
DUBOIS PA 15801 371 1771

PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(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)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

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

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY: 11 02 90 SEX M ( ) F (X)

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

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):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: CLAIM 004222491

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: 01 03 67 SEX 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 ELCAM

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)

1. 854.00
2. E819.1
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X): 25 1428819

26. PATIENT'S ACCOUNT NO.: 6499 1

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

28. TOTAL CHARGE: $ 30 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 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.)

W JOHN SIAR MD

SIGNED 022400 DATE

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

SIAR OFFICE
PO BOX 348
DUBOIS PA 15801

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

GAY AREA MEDICAL ASSOC INC
701 SUNFLOWER DRIVE
DUBOIS PA 15801 371 1771

PIN# GRP#

(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)

PC2S 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:
KAYLA M SHIMMEL	0042224910300	06001335003500	05/22/00

PROVIDER TAX ID:
251428819

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

PAYOR: PROGRESSIVE INSURANCE
POLICY#:
CLAIM#: 004222491-03
REP ID#: SAE EXT. 5266
PATIENT ACCT#:
DATE OF INJURY: 02/03/00
MISC INFO: BILL #4
POLICY HOLDERS NAME: BENJAMIN SHIMMEL

DATE OF SERVICE	PROC CODE	DESCRIPTION OF SERVICE	BILLED CHARGE	FS/UCR	PAID AMOUNT	REASON CODE
02/03/00	99223	NW/EST PT-INTL HSP CARE	150.00	150.00	150.00	
02/04/00	99238	HOSP DISCHARGE DAY MGMT	100.00	70.76	70.76	1
02/10/00	99212	EST OUTPT L2 PROB FOC H&	30.00	30.00	30.00	
		TOTALS:	280.00	250.76	250.76	

DIAGNOSIS CODES:

924.8 CONTUSION OF MULTIPLE SITES, NOT ELSEWHERE CLASSIFIED
866.01 HEMATOMA OF KIDNEY, WITHOUT RUPTURE OF CAPSULE, WITHOUT MENTION OF OPEN WOUND INTO CAVITY
E819.1 MOTOR VEHICLE TRAFFIC ACCIDENT OF UNSPECIFIED NATURE INJURING PASSENGER IN MOTOR VEHICLE OTHER THAN MO

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

TOTAL AMOUNT PAID: **********
250.76
****

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)

0003400471 2 FINAL

PLEASE DO NOT STAPLE IN THIS AREA

#3 DOS: 2/3/00 SAE-5266

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (X) (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): CLM# 00422491SAE - N - 3

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

3. PATIENT'S BIRTH DATE MM DD YY: 11 02 1990 | SEX M ( ) F (X)

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

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 (X) 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: 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: 11 02 1990 | SEX M ( ) F (X)

DAY IN 3/25

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: NONE

DAY OUT

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 (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: 02/11/2000

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: MCANDREW, JOSEPH

17a. I.D. NUMBER OF REFERRING PHYSICIAN: F78857

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 03 2000 TO 03 04 2000

PAID

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. 86601
2. 8798
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	23		99284		1	175 00	1				767260GY8
2												
3												
4												
5												
6												

$175.00 TOMC

25. FEDERAL TAX I.D. NUMBER: 25-1490707 | SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: 0003400471

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

28. TOTAL CHARGE: $ 17500

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 17500

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: MCANDREW, JO DATE: 02/11/2000

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(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)

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:
KAYLA M SHIMMEL	0042224910300	06000952662900	04/05/00

PROVIDER TAX ID:
251490707

PROVIDER:
DUBOIS REG MED CTR
PO BOX 447
DUBOIS PA 15801

PAYOR: PROGRESSIVE INSURANCE
POLICY#:
CLAIM#: 004222491-03
REP ID#: SAE X5266
PATIENT ACCT#:
DATE OF INJURY: 02/03/00
MISC INFO: 3
POLICY HOLDERS NAME: BENJAMIN 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	175.00	103.99	103.99	1
02/03/00	99223	NW/EST PT-INTL HSP CARE	150.00	150.00	150.00	
02/04/00	99238	HOSP DISCHARGE DAY MGMT	100.00	70.76	70.76	1
02/10/00	99212	EST OUTPT L2 PROB FOC H&	30.00	30.00	30.00	
		TOTALS:	455.00	354.75	354.75	

