03-1860-CD
IN RE: SEAN FAIRMAN, etal.

IN RE: Sean Fairman, Ernest Fairman, Lorae Fairman

Civil In RE

Date		Judge
12/19/2003	Filing: Petition for Court Approval of Settlement of the Action of a Minor, Paid by: Robb Leonard Mulvihill Receipt number: 1870758 Dated: 12/19/2003 Amount: $85.00 (Check) No cc.	No Judge
12/26/2003	ORDER filed. 2 Cert. to Atty. AND NOW, to wit, this 24th day of December, 2003, RE: Settlement between parties.	Fredric Joseph Ammerman
01/21/2004	Proof of Deposit of Settlement Proceeds. filed by, s/Tina A. Aracri, Esquire Certificate of Service no cc	Fredric Joseph Ammerman
03/16/2004	Petition For Leave To Settle Claims Of Minor, Sean Fairman. filed by, s/Gregory R. Webber, Esquire Certificate of Service	Fredric Joseph Ammerman
	ORDER, NOW, this 16th day of March, 2004, Rule is issued upon the parties to Appear and Show Cause why the Petition should not be granted. Argument is scheduled the 1st day of April, 2004, at 9:30 a.m. in Courtroom No. 1. by the Court, s/FJA, P.J. 2 cc & Notice of Service to Atty	Fredric Joseph Ammerman
03/24/2004	Affidavit Of Service Of Rule To Show Cause upon Lorae Fairman. filed by, s/Gregory R. Webber, Esquire Certificate of Service 1 cc to Atty	Fredric Joseph Ammerman
04/06/2004	ORDER, NOW, this 1st day of April, 2004, re: Petition for Leave to Settle Claims of Minor, Sean Fairman by the Court, s/FJA, P.J. 2 cc Atty Webber, Aracri	Fredric Joseph Ammerman

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

IN RE: SEAN FAIRMAN, a Minor, by and through his Natural Parents and Guardians, ERNEST and LORAE FAIRMAN,

Petitioners.

CIVIL ACTION

No: 03-1860-CD

PETITION FOR COURT APPROVAL OF SETTLEMENT OF THE ACTION OF A MINOR

COUNSEL OF RECORD FOR THIS PARTY:

DANIEL L. RIVETTI, ESQUIRE
PA I.D. # 73015

TINA A. ARACRI, ESQUIRE
PA I.D. #85327

ROBB LEONARD MULVIHILL
FIRM #249
2300 One Mellon Center
Pittsburgh, PA 15219

(412) 281-5431

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

IN RE: SEAN FAIRMAN, a Minor, by and through his Natural Parents and Guardians, ERNEST and LORAE FAIRMAN,	)	CIVIL ACTION
	)	No:
Petitioner.	)	

PETITION FOR COURT OF APPROVAL OF SETTLEMENT OF THE CLAIM OF A MINOR

TO: The Honorable Judges of Said Court

AND NOW, comes the Petitioners, SEAN FAIRMAN, a Minor, by and through his Natural Parents and Guardians, ERNEST and LORAE FAIRMAN, by and through their attorneys, ROBB LEONARD MULVIHILL and TINA A. ARACRI, ESQUIRE and pursuant to Pa. R.C.P. 2039, move this Honorable Court to approve a settlement in compromise in payment for underinsured motorist benefits and outstanding medical bills for the following reasons:

1. Minor-Petitioner, Sean Fairman (hereinafter "Minor-Petitioner"), is 15-years-old having been born on October 20, 1988, and resides with his natural parents and guardians, Ernest and Lorae Fairman at R.D. #1, Box 391, Hemlock Heights, DuBois, Pennsylvania 15801.

2. The Petitioners, Ernest and Lorae Fairman, are adult individuals and the natural parents and guardians of Minor-Petitioner, Sean Fairman.

3. This action arises out of an automobile accident which occurred on January 31, 2002, at which time the Minor-Petitioner was injured by a vehicle driven by Barrett Johnston.

4. The accident took place on Liberty Boulevard, State Route 19, Clearfield County, Pennsylvania, when the Minor-Petitioner while operating a bicycle exited the DuBois Middle School parking lot and crossed in front of the vehicle driven by Barrett Johnston and collided with the front right portion of Mr. Johnston's vehicle. (See a true and correct copy of the police report attached hereto as **Exhibit "A"**)

5. As a result of the accident, it is alleged that the Minor-Petitioner sustained injuries to his right arm, leg, foot and shoulder. (See true and correct copies of medical records attached hereto as **Exhibit "B"**)

6. In the underlying action, Petitioners, Ernest and Lorae Fairman, the natural parents and guardians of Minor-Petitioner, Sean Fairman, and American Independent Insurance Company have mutually agreed upon a settlement wherein American Independent Insurance Company tendered an offer of settlement to the Minor-Petitioner in the amount of Fifteen Thousand and No/100 ($15,000.00) Dollars which represents the policy limits of Barrett Johnston's automobile liability insurance policy. (See a true and correct copy of the Settlement Agreement and Release attached hereto as **Exhibit "C"**)

7. At all times material to this action, the Petitioners, Ernest and Lorae Fairman were also insured through a policy of automobile liability insurance issued by Ohio Casualty Group (hereinafter "Ohio Casualty") which provided underinsured motorist coverage benefits for bodily injury pursuant to which the herein referenced settlement proposal was made.

8. Robb Leonard Mulvihill and Tina A. Aracri, Esquire have been retained by Ohio Casualty Group to represent its interest in order to obtain court approval for the herein settlement agreement.

9. Petitioners, Ernest and Lorae Fairman, natural parents and guardians of Minor-Petitioner, Sean Fairman, and Ohio Casualty, through counsel, have mutually agreed upon a settlement wherein Ohio Casualty Group has tendered an offer of settlement to Minor-Petitioner in the amount of Twenty-Two Thousand One Hundred and No/100 ($22,100.00) Dollars which includes Twenty Thousand and No/100($20,000.00) Dollars for underinsured motorist benefits and Two Thousand One Hundred and No/100 ($2,100.00) Dollars for outstanding medical bills. (See a true and correct copy of the Settlement Agreement and Release which is attached hereto as **Exhibit "D"**)

10. Minor-Petitioner, through his natural parents and guardians, Ernest and Lorae Fairman, have accepted this settlement.

11. As a result of such settlement, the law firm of Robb Leonard Mulvihill and Tina A. Aracri, Esquire, present to this Honorable Court the within Petition.

12. Ohio Casualty Group will make a lump sum payment of Twenty-Two Thousand One Hundred and No/100 ($22,100.00) Dollars to Minor Petitioner, by and through his natural parents and guardians, Ernest and Lorae Fairman. Said payment will be placed by Tina A Aracri, Esquire, in a federally insured interest-bearing account in the name of the Minor Petitioner, not to be withdrawn and/or transferred to another account until the Minor-Petitioner attains the age of 18, or by further Order of Court.

13. Proof of placement of the proceeds of the settlement will be filed with the Court within thirty (30) days of the date of the Order of Court by Tina A. Aracri, Esquire.

14. All costs and fees associated with obtaining court approval of the herein settlement agreement shall be borne by Ohio Casualty Group.

WHEREFORE, Ohio Casualty Group respectfully requests that this Honorable Court approve the settlement, according to the form of the attached Order.

Respectfully submitted,

ROBB LEONARD MULVIHILL

By: _____
Tina A. Aracri, Esquire
Counsel for Ohio Casualty Group

COMMONWEALTH OF PENNSYLVANIA
POLICE CRASH REPORTING FORM

Crash Number: Computer P0302639 — (●) New

AA 45 1 1 — Case Closed: ( ) Yes ( ) No — Page: 001 — ( ) Change/Continuation

Police Agency Data

Incident Number: DP0604010 2 — Police Agency: 17301 — Patrol Zone:

Agency Name: DuBois City Police — Precinct: — Investigation Date (MM-DD-YYYY): 01-31-2002

Dispatch Time (mil): 1425 — Arrival Time (mil): 1427 — Investigator: SHAGINAW — Badge Number: 00301

Reviewer: — Badge Number: — Approval Date (MM-DD-YYYY):

Crash Data

County: 17 — County Name: CLEARFIELD — Municipality: 301 — Municipality Name: DuBois

Day of Week: ( ) Sun (●) Thu ( ) Mon ( ) Fri ( ) Tue ( ) Sat ( ) Wed ( ) Unk

Crash Date (MM-DD-YYYY): 01-31-2002 — Crash Time (Military): 1424 — No of Units: 02 — No of People: 03 — No Injured: 01 — No Killed: 00 — (If > 00, Complete Form: AA 45 F 1)

Reportable Crash	Notify Highway Maintenance	School Bus Related	School Zone Related	PennDOT Property
(●) Yes ( ) No	( ) Yes (●) No	( ) Yes (●) No	(●) Yes ( ) No	( ) Yes (●) No

Unit Information

Unit Number: 01 — Delete? ( ) — Type Unit: ( ) Motor Vehicle in Transport ( ) Pedestrian ( ) Hit & Run Vehicle ( ) Pedestrian on Skates, in Wheelchair, etc ( ) Illegally Parked ( ) Disabled From Previous Crash ( ) Legally Parked ( ) Train (●) Non - Motorized ( ) Phantom Vehicle

Owner Last Name (If Pedestrian, skip to Form AA 45 3 1): — FI: — MI: — Telephone Number:

Address: — City: — State: — Zip:

Commercial Vehicle: ( ) Yes (●) No (If Yes, Complete Form: AA 45 C 1)

VIN: — Model Year: — Vehicle Make*:

License Plate: — Reg. State: — Travel Speed:

*Refer to List on Back of Overlay

Insurance: ( ) Yes ( ) No ( ) Unknown — Insurance Company: — Policy No: — Insurance Company Phone:

Vehicle Towed: ( ) Yes ( ) No — Towed To: — Towed By: — Tow Agency Phone:

Unit Information

Unit Number: 02 — Delete? ( ) — Type Unit: (●) Motor Vehicle in Transport ( ) Pedestrian ( ) Hit & Run Vehicle ( ) Pedestrian on Skates, in Wheelchair, etc ( ) Illegally Parked ( ) Disabled From Previous Crash ( ) Legally Parked ( ) Train ( ) Non - Motorized ( ) Phantom Vehicle

Owner Last Name (If Pedestrian, skip to Form AA 45 3 1): JOHNSTON — FI: B — MI: L — Telephone Number: 375-5178

Address: RR3 Box 138 — City: DuBois — State: PA — Zip: 15801

Commercial Vehicle: ( ) Yes (●) No (If Yes, Complete Form: AA 45 C 1)

VIN: 2FAPP36X6MB159048 — Model Year: 1991 — Vehicle Make*: 12

License Plate: ECD7133 — Reg. State: PA — Travel Speed: 015

*Refer to List on Back of Overlay

Insurance: (●) Yes ( ) No ( ) Unknown — Insurance Company: AMERICAN IND. SERVICES — Policy No: PA02-0007448 — Insurance Company Phone: 814

Vehicle Towed: ( ) Yes (●) No — Towed To: — Towed By: — Tow Agency Phone:

EXHIBIT A

COMMONWEALTH OF PENNSYLVANIA
POLICE CRASH REPORTING FORM

Crash Number: P0302639 (New)

AA 45 2 1

Page: 002 (Change/Continuation)

Vehicle Information

Unit Number: 01

Trailing Unit(s) — Number of Trailing Units: 0

Type of Unit: 1=Towing Passenger Veh; 2=Towing Truck; 3=Towing Utility Trailer; 4=Mobile or Modular Home; 5=Camper; 6=Trailer; 7=Semi-Trailer; 8=Other; 9=Unknown

Tag No / Tag Year / Tag State

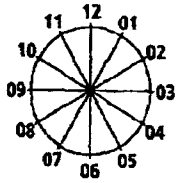
Tag No / Tag Year / Tag State

Vehicle Color: 99
01=Blue; 02=Red; 03=White; 04=Green; 05=Black; 06=Yellow; 07=Silver; 08=Gold; 09=Brown; 10=Orange; 11=Purple; 12=Other; 99=Unknown

Vehicle Type: 20
01=Automobile; 02=Motorcycle; 03=Bus; 04=Small Truck; 05=Large Truck; 10=Snowmobile; 11=Farm Equip; 12=Construction Equip; 18=Other Type Special Veh; 19=Unknown Type Special Veh; 20=Unicycle, Bicycle, Tricycle; 21=Other Pedalcycle; 22=Horse and Buggy; 23=Horse and Rider; 24=Train; 25=Trolley; 98=Other; 99=Unknown

Special Usage: 00
00=Not Applicable; 01=Fire Veh; 02=Ambulance; 03=Police; 08=Other Emergency Vehicle; 11=Pupil Transport; 12=Commercial Passenger Carrier; 13=Taxi; 21=Tractor Trailer; 22=Twin Trailer; 23=Triple Trailer; 31=Modified Veh; 99=Unknown

Initial Impact Point: 12



00=Non-Collision; 13=Top; 14=Undercarriage; 15=Towed Unit; 99=Unknown

Damage Indicator: 1
0=None; 1=Minor (Driveable); 2=Functional (Moderate Damage, May Not be Driveable); 3=Disabling (Severe - Not Driveable); 9=Unknown

Vehicle Role: 1
0=Non-Collision; 1=Striking; 2=Struck; 3=Both Striking and Struck

Vehicle Position: 98
00=Not Applicable; 01=Right Lane (Curb); 02=Right Turn Lane; 03=Left Lane; 04=Left Turn Lane; 05=2-Direction Center Turn Lane; 06=Other Forward Moving Lane; 07=Oncoming Traffic Lane; 08=Left of Trafficway; 09=Right of Trafficway; 10=HOV Lane; 11=Shoulder Right; 12=Shoulder Left; 13=One Lane Road; 98=Other; 99=Unknown