DIAGNOSIS CODES:

866.01 HEMATOMA OF KIDNEY, WITHOUT RUPTURE OF CAPSULE, WITHOUT MENTION OF OPEN WOUND INTO CAVITY
879.8 OPEN WOUND(S) (MULTIPLE) OF UNSPECIFIED SITE(S), WITHOUT MENTION OF COMPLICATION

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

TOTAL AMOUNT PAID: **********
354.75
****

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)

APPROVED OMB NO. 0938-0279

0000340047I 1

DUBOIS REG MED CTR
PO BOX 447
DUBOIS PA 15801
(814) 371-2200

2

3 PATIENT CONTROL NO. 0003400471

4 TYPE OF BILL 111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
25-1490707	020300	020400	001				

12 PATIENT NAME: SHIMMEL,KAYLA 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.
11021990	F	S	020300	18	2	1	13	01	000350366

24 CONDITION CODES 25 26 27 28 29 30 31

32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH
a 01	020300										
b											

37 A B C

38 SHIMMEL,BENJAMIN LEROY
37 COUNTRY PLACE

DUBOIS PA 15801
(814) 371-2931

39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
a 01	470.00				
b					
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	120	MEDICAL-SEMIPRIVATE ROOM	470.00		1	47000		
2	250	PHARMACY			11	9900		
3	258	IV SOLUTIONS			3	7400		
4	270	SUPPLIES			7	14000		
5	305	CBC - PEDIATRIC	85023		1	11000		
6	307	URINALYSIS ROUTINE	81000		2	2000		
7	320	XR-SPINE SINGLE VIEW	72020		1	10100		
8	320	XR-HIP UNI 2 VIEWS	73510		1	9400		
9	320	XR-MANDIBLE COMPLETE	70110		1	13500		
10	351	CT-HEAD UNENHANCED	70450		1	50300		
11	402	US-ABDOMEN COMPLETE	76700		1	6600		
12	450	EMRGNCY DEP VIS E/M DET	99284		1	17600		
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	TOTAL CHARGES				234300		

PAID

	50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	PROGRESSIVE AUTO INS		Y	Y		234300
B	MA INPATIENT *	0994230	Y	Y		
C						

56 F 2708.79
O 106.68
C 263.29
P 3.23

57 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,KAYLA M	01	CLM# 004222491SAE	N-3	999999
B	SHIMMEL,KAYLA M	01	4101358614		
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A		3	NONE	
B		3	NONE	
C				

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
866.01	8798								85400	E8191	

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9						
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: B33187 SIAR WILLIAM J

83 OTHER PHYS. ID

OTHER PHYS. ID

	84 REMARKS
a	
b	
c	
d	

85 PROVIDER REPRESENTATIVE: XBillotte,Michele

86 DATE: 021600

UB-92 HCFA-1450 OCR/ORIGINAL 790-0202

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

DuBois Regional Medical Center

P.O. Box 447 - DuBois, PA 15801-0447
(814) 375-4200
FEDERAL I.D. NO. 25-1490707

DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL	PAGE NO.
F1-I/P	02/10/00	1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
KAYLA M SHIMMEL	00034-00471	F	9Y	02/03/00	02/04/00	1

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
350001 PROGRESSIVE AUTO INS	999999	655567850
350002 AUTO INSURANCE PROF C	999999	655567850
200025 MA INPATIENT		4101358614
200003 MEDICAL ASSISTANCE PR		4101358614

PAYMENT AMOUNT

GUARANTOR NAME AND ADDRESS
BENJAMIN LEROY SHIMMEL
37 COUNTRY PLACE
DUBOIS PA 15801-0000

☐ MasterCard ☐ VISA ☐ DISCOVER

CARD NO. _____
EXPIRATION DATE _____
SIGNATURE _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO	QTY	UNIT PRICE	TOTAL CHARGES
02/03/00	123	ROOM 4120 7	120	7	1	470.00	470.00
		TOTAL SEMIPRIVATE ROOM - MEDICAL					470.00
02/03/00	66621	ACETAMINOPHEN TAB 325MG	250	1	10	0.75	7.50
02/03/00	94008	SOD CHL 0.9% IRR 1000 7138-09	258	13	1	20.00	20.00
02/04/00	60134	IBUPROFEN 100MG/5ML SUSP	250	2	1	1.50	1.50
02/04/00	94160	L R 1000 ML 7953-09	258	17	2	27.00	54.00
		TOTAL PHARMACY					83.00
02/03/00	95052	ICE BAG	270	11	1	6.00	6.00
02/03/00	95059	KLEENEX	270	16	1	1.00	1.00
02/03/00	95070	SLIPPERS - MED	270	15	1	3.00	3.00
02/03/00	95203	DRESSING FLUFF GAUZE	270	12	2	2.00	4.00
		TOTAL SUPPLIES					14.00
02/03/00	24049	CBC - PEDIATRIC	305	4	1	55.00	55.00
02/03/00	27001	URINALYSIS ROUTINE	307	3	1	21.00	21.00
02/04/00	24049	CBC - PEDIATRIC	305	5	1	55.00	55.00
02/04/00	27001	URINALYSIS ROUTINE	307	10	1	21.00	21.00
		TOTAL LABORATORY					152.00
02/03/00	40005	MANDIBLE COMPLETE	320	1	1	135.00	135.00
02/03/00	43023	SPINE, SINGLE VIEW	320	2	1	101.00	101.00
02/03/00	44015	HIP, UNILATERAL, 2 VIEW	320	1	1	94.00	94.00
02/03/00	49012	BEDSIDE/OR RADIOGRAPHY	320	2	1	0.00	0.00
		TOTAL RADIOLOGY					330.00
02/03/00	72724	CT HEAD, NO CONTRAST	351	1	1	503.00	503.00
		TOTAL CT SCAN					503.00
02/04/00	42100	ABDOMEN COMPLETE	402	6	1	616.00	616.00
		TOTAL ULTRASOUND					616.00
02/03/00	16213	EMRGNCY DEP VIS E/M DET MOD CMPL	450	14	1	175.00	175.00
		TOTAL EMERGENCY ROOM					175.00

PATIENT NUMBER	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	CONTINUED
00034-00471			

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENTS may be taken to the East or West registration areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS

DuBois Regional Medical Center

P.O. Box 447 - DuBois, PA 15801-0447
(814) 375-4200
FEDERAL I.D. NO. 25-1490707

DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL	PAGE NO.
F1-I/P	02/10/00	2

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
KAYLA M SHIMMEL	00034-00471	F	9Y	02/03/00	02/04/00	1

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
350001 PROGRESSIVE AUTO INS	999999	655567850
350002 AUTO INSURANCE PROF C	999999	655567850
200025 MA INPATIENT		4101358614
200003 MEDICAL ASSISTANCE PR		4101358614

PAYMENT AMOUNT

GUARANTOR NAME AND ADDRESS
BENJAMIN LEROY SHIMMEL
37 COUNTRY PLACE
DUBOIS PA 15801-0000

☐ MasterCard ☐ VISA ☐ DISCOVER

CARD NO. _____
EXPIRATION DATE _____
SIGNATURE _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	ITEM NO.	DESCRIPTION	CLM. CODE	ORDER NO.	QTY	UNIT PRICE	TOTAL CHARGES
02/03/00	1613	PC EMRGNCY DEPVIS E/M DET MOD CP	450	14	1	175.00	175.00
		TOTAL pro fee misc code(not use ub92					175.00
		TOTAL CHARGES					2,518.00
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PATIENT NUMBER
00034-00471