Direction of Travel: W
N=North; S=South; E=East; W=West; U=Unknown

Movement: 98
01=Going Straight; 02=Slowing/Stopping in Lane; 03=Stopped in Traffic Lane; 04=Passing/Overtaking Veh; 05=Leaving a Parked Position; 06=Parked; 07=Entering a Parked Position; 08=Trying to Avoid Animal, Ped, Object, Veh, etc; 09=Turning Right on Red; 10=Turning Right; 11=Turning Left on Red; 12=Turning Left; 13=Making a U-Turn; 14=Backing Up; 15=Changing Lanes or Merging; 16=Negotiating Curve - Right; 17=Negotiating Curve - Left; 98=Other; 99=Unknown

Gradient: 1
1=Level Roadway; 2=Uphill; 3=Downhill; 4=Sag/Bottom of Hill; 5=Crest/Top of Hill; 9=Unknown

Alignment: 1
1=Straight; 2=Curved; 9=Unknown

Vehicle Information

Unit Number: 02

Trailing Unit(s) — Number of Trailing Units: 0

Type of Unit: 1=Towing Passenger Veh; 2=Towing Truck; 3=Towing Utility Trailer; 4=Mobile or Modular Home; 5=Camper; 6=Trailer; 7=Semi-Trailer; 8=Other; 9=Unknown

Tag No / Tag Year / Tag State

Tag No / Tag Year / Tag State

Vehicle Color: 02
01=Blue; 02=Red; 03=White; 04=Green; 05=Black; 06=Yellow; 07=Silver; 08=Gold; 09=Brown; 10=Orange; 11=Purple; 12=Other; 99=Unknown

Vehicle Type: 01
01=Automobile; 02=Motorcycle; 03=Bus; 04=Small Truck; 05=Large Truck; 10=Snowmobile; 11=Farm Equip; 12=Construction Equip; 18=Other Type Special Veh; 19=Unknown Type Special Veh; 20=Unicycle, Bicycle, Tricycle; 21=Other Pedalcycle; 22=Horse and Buggy; 23=Horse and Rider; 24=Train; 25=Trolley; 98=Other; 99=Unknown

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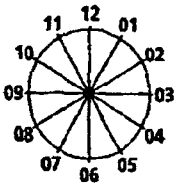
00=Not Applicable; 01=Fire Veh; 02=Ambulance; 03=Police; 08=Other Emergency Vehicle; 11=Pupil Transport; 12=Commercial Passenger Carrier; 13=Taxi; 21=Tractor Trailer; 22=Twin Trailer; 23=Triple Trailer; 31=Modified Veh; 99=Unknown

Initial Impact Point: 10



00=Non-Collision; 13=Top; 14=Undercarriage; 15=Towed Unit; 99=Unknown

Damage Indicator: 1
0=None; 1=Minor (Driveable); 2=Functional (Moderate Damage, May Not be Driveable); 3=Disabling (Severe - Not Driveable); 9=Unknown

Vehicle Role: 2
0=Non-Collision; 1=Striking; 2=Struck; 3=Both Striking and Struck

Vehicle Position: 01
00=Not Applicable; 01=Right Lane (Curb); 02=Right Turn Lane; 03=Left Lane; 04=Left Turn Lane; 05=2-Direction Center Turn Lane; 06=Other Forward Moving Lane; 07=Oncoming Traffic Lane; 08=Left of Trafficway; 09=Right of Trafficway; 10=HOV Lane; 11=Shoulder Right; 12=Shoulder Left; 13=One Lane Road; 98=Other; 99=Unknown

Direction of Travel: S
N=North; S=South; E=East; W=West; U=Unknown

Movement: 01
01=Going Straight; 02=Slowing/Stopping in Lane; 03=Stopped in Traffic Lane; 04=Passing/Overtaking Veh; 05=Leaving a Parked Position; 06=Parked; 07=Entering a Parked Position; 08=Trying to Avoid Animal, Ped, Object, Veh, etc; 09=Turning Right on Red; 10=Turning Right; 11=Turning Left on Red; 12=Turning Left; 13=Making a U-Turn; 14=Backing Up; 15=Changing Lanes or Merging; 16=Negotiating Curve - Right; 17=Negotiating Curve - Left; 98=Other; 99=Unknown

Gradient: 1
1=Level Roadway; 2=Uphill; 3=Downhill; 4=Sag/Bottom of Hill; 5=Crest/Top of Hill; 9=Unknown

Alignment: 1
1=Straight; 2=Curved; 9=Unknown

COMMONWEALTH OF PENNSYLVANIA
POLICE CRASH REPORTING FORM

Crash Number: P0302639

(●) New ( ) Change/Continuation

A 45 3 1 Page: 003

Vehicle Driver/Pedestrian Information

Unit Number: 01 | Last Name: FAIRMAN | FI: S | MI: E | Telephone Number:

Address: RD1 Box 391 | City: DuBois | State: PA | Zip: 15801

License Number: | State: | If License Number is unknown or driver is not licensed, see manual

Alcohol/Drugs Suspected
(●) No ( ) Alcohol ( ) Illegal Drugs ( ) Alcohol and Drugs ( ) Medication ( ) Unknown

Alcohol Test Type
(●) Test Not Given ( ) Blood ( ) Breath ( ) Urine ( ) Other ( ) Unknown if Test Given

Alcohol Test Results
0. | ( ) Test Refused ( ) Test Given, Contaminated Results ( ) Unknown Results

Driver or Pedestrian Physical Condition
(●) Apparently Normal ( ) Had Been Drinking ( ) Illegal Drug Use ( ) Sick ( ) Fatigue ( ) Asleep ( ) Medication ( ) Unknown

Vehicle Code List any Vehicle Code Section this driver has violated and mark if they were charged.

	Charged with Violation?
3324 VEH. CROSSING RDWY.	( ) Yes (●) No
	( ) Yes ( ) No

Owner/Driver Code: 00

00=Not Applicable; 01=Private Vehicle Owned/Leased by Driver; 02=Private Vehicle Not Owned/Leased by Driver; 03=Rented Vehicle; 04=State Police Vehicle; 05=PennDOT Vehicle; 06=Other State Gov Vehicle; 07=Municipal Police Vehicle; 08=Other Municipal Government Vehicle; 09=Federal Gov Vehicle; 98=Other; 99=Unknown

Driver Presence: 1

1=Driver Operated Vehicle; 2=No Driver; 3=Driver Fled Scene; 4=Hit and Run; 9=Unknown

Pedestrian Only Information

Pedestrian Signal at Scene of Crash
( ) No Pedestrian Signal ( ) Pedestrian Signal ( ) Not at Intersection

Pedestrian Location
( ) Marked Crosswalks at Intersection ( ) At Intersection - No Crosswalks ( ) Non-Intersection Crosswalks ( ) Driveway Access ( ) In Roadway ( ) Not in Roadway ( ) Median ( ) Island ( ) Shoulder ( ) Sidewalk ( ) < 10 Feet Off Road ( ) > 10 Feet Off Road ( ) Outside Trafficway ( ) Shared Paths/Trails ( ) Unknown

Vehicle Driver/Pedestrian Information

Unit Number: 02 | Last Name: JOHNSTOWN | FI: B | MI: L | Telephone Number: 375-5178

Address: RR3 Box 138 | City: DuBois | State: PA | Zip: 15801

License Number: 26767761 | State: PA | If License Number is unknown or driver is not licensed, see manual

Alcohol/Drugs Suspected
(●) No ( ) Alcohol ( ) Illegal Drugs ( ) Alcohol and Drugs ( ) Medication ( ) Unknown

Alcohol Test Type
(●) Test Not Given ( ) Blood ( ) Breath ( ) Urine ( ) Other ( ) Unknown if Test Given

Alcohol Test Results
0. | ( ) Test Refused ( ) Test Given, Contaminated Results ( ) Unknown Results

Driver or Pedestrian Physical Condition
(●) Apparently Normal ( ) Had Been Drinking ( ) Illegal Drug Use ( ) Sick ( ) Fatigue ( ) Asleep ( ) Medication ( ) Unknown

Vehicle Code List any Vehicle Code Section this driver has violated and mark if they were charged.

	Charged with Violation?
	( ) Yes ( ) No
	( ) Yes ( ) No

Owner/Driver Code: 01

00=Not Applicable; 01=Private Vehicle Owned/Leased by Driver; 02=Private Vehicle Not Owned/Leased by Driver; 03=Rented Vehicle; 04=State Police Vehicle; 05=PennDOT Vehicle; 06=Other State Gov Vehicle; 07=Municipal Police Vehicle; 08=Other Municipal Government Vehicle; 09=Federal Gov Vehicle; 98=Other; 99=Unknown

Driver Presence: 1

1=Driver Operated Vehicle; 2=No Driver; 3=Driver Fled Scene; 4=Hit and Run; 9=Unknown

Pedestrian Only Information

Pedestrian Signal at Scene of Crash
( ) No Pedestrian Signal ( ) Pedestrian Signal ( ) Not at Intersection

Pedestrian Location
( ) Marked Crosswalks at Intersection ( ) At Intersection - No Crosswalks ( ) Non-Intersection Crosswalks ( ) Driveway Access ( ) In Roadway ( ) Not in Roadway ( ) Median ( ) Island ( ) Shoulder ( ) Sidewalk ( ) < 10 Feet Off Road ( ) > 10 Feet Off Road ( ) Outside Trafficway ( ) Shared Paths/Trails ( ) Unknown

EMS Form Number: 8560[illegible]5 Am Serv Ltd Print Date: 01/31/2002

SERVICE NAME: Amserv Ltd. (17010) UNIT ID: 54 INCIDENT #: 4300190

INCIDENT LOCATION: Liberty Boulevard., Du Bois, PA 15801 -- an other traffic (MCDCode-451700100)

DISPATCHED AT: 14:28 January 31, 2002 OUTCOME: Transported to DuBois Reg Med Ctr - West (00420)

NATURE OF DISPATCH: ALS Emergency

PATIENT INFO USERDEF3: CHIEF COMPLAINT: Pain

PATIENT LAST NAME:	FIRST:	M.I.:	PHONE:	AGE:	DATE OF BIRTH	SEX:
FAIRMAN	SEAN		(814)375-1019	13	10/20/1988	M

STREET ADDRESS: RD 1 BOX 391
SOCIAL SECURITY #: RESIDENT OF CITY/MUNIP: Yes

CITY: DuBois STATE: PA ZIP CODE: 15801

SIGNATURE TO BILL DIRECT: No
RELEASE INFO OBTAINED: No

PRIVATE PHYSICIAN: SIAR MCKINLE

MEDICARE #:
MEDICAID #:

NEXT OF KIN: FAIRMAN, LORACE C (Parent)

BILL TO (COMPANY OR NAME): FAIRMAN, LORACE C PHONE: (814)375-1019
ADDRESS:

INSUR #1: AUTO INS
Group #:
Policy #
INSUR #2: FEB 04

CITY: DuBois STATE: PA ZIP CODE: 15801

Group #:
Policy #:

MILEAGE

OUT:	60374
SCENE:	60374
DEST:	60376
IN:	60379
BILLED:	2
TOTAL:	5

NARRATIVE:

Amserv Ltd., Medic 4354 was dispatched at 14:28 on Jan 31, 2002 to Du Bois, PA 15801 and arrived at scene (an other traffic) at 14:29 in response to a bicycle. Response mode to scene was 'Emergency'. The Incident Number was 4300190.

Patient was a 13 year old male with a chief complaint of pain. Patient condition on scene was moderate. The following illnesses were suspected: Pain and CONTUSION. Injuries were sustained as follows: blunt to the arm, blunt to the leg/foot, and fracture or dislocation of the leg/foot. Incident was NOT work related. This pt was struck by a passenger car while riding a bicycle across Liberty Blvd. Pt was struck by the front of the vehicle, there was windshield damage to the vehicle and also the passenger mirror was broken. This pt stated that his was thrown a short distance from the point of impact, how ever he wasn't sure if he was thrown after the impact. Pt stated that he did remember loosing conciousness for a short period of time of approx 1 min. This pt's C/C of pain in his left shoulder and his right leg. Upon exam. there is a large hematoma approx 2-3inches below his right knee, also noted abraisions just above his right ankle. Pt's treachea was midline, no deveation was noted, no jvd, abd is soft non tender. Pt does move all ext. with purpose, he does have good cap refil, and ext are warm/dry to the touch. Pupils are pearl, lungs are equal and clear bilatterly. Vitals on scene: BP:188/62, P:78, Resp: 22 , PEARL. O2 sat of 100% @ 4l/m, nasal canula. Pt was fully immobilized with c-collar,cid, lsb. Pt's right leg was immobilized with a soft splint and also a ice pak was placed on the injury site. Cardiac monitor was attached to this pt which shows a NSR - 78, no ectopy noted. An I.V. was started in this pt's left hand with a #18 ga cath. I.V. of N.S.S. is running at a kvo rate. DRMC-WEST was notified with a pt report, eta given of 3-5 min. Upon arrival at WEST, this pt was taken to Bed #12, pt was moved from the stretcher while still securred to the lsb,cid,c-collar still attached to this pt. Report was given to Dr. Cameron. Pt care was then released to the ER staff.

HISTORY OF PRESENT CONDITION:

-- Onset and duration --

-- Quality of pain --

EXHIBIT B

4300190 (Service Inc. #)

8560733 5 (State Form #)

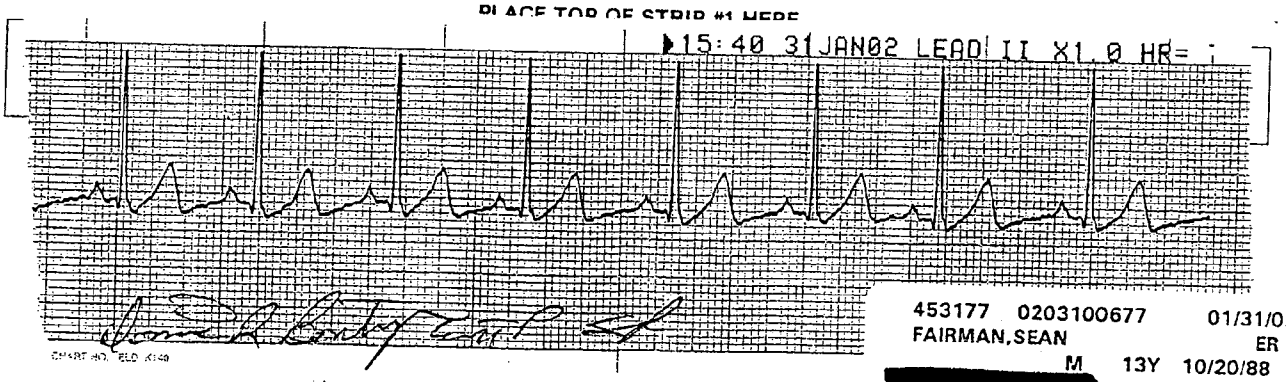
DUBOIS REGIONAL MEDICAL CENTER

CARDIAC MONITOR STRIP RECORD

PRE HOSP

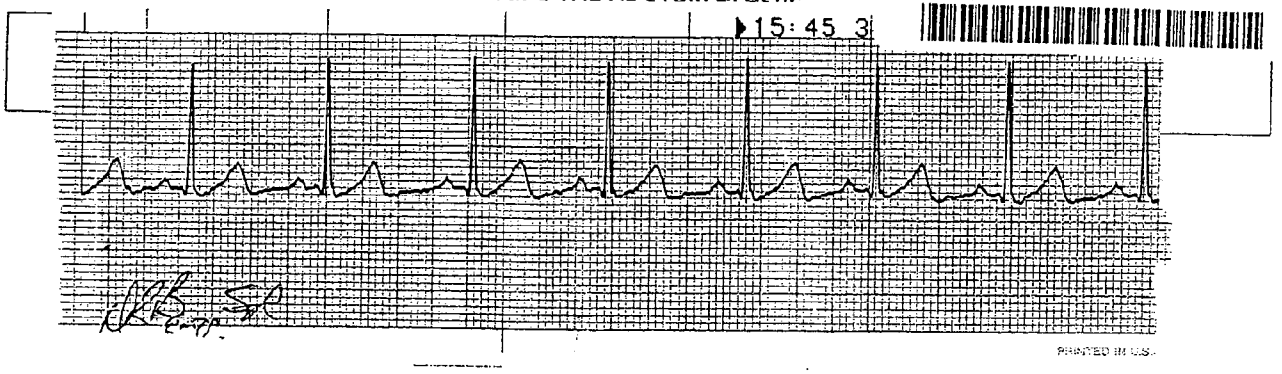
453177 0203100677 01/31/02
FAIRMAN,SEAN ER
M 13Y 10/20/88
[redacted]

PLACE TOP OF STRIP #1 HERE



453177 0203100677 01/31/02
FAIRMAN,SEAN ER
M 13Y 10/20/88
[redacted]

PLACE TOP OF STRIP #2 HERE



PLACE TOP OF STRIP #3 HERE

PLACE TOP OF STRIP #4 HERE

ADVANCE DIRECTIVE ☐ Thu Jan 31 19:03 EST 20

ADMISSION SUMMARY

ORGAN DONOR ☐

MED. REC. NO. 453177

DuBOIS REGIONAL MEDICAL CENTER

PATIENT

NAME AND ADDRESS	PREVIOUS NAME	ADMISSION DATE	TIME	ROOM NO	BED NO.	SMK	PUB	BILLING NO.
FAIRMAN,SEAN RD 1 BOX 391 DUBOIS PA 15801		01/31/02	16:45	4080	02	U	N	0203100677

AGE	BIRTH DATE	P.T.	SEX	RACE	M.S.	REFERRAL	S.C.	F.C.	ADM BY
13Y	10/20/88	I/P	M	1	S	*ER	PED	AU	EMS

COUNTY PA

TELEPHONE NO. (814)375-1019 S.S. NO.

RELIGION-CHURCH: UNKNOWN — RM REQ: S

EMPLOYER, ADDRESS, OCCUPATION, PHONE: NONE STUDENT

ADMITTING DIAGNOSIS	STAFF ALERT	LAST ADM. DATE WHERE	RELATIONSHIP
823.82-FX TIBIA W FIBULA NOS-CL		11/05/01	MOTHER

PERSON TO NOTIFY IN CASE OF EMERGENCY: FAIRMAN,LORAE C — ADDRESS: RD 1 BOX 391 DUBOIS PA — PHONE: (814)375-1019

PARTY

NAME AND ADDRESS	TELEPHONE	REL.	EMPLOYER NAME AND ADDRESS
FAIRMAN,LORAE C RD 1 BOX 391 DUBOIS PA 15801	(814)375-1019 LABORER SOC. SEC. # 177-48-4228		INVENSYS ENERGY METE 805 LIBERTY BLVD DUBOIS PA 15801 (814)371-8000

INS

INSURANCE COMPANY	PLAN	POLICY HOLDER	REL.	POLICY #	GROUP #
AUTO INSURANCE	350001	FAIRMAN,LORAE;C		177484228	999999
AUTO INSURANCE PROF	350002	FAIRMAN,LORAE;C		177484228	999999
CIGNA	302755	FAIRMAN,SEAN		17748422803	999999

ATTENDING PHYSICIAN	REFERRING PHYSICIAN	CONSULTING PHYSICIAN
PIASIO,MARK PRI SIAR,W J	MCKINLEY,ERIN A PIASIO,MARK	

PRINCIPAL DIAGNOSIS: The condition established, after study, to be chiefly responsible for causing the admission to the hospital for care.
SECONDARY DIAGNOSIS: All conditions that coexist at the time of admission or develop subsequently which affect the treatment received and/or the length of stay.
PRINCIPAL PROCEDURE: That procedure most related to the principal diagnosis.

PRINCIPAL AND SECONDARY DIAGNOSIS AND COMPLICATIONS	CODE
Fracture of tib fib, right.	823.82
Fracture of left proximal humerus.	812.00
Pedestrian - Auto trauma.	E826.1
	E849.5

COMPLICATIONS

PRINCIPAL AND SECONDARY PROCEDURES	
2-1-02 Surgeon: M. PIASIO, MD. Closed reduction and long-leg CAST, right leg.	79.06

SPECIAL UNIT DAYS

TRANSFER DESTINATION

TYPE OF ADMISSION ☐ ELECTIVE ☐ URGENT ☐ EMERGENCY

DATE DISCHARGED 2-2-03 TIME 1100 ☒ A.M. ☐ P.M. AUTOPSY ☐ YES ☒ NO

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

ATTENDING PHYSICIAN _____ DATE

PHYSICIAN _____ DATE

DISCHARGE SUMMARY
DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

10/20/1988
PATIENT NAME: FAIRMAN, SEAN 0203100677 - 000453177

ADMISSION DATE: 01/31/2002 DISCHARGE DATE: 02/02/2002

ADMITTING DIAGNOSIS
Fracture of tib fib, right.

ASSOCIATED DIAGNOSIS
Fracture of left proximal humerus.
Pedestrian-auto trauma.

SURGICAL PROCEDURE: Closed reduction of right tib fib performed on 02/01/02 by Dr. Piasio.

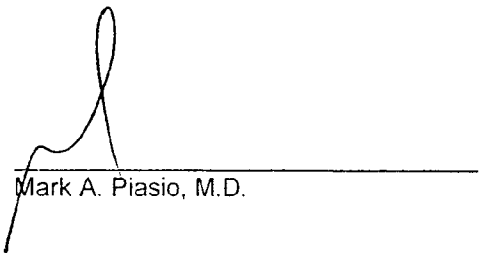
He is discharged home using a wheelchair, crutches, and bedside commode, nonweightbearing of the right lower extremity. Crutches minimally used because of nondisplaced proximal humerus fracture on the left. Advil or Tylenol for pain. Follow up in one week. No gym for 12 weeks. Adaptive school activities.

BRIEF HISTORY: This 13-year-old boy riding a bicycle was struck by a motor vehicle. He hit the windshield, sustained a minimally angulated fracture of the midshaft of the tib fib, greenstick type and nondisplaced linear fracture of the left proximal humerus. Other workup otherwise negative. He had complaints of some mild head discomfort, no bruising, trauma, or obvious process seen. He remains neurologically completely normal. No workup was indicated at this time.

He underwent a closed reduction of his right tib fib. Long leg cast was placed the day following admission which he tolerated very well, tolerating a sling and oral pain medication. He is ready for discharge home. He will probably need a wheelchair for at least a few weeks until the humerus fracture has healed well enough for crutch use with follow up in one week in my office.

D: 02/02/2002 8:58 A
T: 02/05/2002 10:39 A MAP/lmp
DOCUMENT NO: 243460
Job/Tape ID: 000186149

cc: Mark A. Piasio, M.D.



Mark A. Piasio, M.D.

Chart Copy

\SHARING\NURSADM\ERFORM\DEPARTMENTRECORD.DOC 11/9/00 #1 10/24/01SAG

453177 02 0677 01/31/02
FAIRMAN,SE ER
13Y 10/20/88
MCKINLEY,ERIN A
SIAR,W J

DuBois Regional Medical Center — Making the difference for life

EMERGENCY DEPARTMENT RECORD Page 1 of 7

Time: ~~1350~~ ☐ Emergent ☑ Urgent ☐ Nonurgent

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

CHIEF COMPLAINT: Bike accident, hit by car

VITAL SIGNS	Temp	Pulse	Resp	BP	Pain Scale	O_2 Sat	WT
	99.9	80	18	135/64	10/10		

ALLERGIES: NKA

CURRENT MEDS: ☐ See attached list None

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 | Triage Nurse:

Primary Nurse: Susan Baird RN

CHECK THE REQUESTED STUDIES

☐ CBC/AutoDiff/Platelet	☐ Troponin	☐ Monospot	☐ Triage Drug Screen
☐ CBC/Platelet	☐ PT/PTT	☐ RSS	☐ Acetaminophen Level
☐ CBC		☐ RSV	☐ ASA Level
	☐ Pregnancy	☐ C&S	☐ ETOH
☐ Basic Met. Prof.	☐ Chlamydia/GC (DNA probe)	☐ Blood C&S _____	
☐ Compre profile	☐ Wet Mount		☐ Digoxin Level
☐ Amylase	☐ UA w/Microscopic	☐ Type and Screen	☐ Dilantin Level
☐ Lipase	☐ UA w/o Microscopic	☐ Type and Cross _____	☐ Phenobarb Level
☐ Hepatic Prof.	☐ UC		☐ Tegretol Level
☐ Renal Funct. Prof.			☐ Valproic Acid Level
☐ Magnesium			☐

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 — ☑ R Tib/Fib — ☐ CT _____
☐ Portable Chest — ☐ _____ — ☐ Enhanced
☐ Port Lat C Spine — ☑ L Shoulder — ☐ Unenhanced
☐ C Spine — ☐ _____ — ☐ _____
☐ LS Spine — ☐ _____ — ☐ _____

PHYSICIAN REPORT

Dictated T

EXAM TIME: ~~1320~~ 1510

R Tib/Fib Fx

DX ORDERS
IVF: _____
O_2 _____ DT: _____
Monitoring: ☐ Telemetry ☐ Cardiac monitor ☐ Pulse ox
Accucheck ☐ Foley ☐ Stool Hemoccult ☐ Crutches ☐ ☐ Splint: _____
Meds: Dilaudid 4mg 0.5 mg IV — Repeat prn

DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS

Condition: **Satisfactory** **Fair** **Poor** WITH:

☐ Admitted Room No: ☑ Physician Notified/Time: 1614

☐ 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: Ice Elevate Splint

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

PATIENT/ RESPONSIBLE PARTY | NURSE'S SIGNATURE | 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

453177 0203100677 01/31/02
FAIRMAN,SEAN ER
M 13Y 10/20/88
MCKINLEY,ERIN A
SIAR,W J

DuBois Regional Medical Center 18

EMERGENCY PHYSICIAN RECORD

Multiple Trauma (5)

TIME SEEN: 1510 ROOM: 12 __ EMS arrival
HISTORIAN: ✓patient __spouse __paramedics
__HX / __EXAM LIMITED BY:

HPI chief complaint: Injury to R Leg

occurred:
- ✓just PTA
- __today
- __yesterday
- days PTA

where:
- __home
- __school
- __neighbor's
- __city park
- __work
- ✓street

context: On Bike, Hit Car travelling ~ 15-20 mph

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~~

ROS ☐all systems neg except 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

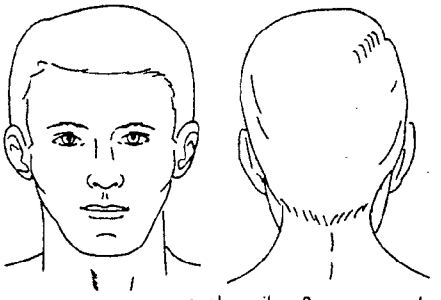
☒Nurses note reviewed ☐ Tetanus immun. UTD ☒Vital signs reviewed

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

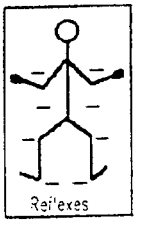
ENT
✓nml external inspection
✓no dental injury
__hemotympanum
__TM obscured by wax
__clotted nasal blood
__dental injury / malocclusion