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT DUE	2,518.00

PAYMENTS may be taken to the East or West registration areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS

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, KAYLA

DUBOIS REGIONAL MEDICAL CENT
100 HOSPITAL AVE
DUBOIS, PA 15801

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

PROVIDER: DUBOIS REGIONAL MEDICAL CE
TAX ID/PROVIDER NO: 39-0086
PATIENT NO: 0003400471

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

MEDLOGIX ID: 068065A -001A
CALCULATION DATE: 03/31/00

EXPLANATION OF BENEFITS

DATE OF SERVICE: 02/03/00

DIAGNOSES: 1) 866.01 KIDNEY HEMATOMA-CLOSED
2) 879.8 OPEN WOUND SITE NOS

THE MED BOX

Total Billed Amount.....:	2,343.00
Calculated Amount.....:	2,343.00
Carrier's Responsibility....:	
TOTAL AMOUNT DUE.....:	2,343.00

Inpatient
PA Automobile

ITEMIZED CHARGES

DATE	SERVICE	DIAGS	UNITS	CHARGE	PAYMENT TYPE	REDUCTION	AMT DUE	STATUS
02/03/00	333	1	1.00	2,343.00	DRG	0.00	2,343.00	

OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17

Hospital Portion:	0.00	Outlier Amount:	0.00		
Federal Portion :	2,708.79	DSH Amount :	106.18		
Sub-Total :	2,708.79	IME Amount :	0.00		
	x 1.10	Cost Ctr Addon:	263.29	Hospital Charges:	2,979.67
	2,979.67	PassThru Addon:	3.23	Add-On Charges:	372.70
			372.70	DRG Total:	3,352.37

Totals:	2,343.00	0.00	2,343.00

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

#1 NT

Dos 2-3-00

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-3

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

3. PATIENT'S BIRTH DATE MM DD YY: 11 02 1990 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 → NE

CITY: DuBois STATE: PA

8. PATIENT STATUS: Single ☒ Married ☐ Other ☐

CITY: DuBois STATE: PA

ZIP CODE: 15801 TELEPHONE (Include Area Code): (814) 371-4981

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

ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814) 371-4981

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Kayla M Shimmel

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 4101358614

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒ 2/28/00

a. INSURED'S DATE OF BIRTH MM DD YY: 11 02 1990 SEX M ☐ F ☐

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

DAY IN

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

DAY OUT

b. EMPLOYER'S NAME OR SCHOOL NAME: None

c. EMPLOYER'S NAME OR SCHOOL NAME: None

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: DEPARTMENT OF PUBLIC WELFARE

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: 021100

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Joseph McAndrew MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

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. 854400
2.
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
02 03 00		1	4	70450	26	1	133 00	1				

3611

TOTAL: 340 00

PROGRESS...

FEB 17 2000

WPA - PIC

RECEIVED

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 ☐ ☐	shimka395398	YES ☒ NO ☐	$ 133 00	$ 0 00	$ 133 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.)

J Alajaji MD

SIGNED 25-1715230 DATE 021100

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

DuBois Reg Medical Ctr
DuBois, PA 15801
0113900086

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

(814) 371-7784
DuBois Radiologists IncMD
PO Box 1106
DuBois PA 15801

PIN# GRP# 25-1715230

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

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

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

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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 Kayla M

3. PATIENT'S BIRTH DATE MM DD YY: 11 02 1990 SEX M [ ] F [X]

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) 371-4981

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

ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814) 371-4981

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Kayla M Shimmel

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 410135866J4

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

a. INSURED'S DATE OF BIRTH MM DD YY: 11 02 1990 SEX M [ ] 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: None

c. EMPLOYER'S NAME OR SCHOOL NAME: None

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

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME: DEPARTMENT OF PUBLIC WELFARE

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: 021100

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Joseph McAndrew MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

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. 959.09 959.09
2. 959.6
3. 854.00
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		1	4	70110	26	1	38 00	1				
2 02 03 00		1	4	73510	26	1	31 00	1				
3 02 03 00		1	4	72070	26	1	22 00	1				
4									PROGRESSIVE			
5									FEB 17 2000			
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 25-1715230 [ ]

26. PATIENT'S ACCOUNT NO.: shimka395397

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

28. TOTAL CHARGE: $ 91 00

29. AMOUNT PAID: $ 0 00 RECEIVED

30. BALANCE DUE: $ 91 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.)

J Alajaji MD

SIGNED: 25-1715230 DATE: 021100

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

DuBois Reg Medical Ctr
DuBois, PA 15801
DU3900086

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

(814) 371-7764
DuBois Radiologists IncMD
PO Box 1106
DuBois PA 15801

PIN#: GRP#: 25-1715230

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

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

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

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

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)	004222491SAE
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Shimmel Kayla M	3. PATIENT'S BIRTH DATE MM DD YY: 11 02 1990 SEX: M [ ] F [X]
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)371-4981	
ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814)371-4981	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Kayla M Shimmel	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 4101358614	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY: 11 02 1990 SEX: M [ ] 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: None	
c. EMPLOYER'S NAME OR SCHOOL NAME: None	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME: DEPARTMENT OF PUBLIC WELFARE	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.
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 MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: W J Siar M D	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 04 00 TO 02 04 00
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. 9591 2. 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 04 00	1	4	76700 26	1	116 00	1				
2										
3										
4							PROGRESS			
5							FEB 17 2000			
6							WPA - PI RECEIVED			

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
25-1715230 [ ] [ ]	shimka395577		$ 116 00	$ 0 00	$ 116 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 #
J Alajaji MD	DuBois Reg Medical Ctr DuBois, PA 15801 DU3900086	(814-371-7784 DuBois Radiologists IncMD PO Box 1106 DuBois PA 15801
SIGNED 25-1715230 DATE 02 11 00		PIN# GRP# 25-1715230

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

Explanation of Reimbursement

Progressive Insurance

Claim Information

Claim Number:	004222491-01	Region:	W PA PIP
Policyholder:	SHIMMEL, BENJAMIN	Office:	MONROEVILL
Claimant:	SHIMMEL, BENJAMIN	Claim Rep:	SAE0005
Date of Loss:	02/03/2000	Party:	First
Updated:	03/04/2000	Bill No:	2
		Audited:	03/04/2000

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	922.1	CONTUSION OF CHEST WALL
2	719.87	OTHER SPECIFIED DISORDERS OF ANKLE AND FOOT JOINT
3	959.09	OTHER AND UNSPECIFIED INJURY TO FACE AND NECK
4	854.00	INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE, WITHOUT MENTION OF OPEN INTRACRANIAL WOUND, WITH STATE OF CONSCIOUSNESS UNSPECIFIED

Item Detail

Item	Date	POS	CPT-Mod	Description	Units	Charge	PAID AMOUNT	Reason Code
1	02/03/00	22	71010-26	X-RAY, CHEST, SINGLE VIEW, FRONTAL		23.00	10.05	FA97P
2	02/03/00	22	72040-26	X-RAY EXAM, CERVICAL SPINE, AP & LATERAL		31.00	12.40	FA97P
3	02/03/00	22	73610-26	X-RAY EXAM, ANKLE, COMPLETE, 3+ VIEWS		31.00	9.66	FA97P
4	02/04/00	22	71010-26	X-RAY, CHEST, SINGLE VIEW, FRONTAL		23.00	10.05	FA97P
5	02/03/00	22	70450-26	CAT SCAN, HEAD/BRAIN, W/O CONTRAST		133.00	46.63	FA97P
				Totals for Bill		241.00	88.79	

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.