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



453177 0203100677 01/31/02
FAIRMAN,SEAN ER
M 13Y 10/20/88
MCKINLEY,ERIN A
SIAR,W J

SKIN
- ✓ intact
- ✓ warm, dry

__see diagram
__crepitus / diaphoresis

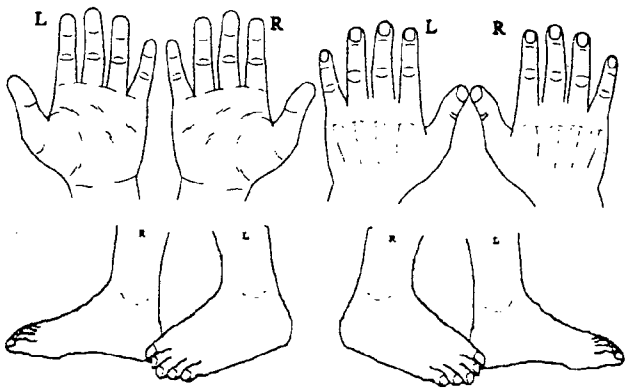
BACK
- ✓ no CVA tenderness
- ✓ no vertebral tenderness

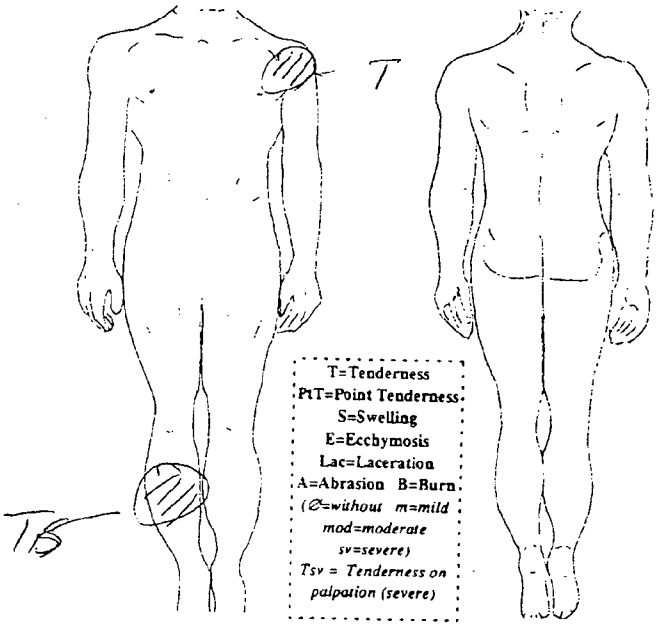
__see diagram
__vertebral point-tenderness
__CVA tenderness
__muscle spasm / limited ROM

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	__reversal / straightening of cerv. lordosis	
__no fracture	__DJD / spondylosis / spurring	
__nml alignment		
__soft tissues nml		

CXR
__nml / NAD
__no infiltrates
__nml heart size
__nml mediastinum
__rib fracture
__infiltrate / atelectasis
R Tib Fib Fx

OTHER ☐ See separate report

PROGRESS:

L Shoulder Xray shows ... no dislocation on one view only ? significance

✓ Discussed with Dr. Davis
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:

contusion

head		wrist	R / L		
face		hand	R / L		
chest		hip	R / L		
abdomen		thigh	R / L		
back		knee	R / L		
shoulder	R / L	leg	R / L		
arm	R / L	ankle	R / L		
elbow	R / L	foot	R / L		
forearm	R / L				

sprain / strain
neck dorsal lumbar

concussion
with LOC *w/o LOC*

laceration

Fx R Tib/Fib

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

DISPOSITION- ☐ home ☒ admitted ☐ transferred_____
CONDITION- ☒ unchanged ☐ improved ☐ stable_____

MD / DO

HISTORY AND PHYSICAL EXAMINATION
DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

10/20/1988
FAIRMAN, SEAN 0203100677 - 000453177 4080

Date of Admission: 01/31/02

ADMITTING DIAGNOSIS: Fractured tib/fib, right.

ASSOCIATED DIAGNOSIS: Fractured left proximal humerus.

CHIEF COMPLAINT: 13-year-old boy with right leg pain.

HISTORY OF PRESENT ILLNESS: This young boy was struck by a car while on his bicycle, sustaining an injury to his right leg and left shoulder. He is complaining of pain in both areas. The patient was brought to the hospital by ambulance, found to have a midshaft tib/fib fracture on the right, incomplete with acceptable alignment, intact neurovascular, and a possible fracture of his left humerus. He reports pain of the left proximal humerus but is able to move the shoulder. Review of his x-rays does show a nondisplaced linear fracture of the proximal humerus on the left side, possible Salter I as well. The tib/fib fracture is incomplete at midshaft with acceptable alignment.

The plan will be as he is really unable to use crutches at this time, for admission, training with possibly a platform walker, and closed reduction tomorrow with some anesthesia.

PAST SURGICAL HISTORY: Significant for a laceration of right leg with subsequent scar revision.

MEDICAL HISTORY: Negative.

ALLERGIES: POSSIBLY TO SOME SUTURE MATERIAL.

MEDICATIONS: None.

SOCIAL HISTORY: He obviously does not smoke or drink, is a middle school student, plays baseball.

FAMILY HISTORY: Noncontributory.

CHILDHOOD HISTORY: Negative.

REVIEW OF SYSTEMS: He denies fever, chills, weight loss, seizure, headache, neck pain, abdominal pain, chest pain, or any other complaint. Otherwise, negative in detail.

PHYSICAL EXAMINATION: Shows a healthy, well-developed white male in mild distress. His skin is cool and dry. His neck is supple. There is no adenopathy, no tenderness. CHEST: Symmetric without tenderness. HEART: Regular rate and rhythm. LUNGS: Clear to auscultation. ABDOMEN: Soft, nontender, with active bowel sounds. EXTREMITIES: Skin is cool and dry. Pulses are intact distally. NEUROLOGIC EXAM: Intact distally. He is in a posterior splint with mid-calf swelling anteriorly on the right side. He is tender over the left proximal humerus with intact neurovascular.

Chart Copy

X-rays reveal the above-mentioned fractures.

PLAN:
1. Admission.
2. Elevation.
3. Ice.
4. Long leg casting, right, tomorrow with some sedation with training of probable platform walker.

D: 01/31/2002 7:27 P
T: 01/31/2002 7:32 P MAP/jw
DOCUMENT NO: 242597
Job/Tape ID: 000185521

Mark A. Piasio, M.D.

cc: Mark A. Piasio, M.D.

Chart Copy

OPERATIVE/SPECIAL PROCEDURE REPORT **DATE**: 02/01/2002
DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

10/20/1988
PATIENT NAME: FAIRMAN, SEAN 0203100677 - 000453177 IP

SURGEON: Mark A. Piasio, M.D. ASSISTANT:

PREOPERATIVE DIAGNOSIS: Tib-fib fracture, right.

POSTOPERATIVE DIAGNOSIS: Tib-fib fracture, right.

NAME OF OPERATION: Closed reduction and long-leg cast, right leg.

ANESTHESIA: IV sedation.

COMPLICATIONS: None.

DISPOSITION: Recovery Room, stable.

PROCEDURE: The patient was taken to the operating room where IV catheters were placed, and IV sedation was given. A closed reduction was then performed of his right tib-fib and a long-leg cast was fashioned. Adequate alignment was confirmed by C-arm fluoroscopy. When the cast was hardened, the patient was taken to the Recovery Room with vital signs stable. Sponge and needle counts were recorded correct.

D: 02/01/2002 5:14 P
T: 02/05/2002 9:47 A MAP/bb
DOCUMENT NO: 243437
Job/Tape ID: 000186061

Mark A. Piasio, M.D.

cc: Mark A. Piasio, M.D.

Chart Copy

100 Hospital Ave, DuBois, PA 15801

FAIRMAN,SEAN
RD 1 BOX 391
DUBOIS PA 15801

PED-4080-02 Unit # 000453177
Age 13Y Acct # D0203100677

Date:01/31/02 Time:1600

CAMERON,RUSSELL E

SIAR,W J
DRMC EAST
DUBOIS PA 15801

Chk-in #	Order	Exam	
515419	0001	44004	XR-SHOULDER, MIN 2*L
			Ord Diag: ;MVA
515419	0001	44022	XR-TIBIA FIBULA 2 VIEWS*R
			Ord Diag: ;MVA

LEFT SHOULDER:

Three views of the left shoulder were obtained.

The osseous structures, joint spaces, and soft tissues are normal.

IMPRESSION: NORMAL STUDY.

RIGHT TIBIA-FIBULA:

There is a non-displaced fracture of the mid-shaft of the right tibia. There is a benign cortical defect of the right distal tibial metaphysis. The remaining findings are unremarkable.

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

02/01/02 0852
RAW

Complete

100 Hospital Ave, DuBois, PA 15801

FAIRMAN,SEAN
RD 1 BOX 391
DUBOIS PA 15801

PED-4080-02 Unit # 000453177
Age 13Y Acct # D0203100677

Date:02/01/02 Time:0900

PIASIO,MARK
145 HOSPITAL AVE MED ARTS
DUBOIS PA 15801

SIAR,W J
DRMC EAST
DUBOIS PA 15801

Chk-in #	Order	Exam	
515499	0005	49001	FL-FLUOROSCOPY TO 1 HOUR

Ord Diag: 823.82-FX TIBIA W FIBULA NOS-C

FLUOROSCOPY:

Fluoroscopy was provided by the attending physician for a closed reduction of the right tibia fibula in the OR. No films were obtained.

/READ BY/ G. ALI SHAH
/Released By/ G. ALI SHAH

02/01/02 1449
JLB

Complete

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

FAIRMAN,SEAN
RD 1 BOX 391
DUBOIS PA 15801

PED-4080-02 Unit # 000453177
Age 13Y Acct # D0203100677

Date:02/01/02 Time:1526

PIASIO,MARK
145 HOSPITAL AVE MED ARTS
DUBOIS PA 15801

SIAR,W J
DRMC EAST
DUBOIS PA 15801

Chk-in #	Order	Exam	
515559	0009	44022	XR-TIBIA FIBULA 2 VIEWS*R

Ord Diag: ;FX TIB/FIB

RIGHT TIBIA AND FIBULA:

AP and lateral views of the tibia and fibula, incorporated in a fiberglass cast, again identify the fractured tibia showing minimal bowing medially. Alignment appears to be satisfactory.

/READ BY/ ROBERT J BORON
/Released By/ ROBERT J BORON

02/02/02 1206
RAW

Complete

OHIO CASUALTY GROUP

Paul Rutman, *Manager*
Jeff Phillips, Supervisor

Out of pocket
$2100

September 8, 2003
SECOND REQUEST

Sent 9-11-03
G

Gateway Area Medical Assoc.
Sundar Chandrasekhar
M635 C Maple Ave.
Dubois, PA 15801

RE: Our Claim No.: 02 77 80 88
Our Insured: Sean Fairman
Date of Loss: 13102
Patient: Sean Fariman
Date of Service: 2/12/02

Dear Manager:

Please be advised that we are the third party carrier for Sean Fairman, who is in the process of presenting a claim for his/her injuries.

I am enclosing a medical authorization signed by Sean Fairman and ask that you forward copies of all records pertaining to this accident.

Thank you for your attention to this matter and should you have any questions, please feel free to give me a call.

Very truly yours,

WEST AMERICAN INSURANCE CO.

Patricia Verish

Patricia Verish
Claims Representative

OCG CLAIMS
SEP 15 2003
P. VERISH

/pv
ENC

cc: Sean Fairman

CLAIM OFFICE: Mailing Address: P. O. Box 503, Phoenixville, PA 19460
Telephone: 610-935-9360
Fax: 610.935.9364

Progress Record

Date	Prob. No.	Findings (S – Subjective, O – Objective, A – Assessment, P – Plans)
1/12/02	NKDA Tylenol Advil	S) Hit by car 1-31-02. Broken (R) leg. (R) shoulder crack, on bike. Did have bump on head - did not pray. Was getting headaches and dizzyness occuring in hospital. Said he was fine - Still having occasional headaches & dizzyness daily. Mom thinks (R) eye looks droopy, should tires him out. ~~Prospal~~ O) Bp 110/68 P. 72 CT Scan head 13-02 Scheduled CT Scan 2/14/02 @ 3:30 - ACW

Sean Fairman 1009 02/12/2002

S: Pt was hit by a car on 01-31-01 while riding a bike. He broke his right leg and also had some problems with his left shoulder. He hit the windshield. Had a lump on the head. Complains of headaches on and off and dizziness. Pt was admitted, however no exam was done of the head.

O: Examination revealed an afebrile child. Pupils were equal and reacting well to light. Respiratory System is normal. Cardiovascular System is normal. Abdominal examination is normal.

A: Normal Neurologic exam. , Head trauma

P: In view of the continuing dizziness, I would like to get a CT scan of the head without contrast. Follow-up based on that.