DUBOIS REGIONAL MEDICAL CENTER
Sat Feb 05, 2000 12:02 am
Discharge Cumulative Trend Report from 02/03/00 1929 to 02/04/00 1200

Patient Name: SHIMMEL,KAYLA M
Med Rec #: 000350366
Dis Date 02/04/00
Phys-Service: SIAR,W J - *PEDIATRIC

Adm: 02/03/00

****

Hematology

Last Tech: 02541

Date: / Time: / New Work:	02/04 0630 PREV RPT	02/03 2020 PREV RPT				Normal Range	
WBC	6.93	13.32				4.5-13.5	(X(10)3
RBC	4.65	4.73				3.9-5.3	(x10 6/u
Hgb	12.5	12.8				11.5-15.5	(gm/dl)
Hct	36.9	37.3				34-40	(%)
MCV	79.3	78.9				77-95	(fl)
MCH	26.9	27.1				25-33	(pg)
MCHC	34.0	34.4				31-37	(g/dl)
Plt	233	250				150-380	(X(10)3
RDW-CV	13.9	13.9				11.8-14.2	(%)
MPV	8.5	7.4 L				8.4-10.8	(fl)
Manual Diff	Perform^	Perform^					
Bands	5	13					(%)
Segs	72	78					(%)
Lymphs	17	5					(%)
Monos	5	4					(%)
Basos	1						(%)
RBC Morph		1+ Micro					

General Comments

02/03/00 2020 CBC & DIFF-Order Comment: BED 10
02/03/00 2020 CBC - PEDIATRIC-Order Comment: BED 10

In: 02/04/00 1212
Out: 02/04/00 1304
Coll Time: 02/04/00 1200
Order Phys: SIAR,W J

URINALYSIS ROUTINE

Spec: Urine Voided
Techs: VNURS T00240,00323

[D0003400471/11158301

Result Name	Result
Color:	YELLOW
Clarity:	CLEAR
Glucose(mg/dl):	NEGATIVE
Bili,Ua:	NEGATIVE
Ketone, Ua(mg/dl):	NEGATIVE
Specific Gravity:	1.010
Blood, Occult:	NEGATIVE
pH(pH Units):	6.5

(Continued on next page)

DUBOIS REGIONAL MEDICAL CENTER
Sat Feb 05, 2000 12:02 am
Discharge Cumulative Trend Report from 02/03/00 1929 to 02/04/00 1200

Patient Name: SHIMMEL,KAYLA M
Med Rec #: 000350366
Dis Date 02/04/00
Phys-Service: SIAR,W J - *PEDIATRIC

****

In: 02/04/00 1212
Out: 02/04/00 1304
Coll Time: 02/04/00 1200
Order Phys: SIAR,W J

URINALYSIS ROUTINE

Spec: Urine Voided
Techs: VNURS T00240,00323

[D0003400471/1158301

Result Name	Result

(Continued from previous page)

Protein(mg/L):	NEGATIVE
Urobilinogen(EU/dl):	0.2 E.U./dL
Nitrites:	NEGATIVE
Leukocytes:	NEGATIVE
WBCs(/HPF):	0-2
RBCs(/HPF):	0
Epithelial Cells(/LPF):	2-4
Mucus:	Trace

In: 02/03/00 1931
Out: 02/03/00 1945
Coll Time: 02/03/00 1929
Order Phys: SIAR,W J

URINALYSIS ROUTINE

Spec: Urine Voided
Techs: VNURS T2379*

[D0003400471/1115481]

*STAT*STAT*STAT*

Result Name	Result
Color:	YELLOW
Clarity:	CLEAR
Glucose(mg/dl):	NEGATIVE
Bili,Ua:	NEGATIVE
Ketone, Ua(mg/dl):	NEGATIVE
Specific Gravity:	1.015
Blood, Occult:	LARGE
pH(pH Units):	6.0
Protein(mg/L):	NEGATIVE
Urobilinogen(EU/dl):	0.2 E.U./dL
Nitrites:	NEGATIVE
Leukocytes:	NEGATIVE
WBCs(/HPF):	0
RBCs(/HPF):	10-15
Epithelial Cells(/LPF):	4-6
Mucus:	1+
Order Comment:	BED 10

End of Report

Jose Costa M.D./Gregory Suslow M.D.
** DO NOT DISCARD **

DUBOIS REGIONAL MEDICAL CENTER
P.O. BOX 447 — DUBOIS, PA. 15801-0447

128417

128417 [illegible]

DATE	INVOICE NO.	PURCHASE ORDER NO.	AMOUNT OF INVOICE	DEDUCTIONS	BALANCE

CARRIER PLAN NAME: PROGRESSIVE COMPANIES
PATIENT'S NAME : KAYLA M SHIMMEL
INSURED'S NAME : KAYLA M SHIMMEL
SS#/ID#/CLAIM# : 183-72-2977/CLM# 004222491SAE/999999
:NONE
DATES OF SERVICE : 02/03/00 - 02/04/00 AMOUNT : $250.76

SAE

PROGRESSIVE
MAY 02 2000
WPA - PIP
RECEIVED

DETACH BEFORE DEPOSITING

00422491 SAC Shimmel

03400471 128417

ISBURSEMENT ACCOUNT
EPOSIT NATIONAL BANK
DUBOIS, PA.

DUBOIS REGIONAL MEDICAL CENTER

P.O. BOX 447 — DUBOIS, PA. 15801-0447

NO. 128417

60-416
313

VOID AFTER 90 DAYS
DATE
04/28/00

AMOUNT
********250.76

'AY TWO HUNDRED FIFTY AND 76/100 DOLLARS**********

DUBOIS REGIONAL MEDICAL CENTER
OPERATING FUND ACCOUNT

Raymond Bauer
AUTHORIZED SIGNATURE

PAY
TO THE
ORDER OF

PROGRESSIVE COMPANIES
ONE MONROEVILLE CENTER
SUITE 510
MONROEVILLE PA 15146

⑈128417⑈ ⑆031304160⑆ 471-4449⑈

PS2L PRVDR

PROGRESSIVE

EXPLANATION OF REVIEW
PROVIDER COPY

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

red Noady

PATIENT NAME:	PATIENT ID#:	INTERNAL CONTROL#:	DATE PROCESSED:
KAYLA M SHIMMEL	0042224910300	06000952662900	04/05/00

PROVIDER TAX ID:
251490707

PROVIDER:
DUBOIS REG MED CTR
PO BOX 447
DUBOIS PA 15801

PAYOR: PROGRESSIVE INSURANCE
POLICY#:
CLAIM#: 004222491-03
REP ID#: SAE X5266
PATIENT ACCT#:
DATE OF INJURY: 02/03/00
MISC INFO: 3
POLICY HOLDERS NAME: BENJAMIN 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	175.00	103.99	103.99	1
02/03/00	99223	NW/EST PT-INTL HSP CARE	150.00	150.00	150.00	
02/04/00	99238	HOSP DISCHARGE DAY MGMT	100.00	70.76	70.76	1
02/10/00	99212	EST OUTPT L2 PROB FOC H&	30.00	30.00	30.00	
		TOTALS:	455.00	354.75	354.75	

DIAGNOSIS CODES:

866.01 HEMATOMA OF KIDNEY, WITHOUT RUPTURE OF CAPSULE, WITHOUT MENTION OF OPEN WOUND INTO CAVITY
879.8 OPEN WOUND(S) (MULTIPLE) OF UNSPECIFIED SITE(S), WITHOUT MENTION OF COMPLICATION

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

TOTAL AMOUNT PAID: **********
354.75
****

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)