SCS/kld

Sundar Chandrasekhar, MD

Fairman

Date	Prob. No.	Findings (S – Subjective, O – Objective, A – Assessment, P – Plans)
		Sean Fairman 1009 09/27/2002 S: Patient comes in for pharyngitis and pain in his knees. O: Examination revealed that he has a repairable laceration in that area with a scar. The knee appears to be rather stable. He says that it tends to lock and makes him limp, especially with running. The patient also has congestion and pharyngitis. The TM's are normal. Pharynx is inflamed. Rapid Strep is negative. A: Pharyngitis. Knee pain. P: Refer to Dr. Piasio whom he has seen before for other orthopedic problems. Use Allegra D and get a throat culture. Return PRN. [signature] REG/kmj Richard E. Grout, MD
15/03	NKA no meds Allergic to Keflex?	S) (L) testicle is sore, slightly swollen, no fever. Sx x 1 days. Had been skiing over weekend. Had similar episode 1wk ago [illegible] O) ht 6'1¼" wt. 137# BP 96/72 Testes non tender today - Pe nl - [illegible] Non swollen A) Transient testicular torsion P) Sonogram of Testes - hold for now Refer to Dr Cherry [signature]
15/03		Ellen made appt c Cherry 2/18/03 MF

Progress Record

Date	Prob. No.	Findings (S – Subjective, O – Objective, A – Assessment, P – Plans)
9-27-02	NKDA Omeds	S) Stuffy nose, from middle of August. Yellow-Green nasal drainage. Bilateral plugged ears. No other symptoms. Bprospu (pw)
	add	(R) leg hurting when running - if stops quick knee locks up, has a limb in it. Won't do any running activities afraid knee will hurt. 1998 stitches (28) same knee. from fall. Bpw

AMA - DRMC East - Mengle 2 - DuBois, PA 15801

Date: 9-27-02 Initials: BPW

HgB: _____ Urinalysis:

SS: NW

C: _____

C: _____

ther: _____

leukocytes	
nitrites	
urobili	
protein	
pH	
blood	
SG	
ketone	
bilirubin	
glucose	

9-27-02

Oct 7-mon 02 2:00pr Dr Piasio

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

FAIRMAN,SEAN
RD 1 BOX 391
DUBOIS PA 15801

MAB 1609 Unit # 000453177
Age 13Y Acct # D0214800752

Date:05/28/02 Time:1422

PIASIO,MARK
145 HOSPITAL AVE MED ARTS
DUBOIS PA 15801

SIAR,W J
635C MAPLE AVENUE
DUBOIS PA 15801

Chk-in #	Order	Exam	
538804	0001	44522	DI-TIBIA FIBULA 2 VIEWS*R

Ord Diag: 823.22-FX SHAFT FIB W TIB-CLOS

RIGHT TIBIA AND FIBULA:

AP and lateral views of the tibia and fibula, to and including the knee and ankle, show neither fracture or dislocation. The joint spaces and epiphyses of the knee and ankle are intact and normal. In the distal aspect of the tibia there is a defined area of bony sclerosis along with a radiolucent area.

/READ BY/ ROBERT J BORON
/Released By/ ROBERT J BORON

05/28/02 1530
RAW

S

Report reviewed by: BMSE
Date reviewed: 5-30-02
Notified patient:
___ phone ___ in person ___ mail
normal results-not notified
Treatment plan:

Date notified:
Notified by:

Complete

DU[redacted]IS REGIONAL MEDICAL CENTE[redacted]
10[redacted] Hospital Ave, DuBois, PA 15801

FAIRMAN,SEAN
RD 1 BOX 391
DUBOIS PA 15801

REF
Age 13Y

Unit # 000453177
Acct # D0204500751

Date:02/14/02 Time:1639

CHANDRASEKHAR,SUNDAR
635C MAPLE AVENUE
DUBOIS PA 15801

SIAR,W J
635C MAPLE AVENUE
DUBOIS PA 15801

Chk-in #	Order	Exam	
518200	0001	72724	CT-HEAD UNENHANCED

Ord Diag: 784.0-HEADACHE

UNENHANCED CT OF BRAIN:

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 OF THE BRAIN.

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

02/15/02 1354
RAW

1009

mplete

DUBOIS REGIONAL MEDICAL CENTER
1(Hospital Ave, DuBois, PA)801

FAIRMAN,SEAN
RD 1 BOX 391
DUBOIS PA 15801

REF
Age 13Y

Unit # 000453177
Acct # D0204500751

Date:02/14/02 Time:1639

CHANDRASEKHAR,SUNDAR
635C MAPLE AVENUE
DUBOIS PA 15801

SIAR,W J
635C MAPLE AVENUE
DUBOIS PA 15801

Chk-in #	Order	Exam	
518200	0001	72724	CT-HEAD UNENHANCED

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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 OF THE BRAIN.

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

02/15/02 1354
RAW

by: MT 2/19/02
al results-not
t plan:

1009

Complete

Robert J. Cherry, M.D.
Urologic Surgery
Diplomate, The American Board of Urology
145 Hospital Avenue, Suite 206
DuBois, Pennsylvania 15801
Phone (814) 371-2066
Facsimile (814) 371-2063

February 21, 2003

W. Siar, M.D.
Sunflower Drive
DuBois, PA 15801

1009

Dear John:

Thank you for your referral of Sean Fairman. He is a pleasant young man with a one week history of a tender left testicle. It is not associated with trauma, dysuria, dribbling or hesitancy. He does note that it worsens while he is lifting weights or playing basketball.

On exam his penis is normal. Meatus appears normal. The right inguinal region and right testes are entirely normal. The left testis is essentially normal. there is a slightly tender left epididymis. Inguinal exam reveals a very small herniation that I do not believe at this time is significant.

My instinct is that this is a very simple epididymitis. I have placed him on Bactrim twice a day for seven days and will follow him in a few weeks. I have also ordered an ultrasound that will confirm that there are no abnormalities that would have lead to this problem.

Thank you for the opportunity to care for him.

Sincerely,

RC

Robert J. Cherry, M.D.

RJC/mas

5

...RSADMER\FORMS\ERDEPARTMENTRECORD.DOC 11/9/00 Revised: #1 10/24/01SAG

FAIRMAN,SEAN M 13Y 10/20/88 ER
MCKINLEY,E... A
SIAR,W J

1004

...Regional ...al Center EMERGENCY DEPARTMENT ...ORD Page 1 of 7

1550 ☐ Emergent ☐ Urgent ☐ Nonurgent

...ION ON ARRIVAL: ☐ Poor ☐ Fair ☐ Satisfactory ☐ DOA

...OMPLAINT: Bike accident, RLE pain

Temp	Pulse	Resp	BP	Pain Scale	O_2 Sat	WT
97.1	80	18	135/64	10/10		

...IES: NKA

...NT MEDS: ☐ See attached list None

...ZATIONS: ☐ DNA ☐ UP TO DATE LAST TT/TD: _____

ACUITY	OD	OS	OU	☐ CORRECTED ☐ UNCORRECTED

...NANT? ☐ DNA ☐ YES ☐ NO ☐ UNSURE ☐ HYSTERECTOMY ☐ TUBAL LIGATION
LMP _____

...O ☐ Registration | Triage Nurse: _____

Nurse: Fairman, Brian, RN

CHECK THE REQUESTED STUDIES

☐ CBC/AutoDiff/Platelet	☐ Troponin	☐ Monospot	☐ Triage Drug Screen
☐ CBC/Platelet	☐ PT/PTT	☐ RSS	☐ Acetaminophen Level
☐ CBC		☐ RSV	☐ ASA Level
	☐ Pregnancy	☐ C&S	☐ ETOH
☐ Basic Met. Prof.	☐ Chlamydia/GC (DNA probe)	☐ Blood C&S _____	
☐ Compre profile	☐ Wet Mount		☐ Digoxin Level
☐ Amylase	☐ UA w/Microscopic	☐ Type and Screen	☐ Dilantin Level
☐ Lipase	☐ UA w/o Microscopic	☐ Type and Cross _____	☐ Phenobarb Level
☐ Hepatic Prof.	☐ UC		☐ Tegretol Level
☐ Renal Funct. Prof.			☐ Valproic Acid Level
☐ Magnesium			☐

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	☑ (R) T-L Hand	☐ CT _____	
☐ Portable Chest	☐ _____	☐ Enhanced	
☐ Port Lat C Spine	☑ (L) Shoulder	☐ Unenhanced	
☐ C Spine	☐ _____	☐ _____	
☐ LS Spine	☐ _____	☐ _____	

PHYSICIAN REPORT

Dictated T

TIME: ~~1530~~ 1510

R Tib/Fib Fx

...NT: _____

...N _____ DT: _____

...onitoring: ☐ Telemetry ☐ Cardiac monitor ☐ Pulse ox

...ccucheck ☐ Foley ☐ Stool Hemoccult ☐ Crutches ☐ ☐ Splint: _____

...ns: Dilaudid 1mg 0.5 mg IV - Ancef 1g

...POSITION OF PATIENT AND PATIENT INSTRUCTIONS

Condition: **Satisfactory** **Fair** **Poor** WITH:

...fied ☑ Physician Notified/Time: 1614
...e No:

☐ Sent Home ☐ Return to work ☐ Deceased ☐ Transferred

NOTIFIED: ☐ Relative ☐ Police ☐ Coroner ☐ Poison Center

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

...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

...INSTRUCTION: Ice Elevate Keep Splint

...ork or School ...ysical Education Work Only — Date: _____ ☐ Until Released by Physician

...BLE PARTY | NURSE'S SIGNATURE | PHYSICIAN'S SIGNATURE

...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 ...cal conditions/test results are known or treated. I will arrange for follow-up care. DuBois Regional Medical Center-DuBois, PA 15801

PHYSICIAN COPY

DISCHARGE SUMMARY
DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

10/20/1988
PATIENT NAME: FAIRMAN, SEAN 0203100677 - 000453177

ADMISSION DATE: 01/31/2002 DISCHARGE DATE: 02/02/2002

ADMITTING DIAGNOSIS
Fracture of tib fib, right.

ASSOCIATED DIAGNOSIS
Fracture of left proximal humerus.
Pedestrian-auto trauma.

SURGICAL PROCEDURE: Closed reduction of right tib fib performed on 02/01/02 by Dr. Piasio.

He is discharged home using a wheelchair, crutches, and bedside commode, nonweightbearing of the right lower extremity. Crutches minimally used because of nondisplaced proximal humerus fracture on the left. Advil or Tylenol for pain. Follow up in one week. No gym for 12 weeks. Adaptive school activities.

BRIEF HISTORY: This 13-year-old boy riding a bicycle was struck by a motor vehicle. He hit the windshield, sustained a minimally angulated fracture of the midshaft of the tib fib, greenstick type and nondisplaced linear fracture of the left proximal humerus. Other workup otherwise negative. He had complaints of some mild head discomfort, no bruising, trauma, or obvious process seen. He remains neurologically completely normal. No workup was indicated at this time.

He underwent a closed reduction of his right tib fib. Long leg cast was placed the day following admission which he tolerated very well, tolerating a sling and oral pain medication. He is ready for discharge home. He will probably need a wheelchair for at least a few weeks until the humerus fracture has healed well enough for crutch use with follow up in one week in my office.

D: 02/02/2002 8:58 A
T: 02/05/2002 10:39 A MAP/lmp
DOCUMENT NO: 243460
Job/Tape ID: 000186149

Mark A. Piasio, M.D.

cc: Mark A. Piasio, M.D.

Copy to:Mark A. Piasio, M.D.

HISTORY AND PHYSICAL EXAMINATION
DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

10/20/1988
FAIRMAN, SEAN 0203100677 - 000453177 4080

Date of Admission: 01/31/02

ADMITTING DIAGNOSIS: Fractured tib/fib, right.

ASSOCIATED DIAGNOSIS: Fractured left proximal humerus.

CHIEF COMPLAINT: 13-year-old boy with right leg pain.

HISTORY OF PRESENT ILLNESS: This young boy was struck by a car while on his bicycle, sustaining an injury to his right leg and left shoulder. He is complaining of pain in both areas. The patient was brought to the hospital by ambulance, found to have a midshaft tib/fib fracture on the right, incomplete with acceptable alignment, intact neurovascular, and a possible fracture of his left humerus. He reports pain of the left proximal humerus but is able to move the shoulder. Review of his x-rays does show a nondisplaced linear fracture of the proximal humerus on the left side, possible Salter I as well. The tib/fib fracture is incomplete at midshaft with acceptable alignment.

The plan will be as he is really unable to use crutches at this time, for admission, training with possibly a platform walker, and closed reduction tomorrow with some anesthesia.

PAST SURGICAL HISTORY: Significant for a laceration of right leg with subsequent scar revision.

MEDICAL HISTORY: Negative.

ALLERGIES: **POSSIBLY TO SOME SUTURE MATERIAL.**

MEDICATIONS: None.

SOCIAL HISTORY: He obviously does not smoke or drink, is a middle school student, plays baseball.

FAMILY HISTORY: Noncontributory.

CHILDHOOD HISTORY: Negative.

REVIEW OF SYSTEMS: He denies fever, chills, weight loss, seizure, headache, neck pain, abdominal pain, chest pain, or any other complaint. Otherwise, negative in detail.

PHYSICAL EXAMINATION: Shows a healthy, well-developed white male in mild distress. His skin is cool and dry. His neck is supple. There is no adenopathy, no tenderness. CHEST: Symmetric without tenderness. HEART: Regular rate and rhythm. LUNGS: Clear to auscultation. ABDOMEN: Soft, nontender, with active bowel sounds. EXTREMITIES: Skin is cool and dry. Pulses are intact distally. NEUROLOGIC EXAM: Intact distally. He is in a posterior splint with mid-calf swelling anteriorly on the right side. He is tender over the left proximal humerus with intact neurovascular.

Copy to: Mark A. Piasio, M.D.

X-rays reveal the above-mentioned fractures.

PLAN:
1. Admission.
2. Elevation.
3. Ice.
4. Long leg casting, right, tomorrow with some sedation with training of probable platform walker.

D: 01/31/2002 7:27 P
T: 01/31/2002 7:32 P MAP/jw
DOCUMENT NO: 242597
Job/Tape ID: 000185521

Mark A. Piasio, M.D.

cc: Mark A. Piasio, M.D.

Copy to: Mark A. Piasio, M.D.