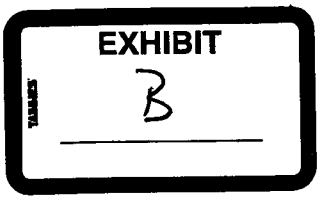
PROGRESSIVE
MAY 02 2000
PA-PIP

Dr W. J. Siar
Gateway Area Medical Associates
Sunflower Drive
DuBois PA 15801

FULL AND FINAL RELEASE

KNOW ALL MEN BY THESE PRESENTS, that I, Kathy Shimmel, individually and as parent and natural guardian of Kayla Shimmel, being of full legal age and of sound mind, for and in consideration of the sum of FIVE THOUSAND AND 00/100 DOLLARS ($5,000.00), 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 Kayla 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 Kayla 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 Kayla Shimmel

Kathy Shimmel Soc. Sec. No.:_____

Kayla 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

William A. Shaw
Prothonotary

3:36 atty Harrington

pd $80.00

1 cc

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

KAYLA SHIMMEL, a minor, by his :
Parent and Natural Guardian, : No. 01 – 1126 – CD
KATHY SHIMMEL :

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, KAYLA 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 Kayla 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 Kayla Shimmel, said funds not to be withdrawn until Kayla 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

E KBB

KAYLA SHIMMEL, a minor, by her Parent and natural guardian, KATHY SHIMMEL,	:	IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PA
Petitioner	:	No. 01-1126-CD

REVISED ORDER

AND NOW, this 28th 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, KAYLA 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 Kayla Shimmel of a lump sum of Five Thousand Dollars ($ 5,000.00) by Benjamin Shimmel and Progressive Insurance, with said funds to be deposited by Kathy Shimmel into an interest-bearing account on behalf of Kayla Shimmel, said funds not to be withdrawn until Kayla Shimmel reaches the age of majority on NOVEMBER 2, 2008;

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.

___ J.

FILED

SEP 28 2001

William A. Shaw
Prothonotary

01 4:00 1cc atty Harrington

KAYLA SHIMMEL, a minor, by her Parent and natural guardian, KATHY SHIMMEL,	:	IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PA
Petitioner	:	No. 01-1126-CD

REVISED ORDER

AND NOW, this 28th 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, KAYLA 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 Kayla Shimmel of a lump sum of Five Thousand Dollars ($ 5,000.00) by Benjamin Shimmel and Progressive Insurance, with said funds to be deposited by Kathy Shimmel into an interest-bearing account on behalf of Kayla Shimmel, said funds not to be withdrawn until Kayla Shimmel reaches the age of majority on NOVEMBER 2, 2008;

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:

_____ J.

FILED

SEP 28 2001
04:00 lcc atty
William A. Shaw
Prothonotary Hannington

KAYLA SHIMMEL, a minor, by her Parent and Natural Guardian, KATHY SHIMMEL,	: IN THE COURT OF COMMON PLEAS : OF CLEARFIELD COUNTY, PA
Petitioner	: No. 01-1126-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	01042000000300	$5,000.00

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: **1042000000300**
KAYLA SHIMMEL
KATHERINE SHIMMEL GUARDIAN
BY ORDER OF COURT UNTIL 11-2-0[illegible]

ADDRESS
38 COUNTRY PLACE
DUBOIS PA 15801

TELEPHONE: **814 371-8727**

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 $5000 dol's 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: **KAYLA SHIMMEL**
TAXPAYER IDENTIFICATION NUMBER: **183-72-2977**

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 ▶ Barbara J Ross <SEAL> DATE ▶ 10-16-01

CUSTOMER COPY

FILED NO CC
m 10:52 BTC
NOV 07 2001
William A. Shaw
Prothonotary

KAYLA SHIMMEL, a minor, by her Parent and Natural Guardian, KATHY SHIMMEL,	: IN THE COURT OF COMMON PLEAS : OF CLEARFIELD COUNTY, PA
	: No. 01-1126-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:
Kayla Shimmel, a minor, by her
Parent and Natural Guardian,
Kathy Shimmel

No. 2001-01126-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