OPERATIVE/SPECIAL PROCEDURE REPORT
DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

DATE: 02/01/2002

10/20/1988
PATIENT NAME: FAIRMAN, SEAN 0203100677 - 000453177 IP

SURGEON: Mark A. Piasio, M.D. ASSISTANT:

PREOPERATIVE DIAGNOSIS: Tib-fib fracture, right.

POSTOPERATIVE DIAGNOSIS: Tib-fib fracture, right.

NAME OF OPERATION: Closed reduction and long-leg cast, right leg.

ANESTHESIA: IV sedation.

COMPLICATIONS: None.

DISPOSITION: Recovery Room, stable.

PROCEDURE: The patient was taken to the operating room where IV catheters were placed, and IV sedation was given. A closed reduction was then performed of his right tib-fib and a long-leg cast was fashioned. Adequate alignment was confirmed by C-arm fluoroscopy. When the cast was hardened, the patient was taken to the Recovery Room with vital signs stable. Sponge and needle counts were recorded correct.

D: 02/01/2002 5:14 P
T: 02/05/2002 9:47 A MAP/bb
DOCUMENT NO: 243437
Job/Tape ID: 000186061

Mark A. Piasio, M.D.

cc: Mark A. Piasio, M.D.

Copy to:Mark A. Piasio, M.D.

FAIRMAN, SEAN 2/14/02

S: This young boy is followed for a left proximal humerus fracture and a right tib fib fracture.

O: The humerus is nontender. X-rays show the fracture to be healing uneventfully. The right tibia shows acceptable alignment.

P: Crutches, nonweightbearing, and follow-up in four weeks with x-ray in cast.

Mark A. Piasio, M.D.
MAP/tls

FAIRMAN, SEAN 2/22/02

S: This young boy is followed for a left proximal humerus fracture and right tib fib fracture. He has been maintained with his crutches, nonweightbearing, and a long leg cast of the left lower extremity. He reports today for evaluation. He reports that while at school yesterday, someone kicked the crutches out from underneath him and he fell. He was having significant pain of the left lower extremity.

O: Exam today reveals him to actually be quite comfortable in the cast at this time. There is no significant swelling noted of the lower extremity. Neurovasculature is intact. His x-rays were reviewed today of the right tibia which reveals the fracture in the tib fib to be in acceptable alignment with some early healing noted. The fibula fracture is nondisplaced and shows early healing as well.

I: Early healing left tib fib fracture with acceptable alignment.

P: He has been reassured that the fracture looks to be maintaining its alignment with some early healing seen as well. He is to continue the cast and crutches as before. We will see him at his regularly scheduled follow-up.

Amy Vezza, CRNP
AV/tls

FAIRMAN, SEAN 3/14/02

S: This young boy is followed for a left proximal humerus fracture and a right tib fib fracture. He is now six weeks in a long leg cast, nonweightbearing with crutches.

O: X-rays taken today in the cast reveal some early healing of the mid shaft tib fib fracture with early periosteal striping noted. Alignment is acceptable. We converted his long leg cast to a short leg cast today. We have given him a cast shoe and instructed him in partial weightbearing as tolerated for the left lower extremity.

P: We will leave him in this cast for another four weeks. X-ray him out of the cast at his next visit. He appears to be having no discomfort in the proximal humerus at this time. He is functioning well with the crutches. I do not think that we will need an x-ray of that at the next visit. Follow-up in four weeks.

Amy Vezza, CRNP
AV/tls

FAIRMAN, SEAN 4/11/02

S: This young boy is followed for a mid shaft tibial fracture from a bike-auto accident. He has a large palpable callus although he still has a little bit of tenderness a bit more distal to the fracture.

O: His x-rays show fractures to be healing. There is some minimal periosteal striping. There appears to be fairly dense soft tissue swelling over the entire medial aspect of the tibia. I suspect that is probably callus which has not yet ossified.

P: He is still a little bit tender. I think it is probably reasonable to still protect him. We placed him in an orthosis. He can start ankle range of motion, be partial weightbearing with the crutches, and we will see him back in four weeks with x-rays.

Mark A. Piasio, M.D.
MAP/tls

FAIRMAN, SEAN 5/6/02

S: This young boy is now about 12 weeks into a mid shaft, tib-fib fracture from a pedestrian- motor vehicle injury.

O: His splint is removed today. He actually has a small palpable bursa or fluid sac overlying the fracture with bony thickening and no tenderness. X-rays show the fracture to be healing uneventfully.

P: Discontinue the brace, start a PT program for strengthening and weightbearing activities. He can start playing some light baseball but no interactive play. Follow-up in one month with x-rays. IF all looks good at that time, we will release to full activities.

Mark A. Piasio, M.D.
MAP/tls

DuBois Regional Medical Center
P.O. Box 447
DuBois, Pennsylvania 15801-0447

(8:55→9:10)

PHYSICAL THERAPY INITIAL EVALUATION

Making the difference for life.

PATIENT: Farmer Sean **DATE:** 2/14/02

DIAGNOSIS: Fx tib fib (R) **ONSET DATE** few days ago 2/11/02

PHYSICIAN: Plasio

PRIMARY INSURANCE: Auto/Cigna **ID#**

SUBJECTIVE:
Pt's dad reports that he was hit by a car crossing the street near his school, where he shouldn't have been crossing the street. 2 stairs into house 12-15 stairs to BR/RR.

OBJECTIVE:
Crutch training ⓑ crutches ⓡ LE NWB and in AK cast.
Amb 12 stairs ⓡ LE NWB ⓒ ⓑ crutches ↑ and crutches/1 HK ↓

PATIENT/FAMILY PARTICIPATION IN PLAN:

yes, however dad encourage use of WC more that crutches

UNDERSTANDING OF EXERCISE PROGRAM:

N/A

PATIENT EXPECTATIONS:

return to playing baseball

ASSESSMENT:
good use of crutches gt ↑ stairs c NWB.

PLAN:
D/C

V. Mitchell Dee and Carla Miller PT

LIC. # MD 043778-E

NAME [illegible] AGE

ADDRESS DATE 2/1/

℞

[illegible]

REFILL ____ TIMES

☐ LABEL

SUBSTITUTION PERMISSIBLE [signature]

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HAND WRITE **"BRAND NECESSARY"** OR **"BRAND MEDICALLY NECESSARY"** IN THE SPACE BELOW.

0KOS1390197

ıte:	**05/08/02**	Initial Eval:	**05/08/02**
ıtient:	**FAIRMAN, SEAN**	Patient Code:	**FAISEA**
ıysician:	**MARK PIASIO MD**	Provider:	**WELCH, EDWARD (ELW)**
te:	**Leg**	Total Visits:	**1**
agnosis:	**(823.20)FX SHAFT TIBIA-CLOSED**		

Assessment:

Pt presents S/P R tibial FX (hit by car 1/02) with immobilization in cast until 5/6/02. Pt presents with severe soft tissue restrictions in RLE from knee to ankle. He has decreased knee and ankle ROM and poor functional knee and ankle strength. He has a significant limp with decreased step length in LLE secondary to inability to DF R ankle during stance phase of gait. Severe restricitions are present in G/S complex with pain at achilles. He has significant ER restrictions and plantar fascia restrictions which cause anterior ankle and foot pain.

Long Term Goals:

1. AROM R knee and ankle = L knee and ankle.
2. Decrease MF restrictions.
3. Improve LE flexibility.
4. pt will be able to perform full squat and return without pain or hesitation.
5. Increase Strength RLE = LLE.
6. Return to full unrestricted activities without symptoms.
7. Independence in a HEP to maintain improvement.

Treatment Plan

Initial treatment today consisted of patient education concerning the effects of immobilization on soft tissues of the LE. We reviewed the importance of increased flexibility, ROM and functional strength prior to returning to baseball. We instructed pt on proper technique and intensity for a prone rectus stretch, posterior LE release with poly ball, Gastroc/Soleus stretch, plantar fascia stretch, extensor retinaculum stretch and we ended with calf raises and mini walls slides. We performed an anterior compartment release. ER release, PF release, G/S release today. Patient was issued a written home exercise program outlining the above including the use of ice prn for pain and inflammation management.

Plan to continue with the above with progression of therapeutic exercises, stretching techniques, development of HEP, soft tissue techniques and modalities as needed to control pain and inflammation. Plan to see pt 3x/wk x 2 weeks and 2x/wk x 3 weeks and progress to I HEP.

The patient's rehabilitation potential is Excellent.

Thank you for this referral.

Provider: _____ Date: 5/8/02

EDWARD WELCH, License #PT-008866-L

I certify that the above rehabilitative services are required and authorized by me, and that the patient's plan will be reviewed every thirty(30) days.

Physician: _____ Date: _____

Physician's Instructions:

( ) Evaluate and Treat ( ) Other: _____

RECEIVED
JUN 12 2002
CLAIMS
RALEIGH

Date:	05/08/02	Initial Eval:	05/08/02
Patient:	FAIRMAN, SEAN	Patient Code:	FAISEA
Physician:	MARK PIASIO MD	Provider:	WELCH, EDWARD (ELW)
Site:	Leg	Total Visits:	1
Diagnosis:	(823.20)FX SHAFT TIBIA-CLOSED		

Observation
See patient file.

Palpation/Pain
See patient file.

Site Specific Text
See patient file.

Assessment
Pt presents S/P R tibial FX (hit by car 1/02) with immobilization in cast until 5/6/02. Pt presents with severe soft tissue restrictions in RLE from knee to ankle. He has decreased knee and ankle ROM and poor functional knee and ankle strength. He has a significant limp with decreased step length in LLE secondary to inability to DF R ankle during stance phase of gait. Severe restricitions are present in G/S complex with pain at achilles. He has significant ER restrictions and plantar fascia restrictions which cause anterior ankle and foot pain.

Rehab Potential
The patient's rehabilitation potential is Excellent.

Short Term Goals
1. Increase flexibility of RLE.
2. Increase ROM R knee and ankle
3. Increase Strength RLE.
4. Decrease Inflammation at mid tibial shaft.
5. Restore Normal Gait pattern.
6. Provide Written Home Exercise Instruction.

Long Term Goals
1. AROM R knee and ankle = L knee and ankle.
2. Decrease MF restrictions.
3. Improve LE flexibility.
4. pt will be able to perform full squat and return without pain or hesitation.
5. Increase Strength RLE = LLE.
6. Return to full unrestricted activities without symptoms.
7. Independence in a HEP to maintain improvement.

Plan
Initial treatment today consisted of patient education concerning the effects of immobilization on soft tissues of the LE. We reviewed the importance of increased flexibility, ROM and functional strength prior to returning to baseball.

We instructed pt on proper technique and intensity for a prone [illegible]
Gastroc/Soleus stretch, plantar fascia stretch, extensor retinaculum stretch and we ended with calf raises and mini walls slides. We performed an anterior compartment release, ER release, PF release, G/S release today. Patient was issued a written home exercise program outlining the above including the use of ice prn for pain and inflammation management.

Plan to continue with the above with progression of therapeutic exercises, stretching techniques, development of HEP, soft tissue techniques and modalities as needed to control pain and inflammation. Plan to see pt 3x/wk x 2 weeks and 2x/wk x 3 weeks and progress to I HEP.

Provider: Edward, PT Date: 5/8/02
EDWARD WELCH, License #PT-008866-L

Diagnosis (R) tibia fracture **Physician** Piasio

Recheck Date 6-3-02? **Insurance** Auto

Subjective: (*Please refer to Initial Eval Subjective Report for additional subjective report.*)

Objective:

During a Postural Analysis the following structural imbalances were noted:

HEAD: ___Forward ___Tilted R/L ___Rotated R/L ___CT junction kyphosis

SHOULDERS: ___Elevated R/L ___Anterior R/L ___IR R/L ___ER R/L ___Scap winging

CLAVICLE: ___Elevated R/L ___Anterior R/L

TRUNK: ___Tx kyphosis ___Lx lordosis ___Lateral trunk shortened R/L ___Rotated R/L

___Spinal convexity: ___Thoracic ___Lumbar

PELVIS (standing): ___ASIS___ ___PSIS___

___Lateral shift R/L ___Excessive pelvic tilt ANT/POST

LOWER EXTREMITIES: ___↑ BOS ↓ ___ ___Pes Planus ___Pes Cavus

___Femoral rotation INT/EXT ___Genu valgus/varus R/L ___Genu recurvatum R/L BL

___Increased wt bearing thru R/L LE ___Increased wt bearing thru forefoot/hindfoot

___Increased wt bearing thru med. foot/ lat. foot

OTHER IMBALANCES: ↓ girth (R) calf keeps foot supinated no weight bearing to 1st metat

MYOFASCIAL RESTRICTIONS ✓ = minor dysfunction ✖ = moderate dysfunction ✖ = major dysfunction

CRANIAL: ✖ Temporalis ☐ Masseter ☐ Pterygoids ☐ Digastrics ☐ Hyoid

CERVICAL: ☐ Suboccipital ☐ Anterior ☐ L Lateral ☐ R Lateral ☐ Posterior ☐ Traps

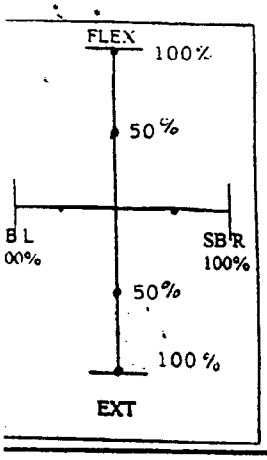
TRUNK: ☐ Thoracic inlet ☐ Anterior chest ☐ Pectorals ☐ Intercoastals ☐ Medial scapular L/R ☐ Lateral scapular L/R ☐ L Lateral Trunk ☐ Resp. Diaphragm ✓ R Lateral Trunk ☐ Paraspinals L/R ☐ Dural Tube ✓ Quadratus Lumborum L/R ✖ Psoas L/R

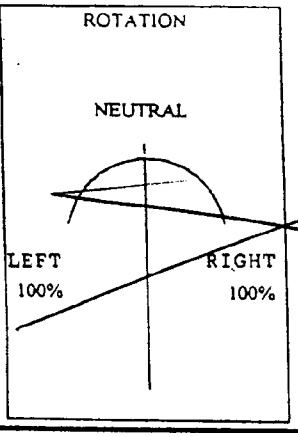
PELVIS: ☐ Pelvic Floor ☐ Gluteals L/R ✓ Piniformis L/R ☐ TFL L/R

LOWER EXT: ✖ L/R Quads ✖ L/R Hams ☐ L/R Adductors ✖ L/R ITB ✖ L/R Calves ✖ L/R Plantar Fascia

UPPER EXT: ☐ L/R Biceps ☐ L/R Tricep ☐ L/R Flexor forearm ☐ L/R Carpal Tunnel ☐ L/R Rotator Cuff

CERVICAL SPINE MOTION TESTING





____Cervical flex—pain down post mm

____Cervical ext—movement only at C5-C6

LR R ____Pull in opp trap ____Pinch same side

LR L ____Pull in opp trap ____Pinch same side

SB R ____Restricted by forward head ____Pull in opp trap

SB L ____Restricted by forward head ____Pull in opp trap

____Side bending restricted by forward head & shoulder posture

____Other_____

~~SHOULDER~~ MOTION TESTING

	AROM R	AROM L	PROM R	PROM L
FLEX				
ABD				
IR				
ER				

____ Abd Arc ____ Flex Arc

____ Pain at end range ____ Capsular EF

____ Empty EF ____ Lev Substitution

____Poor G-H Rhythm

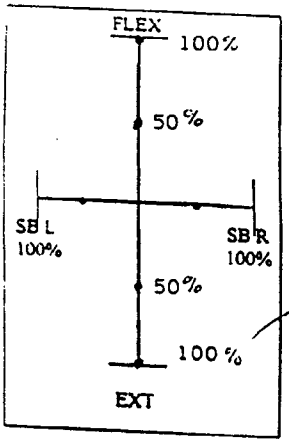
STRENGTH :

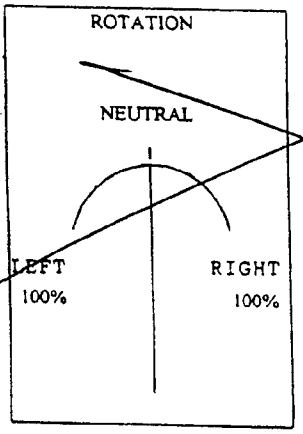
WNL except Can not crouch fully without pain into (R) medial ankle

____Unable to stabilize scap with M / L traps --- Levator / Upper Traps / Pect Substitution

Painful Isometrics: ABD / EXT / FLEX / IR / ER

LUMBAR SPINE MOTION TESTING





____ Rotation at _____

____ Hyperext at _____

____ Lumbar ext – decreased segmental movement at all lumbar segments

____ Lumbar flex – ↓ ROM with complaints of

____ pain PSIS level

____ pulling lower ext

____ other_____

PELVIC ALIGNMENT	L-ASIS	L-PSIS	R-ASIS	R-PSIS
Supine	High / Low	High / Low	High / Low	High / Low

Upslip L / R
Downslip L / R
Ant. Rot. L / R
Post. Rot. L / R

(R) ASIS ant.

AROM	R	L
FLEX		
IR		
ER		

___Point tender greater trochanter

___Groin pain with ER / Flex

___Substitution of iliopsoas for Abd / Hip Abd stabilization

ANKLE/ KNEE MOTION TESTING

Supine

KNEE

AROM			PROM	
R	L		R	L
135	145°	FLEX		
		EXT		

ANKLE

AROM			PROM	
R	L		R	L
		DF	0°	10°
		PF	55°	55°
		IN	3/4	Full
		EV	3/5	Full

EDEMA: GRADE I II III

ECCHYMOSIS: FOOT MID SHIN LAT / MED

Strength

hip V 4/5 BL

hip (4+/5 BL

knee / (R) 4/5

(L) 4+/5

knee V (R) 4/5

(L) 4+/5

ankle DF (R) 4-/5

(L) 4+/5

PF (R) 4+/5

(L) 5/5

INV/EV 4+/5 BL

Proprioception tolerance to stork standing _____secs

___Ext Ret Tight with scarring to anterior compartment tendons

___Squat: FULL ½ LESS

___Inability to contract VMO during SLR with compensation of VLO and IT bad

___Patellar tilt/ medial border: SUP / INF

___Straight plan patellar mobility limited

S / L M / I

___Inversion/ EV Stress

___Plantar fascia test

___Independent toe raise

___VMO atrophy

___Lateral patellar tracking

___Other_____

girth @ 21cm Proximal to patella

33.5cm (R)

35cm (L)

RECOMMENDED TREATMENT to include a combination of the following:

- [X] Myofascial Release techiniques
- [X] Functional Training Program
- [X] Therapeutic exercise training
- [ ] TENS
- [ ] Neck Traction
- [ ] Postural awareness training
- [ ] Awareness through movement training
- [ ] Moist heat
- [ ] FES with muscle reeducation
- [ ] Back Traction
- [X] HEP & self management education
- [ ] Ice
- [X] Biofeedback
- [ ] Relaxation training
- [X] Other Progressive strategy

PLAN:

Frequency of treatment 3/2 Treatments/ week for 2-3 weeks Start date 5-8-02

By_____Physical Therapist

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Date: May 0 2002

Name Sean Fairman Nickname _____

Age 13 Occupation student

1. Are you working? YES / (NO) Hours per week _____
2. Do you presently take care of small children or elderly parents? YES / NO
3. How did you hear about P&G Physical Therapy? _____
4. What problems brought you to physical therapy? _____

_____

5. Do you have any other areas of discomfort? ankle
6. What date did your symptoms start? 1-30-02 ?
7. Is your pain from:
   - ___ Accident at work
   - _√_ Motor vehicle accident
   - ___ Sporting accident
   - ___ Fall
   - ___ Unknown origin
   - ___ Intermittent over a period of time

   Please describe I got hit by a car
8. Since onset has the pain increased or (decreased)? decreased
9. What positions/activities increase your pain? It hurts my (ankle) when I run & sometimes when I walk
10. What positions/activities decrease your pain? _____
11. Can you sleep through the night? yes
12. Do you feel better in the MORNING √ NIGHT √
13. Does increased movement make your pain BETTER ___ WORSE √
14. Have you ever received the following treatment for your current condition?

Treatment	YES	NO	How Long?	Helpful?	Where?
Physical Therapy	√	___	_____	_____	DAMC
Myofascial Release	___	___	_____	_____	_____

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OCG WC CLAIMS
RALEIGH

activity before you feel that you need to stop because of your symptoms. If you have no difficulty with the activity, mark 'OK'. If you are unable to perform the activity, mark 'UNABLE'.

Activity	Tolerance	Activity	Tolerance
Sitting	_____	Computer Work	_____
Standing	_____	Exercise	_____
Walking	_____	Writing	_____
Stairs (# of stairs/ flight)	_____	Shopping	_____
Driving	_____	Bending	_____
Sleeping	_____	Reaching (# of repetitions)	_____
Household Chores Vacuuming	_____	Lifting (# of pounds)	_____
Cooking	_____	Carrying (# of pounds)	_____
Laundry	_____	Other_____	
Dish Washing	_____	_____	_____

On the lines below place a slash (/) to indicate:

FUNCTIONAL ABILITY

Good Day 0%——————————————————100%

Bad Day 0%——————————————————100%

INTENSITY

No Pain ——————/——————— Worst Pain Imaginable

FREQUENCY

No Pain ——————————————————Constant Pain

16. Has your doctor prescribed any medications for this condition? YES / NO

If yes, please list_____

17. Have you received any injections for this problem? YES / NO When_____

18. Do you take any other medications? YES / NO If known please list_____

_____

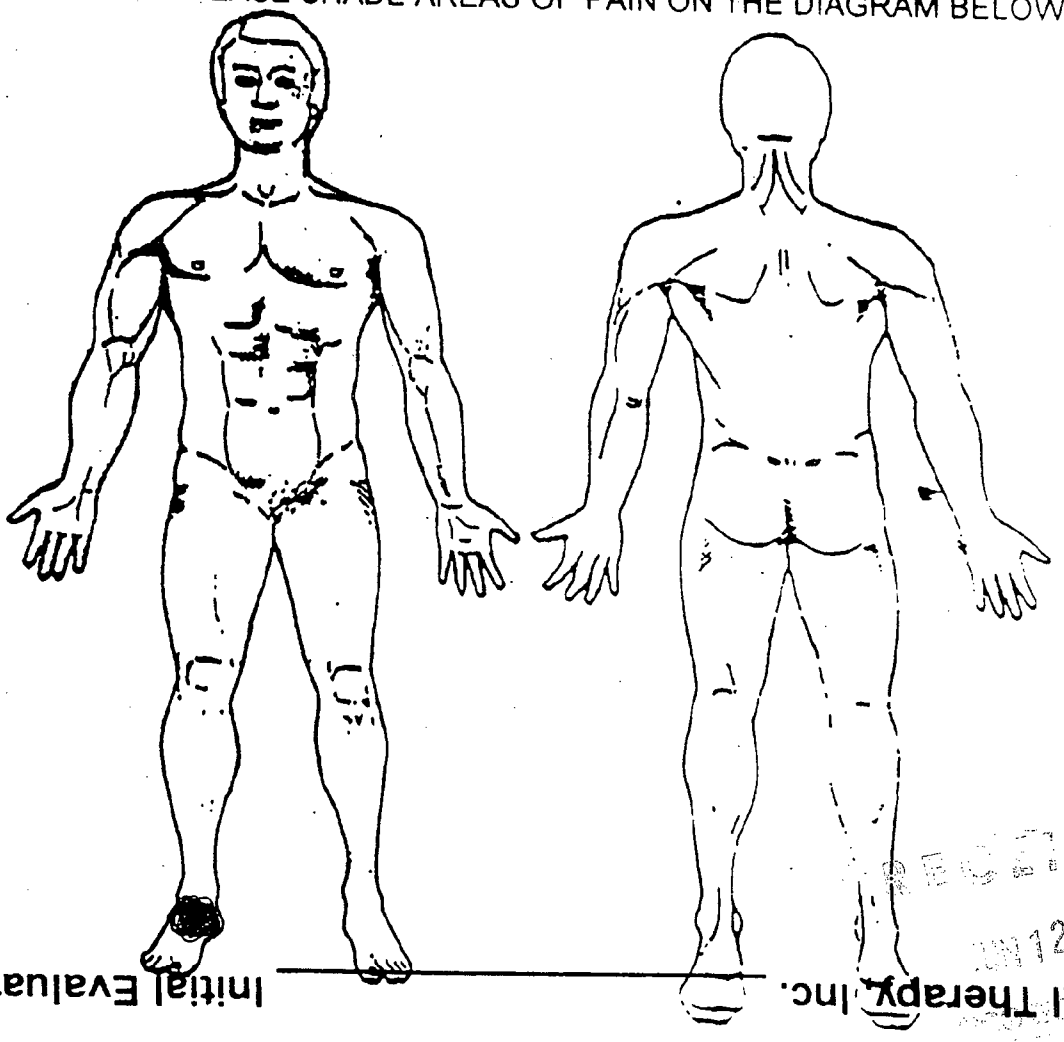
	YES	NO
Circulatory Problems		V
High Blood Pressure		V
Heart Trouble		V
Pacemaker		V
Epilepsy		V
Diabetes		V
Pregnancy		V
Stroke		V

	YES	NO
Blackouts		V
Visual Disturbances		V
Weight changes (>15 lbs)	V	
Headaches Sometimes		
Ringing in ears		V
Bowel/Bladder Problems		V
Malignancy		V

20. Please list any surgeries, traumas, accidents or other conditions with date of injury.

21. What can't you do today that you would like to do at the end of physical therapy? I want to play baseball

PLEASE SHADE AREAS OF PAIN ON THE DIAGRAM BELOW



Date:	05/10/02	Initial Eval:	05/08/02
Patient:	FAIRMAN, SEAN	Patient Code:	FAISEA
Physician:	MARK PIASIO MD	Provider:	WELCH, EDWARD (ELW)
Site:	Leg		
Diagnosis:	(823.20)FX SHAFT TIBIA-CLOSED		

Subjective

Patient reports decreased pain and increased movement after last session. However he reports pain into achilles area with mini wall slides and pain into anterior ankle and heel when he first stands up.

Objective

Patient continued with self MF release and isolated stretching program as charted on flow with therapist correcting form as needed. We added a hamstring stretch at pole and bike activities focusing on endurance and AROM of hip, knee and ankle. Pt was able to tolerte increasee reps of mini wall slides (3-11) and calf raises (12-15) today. Patient received 30 min of one on one self MF release/HEP instruction and manual techniques. Functional exercise training to include: proper form technique and intensity with mini wall slides, calf raises and hamstring stretch. Body awareness, proper breathing patterns and elongation taught. MFR to include: anterior compartment release, ER release, PF release, G/S release, psoas release and anterior thigh release. HEP updated and reviewed with patient.

Assessment

Pt presents S/P tibial FX and immobilization. He has severe soft tissue restrictions, decreased ROM at knee and ankle, poor functional knee and ankle strength and poor endurance.

Plan

Plan to continue with the above with progression of therapeutic exercises, stretching techniques, development of HEP, soft tissue techniques and modalities as needed to control pain and inflammation.

Status

Provider: Edward PT Date: 5/10/02

WELCH, EDWARD

Date:	05/13/02	Initial Eval:	05/08/02
Patient:	FAIRMAN, SEAN	Patient Code:	FAISEA
Physician:	MARK PIASIO MD	Provider:	WELCH, EDWARD (ELW)
Site:	Leg		
Diagnosis:	(823.20)FX SHAFT TIBIA-CLOSED		

Subjective

Patient reports decreased pain into achilles area with mini wall slides after moving feet further away from wall. He reports continued pain accross dorsum of foot/ankle with any type of running of with DF.

Objective

Patient continued with self MF release and isolated stretching program as charted on flow with therapist correcting form as needed. We reviewed a hamstring stretch at pole and increased bike duration to 26 mins today. Pt was able to tolearte increased reps of mini wall slides (15) and calf raises (17) today. Patient received 30 min of one on one self MF release/HEP instruction and manual techniques. Functional exercise training to include: proper form technique and intensity with mini wall slides, calf raises and hamstring stretch. Body awareness, proper breathing patterns and elongation taught. MFR to include: anterior compartment release, ER release, PF release, G/S release, psoas release and anterior thigh release. HEP updated and reviewed with patient.

Assessment

Pt presents S/P tibial FX and immobilization. He has severe soft tissue restrictions, decreased ROM at knee and ankle, poor functional knee and ankle strength and poor endurance. Significant restrictions in G/S complex adds to strain in achilles with loading activities.

Plan

Plan to continue with the above with progression of therapeutic exercises, stretching techniques, development of HEP, soft tissue techniques and modalities as needed to control pain and inflammation.

Status

Provider: Edward L PT Date: 5/13/02
WELCH, EDWARD

Date:	05/14/02	Initial Eval:	05/08/02
Patient:	FAIRMAN, SEAN	Patient Code:	FAISEA
Physician:	MARK PIASIO MD	Provider:	WELCH, EDWARD (ELW)
Site:	Leg		
Diagnosis:	(823.20)FX SHAFT TIBIA-CLOSED		

Subjective

Patient reports continued pain into achilles area with running and with waal slides if does not use proer form. He reports continued pain accross dorsum of foot/ankle with G/S stretch and end range DF. Pt asked when he could begin playing baseball again.

Objective

Patient continued with self MF release and isolated stretching program as charted on flow with therapist correcting form as needed. We continuedhamstring stretch at pole and bike duration of 26 mins today. We continued mini wall slides (18) and calf raises (20) today. We tried walking on treadmill and short sprints but pt was unable to complete without significant limping and pain into achilles and dorsum of foot. Patient received 30 min of one on one self MF release/HEP instruction and manual techniques. Functional exercise training to include: proper form technique and intensity with mini wall slides, calf raises and hamstring stretch. Body awareness, proper breathing patterns and elongation taught. MFR to include: anterior compartment release, ER release, PF release, G/S release, psoas release and anterior thigh release. HEP updated and reviewed with patient.

Assessment

Pt presents S/P tibial FX and immobilization. He has severe soft tissue restrictions, decreased ROM at knee and ankle, poor functional knee and ankle strength and poor endurance. Significant restrictions in G/S complex prevents DF with increased losding into foot without pain and limping. He is unable to return to baseball except to bat with shin protection and run to first base 1x only. He is is unable to catch and not allowed to play 1st base where some one may collide with him.

Plan

Plan to continue with the above with progression of therapeutic exercises, stretching techniques, development of HEP, soft tissue techniques and modalities as needed to control pain and inflammation.

Status

Provider: Edward, PT Date: 5/14/02

WELCH, EDWARD

Date:	**05/17/02**	Initial Eval:	**05/08/02**
Patient:	**FAIRMAN, SEAN**	Patient Code:	**FAISEA**
Physician:	**MARK PIASIO MD**	Provider:	**WELCH, EDWARD (EWSB)**
Site:	**Leg**		
Diagnosis:	**(823.20)FX SHAFT TIBIA-CLOSED**		

Subjective

Patient reports his cc continues to be pain accross front of talo cural joint with DF and pain into achilles with running.

Objective

Patient continued with self MF release and isolated stretching program as charted on flow with therapist correcting form as needed. We continuedhamstring stretch at pole and bike duration of 26 mins today. We continued mini wall slides (18) and calf raises (20) today. Patient received 30 min of one on one self MF release/HEP instruction and manual techniques. Functional exercise training to include: proper form technique and intensity with mini wall slides, calf raises and hamstring stretch. Body awareness, proper breathing patterns and elongation taught. MFR to include: anterior compartment release, TFM to ER and extensor tendons, ER release, PF release, G/S release, psoas release and anterior thigh release. HEP updated and reviewed with patient.

Assessment

Pt presents S/P tibial FX and immobilization. He has severe soft tissue restrictions, decreased ROM at knee and ankle, poor functional knee and ankle strength and poor endurance. Significant restrictions in G/S complex prevents DF with increased losding into foot without pain and limping. Significant restrictions in long toe extensor tendons and ER continue to crerate pain with DF.

Plan

Plan to continue with the above with progression of therapeutic exercises, stretching techniques, development of HEP, soft tissue techniques and modalities as needed to control pain and inflammation.

Status

Provider: Edward Welch PT Date: 5/17/02

WELCH, EDWARD

Date:	**05/22/02**	Initial Eval:	**05/08/02**
Patient:	**FAIRMAN, SEAN**	Patient Code:	**FAISEA**
Physician:	**MARK PIASIO MD**	Provider:	**WELCH, EDWARD (EWSB)**
Site:	**Leg**		
Diagnosis:	**(823.20)FX SHAFT TIBIA-CLOSED**		

Subjective

Patient reports pain accross front of talo cural joint with DF has eased significantly after last visit and using ice. He reports he was able to run in practice without a significant limp and he has decreased "heel" pain.

Objective

Patient continued with self MF release and isolated stretching program as charted on flow with therapist correcting form as needed. We continuedhamstring stretch at pole and bike duration of 26 mins today. We continued mini wall slides (20) and calf raises (20) today. We did some training which included sprints over plyo board(2) incorporating change of direction. Pt tolerated 10 reps prior to fatigue. Pt was able to tolerate 5 mins of fast walking on treadmill (4mph) x 5 mins today without ankle or heel pain. Patient received 30 min of one on one self MF release/HEP instruction and manual techniques. Functional exercise training to include: proper gait pattern and proper technique with running activites. Body awareness, proper breathing patterns and elongation taught. MFR to include: anterior compartment release, TFM to ER and extensor tendons, ER release, PF release, G/S release, psoas release and anterior thigh release. HEP updated and reviewed with patient.

Assessment

Pt presents S/P tibial FX and immobilization. He has decreased soft tissue restrictions, improved ROM at knee and ankle. He has poor functional knee and ankle strength and poor endurance. Restrictions in G/S complex and long toe extensor tendons have improved with decreased pain and limping noted. Pt was able to tolerate running and fast walking today without increased pain. We will begin more aggressive endurance and strengthening activities again next visit.

Plan

Plan to continue with the above with progression of therapeutic exercises, stretching techniques, development of HEP, soft tissue techniques and modalities as needed to control pain and inflammation.

Status

Provider: _____ PT Date: 5/22/02
WELCH, EDWARD

Date:	05/24/02	Initial Eval:	05/08/02
Patient:	FAIRMAN, SEAN	Patient Code:	FAISEA
Physician:	MARK PIASIO MD	Provider:	WELCH, EDWARD (EWSB)
Site:	Leg		
Diagnosis:	(823.20)FX SHAFT TIBIA-CLOSED		

Subjective

Patient reports he continues to feel alot better this week. He reports no pain into talo cural joint with DF and he states he has been able to run and walk without heel pain.

Objective

Patient continued with self MF release and isolated stretching program as charted on flow with therapist correcting form as needed. We continued hamstring stretch at pole and bike duration of 20 mins today. We continued mini wall slides (20) and calf raises (20) today. We did some training which included sprints, change of direction and cutting activities over plyo boards and trampoline for proprioceptive activity. Pt tolerated 10 reps prior to fatigue. Pt was able to tolerate 5 mins of fast walking on treadmill (4.2mph) x 5 mins on random setting with up to a 2 degree incline without pain or limping. We alos initiated single leg hopping on trmpoline (pt fatigued at 20). Patient received 30 min of one on one self MF release/HEP instruction and manual techniques. Functional exercise training to include: proper gait pattern and proper technique with running activites. Body awareness, proper breathing patterns and elongation taught. MFR to include: anterior compartment release, TFM to ER and extensor tendons, ER release, PF release, G/S release, psoas release and anterior thigh release. HEP updated and reviewed with patient.

Assessment

Pt presents S/P tibial FX and immobilization. He has decreased soft tissue restrictions, improved ROM at knee and ankle. R knee ROM is equal to left. Ankle DF was measured at 10 degrees L and 8 degrees R; PF was measured at 55 degrees BLE. Ankle strength was as follows: DF 4/5 R, 4+/5 L; PF 5/5 bilaterally. Functional knee and ankle strength have improved but endurance is still poor. Restrictions in G/S complex and long toe extensor tendons have improved with no C/O pain with running or walking. He was able to tolerate all activities today including sprints in parking lot without pain. We will continue with more aggressive endurance and strengthening activities again next visit.

Plan

Plan to continue with the above with progression of therapeutic exercises, stretching techniques, development of HEP, soft tissue techniques and modalities as needed to control pain and inflammation.

Status

Patient is compliant with treatment and exercise protocol. Patient reports improvement in symptoms and improved function. I will await Dr. Piasio's recommendations. If you have any questions or concerns please call me at 375-6830.

RECEIVED JUN 12

Provider: _____ PT Date: 5/24/02

WELCH, EDWARD

Date:	05/31/02	Initial Eval:	05/08/02
Patient:	FAIRMAN, SEAN	Patient Code:	FAISEA
Physician:	MARK PIASIO MD	Provider:	WELCH, EDWARD (ELW)
Site:	Leg		
Diagnosis:	(823.20)FX SHAFT TIBIA-CLOSED		

Subjective

Patient reports he continues to feel good this week. He reports slight pain into medial and lateral ankle with running occasionally. He reports no problem with HEP and states he has returned to playing baseball.

Objective

Patient continued with self MF release and isolated stretching program as charted on flow with therapist correcting form as needed. We continued hamstring stretch at pole and bike duration of 20 mins today. We continued mini wall slides (20) and calf raises (20) today. Pt was able to tolerate 5 mins of fast walking on treadmill (4.2mph) x 5 mins on random setting with up to a 2 degree incline without pain or limping. We also continued single leg hopping on trampoline (pt fatigued at 20). Patient received 30 min of one on one self MF release/HEP instruction and manual techniques. Functional exercise training to include: proper gait pattern and proper technique with functional exercises. Body awareness, proper breathing patterns and elongation taught. MFR to include: anterior compartment release, TFM to ER and extensor tendons, ER release, PF release, TFM to medial and lateral ligaments, and anterior thigh release. HEP reviewed with patient.

Assessment

Patient has achieved full ROM and is I with HEP. He has poor endurance and decreased functional strength but HEP will address. He is I in HEP. No c/o pain with ADLS.

Plan

D/C to independent status. New script to return.

Status

Therapy is complete. If you have any questions or concerns please call me at 375-6830.

Provider: Edward J PT Date: 5/31/02
WELCH, EDWARD

ISEA FAIRMAN SEAN

8/2002

eatment	Sets	Reps	Weight	Duration
antar Fascia Stretch	1	0	0	5
astroc Stretch	1	0	0	5
tensor Retinaculum Stretch	0	0	0	0
wer extermity release with ball	0	0	0	0
ALF RAISES	0	0	0	0
all Slides	0	0	0	0
one rectus stretch	0	0	0	0
	0	0	0	0

10/2002

eatment	Sets	Reps	Weight	Duration
antar Fascia Stretch	1	0	0	5
astroc Stretch	1	0	0	5
tensor Retinaculum Stretch	1	0	0	5
wer extermity release with ball	1	0	0	5
ALF RAISES	1	15	0	0
all Slides	1	11	0	0
one rectus stretch	1	0	0	5
amstring stretch in doorway	1	0	0	5
IKE	1	0	0	10

13/2002

reatment	Sets	Reps	Weight	Duration
lantar Fascia Stretch	1	0	0	5
astroc Stretch	1	0	0	5
xtensor Retinaculum Stretch	1	0	0	5
ower extermity release with ball	1	0	0	5
ALF RAISES	1	15	0	0
all Slides	1	11	0	0
rone rectus stretch	1	0	0	5
amstring stretch in doorway	1	0	0	5
IKE	1	0	0	10

14/2002

reatment	Sets	Reps	Weight	Duration
lantar Fascia Stretch	1	0	0	5
astroc Stretch	1	0	0	5
xtensor Retinaculum Stretch	1	0	0	5
ALF RAISES	1	15	0	0
all Slides	1	11	0	0
rone rectus stretch	1	0	0	5
amstring stretch in doorway	1	0	0	5
IKE	1	0	0	10
unning with directional changes	1	0	0	5

17/2002

reatment	Sets	Reps	Weight	Duration
lantar Fascia Stretch	1	0	0	5
astroc Stretch	1	0	0	5
xtensor Retinaculum Stretch	1	0	0	5
ALF RAISES	1	15	0	0
all Slides	1	11	0	0
rone rectus stretch	1	0	0	5

KE	1	0	0	10

2/2002

atment	Sets	Reps	Weight	Duration
ntar Fascia Stretch	1	0	0	5
stroc Stretch	1	0	0	5
tensor Retinaculum Stretch	1	0	0	5
LF RAISES	1	15	0	0
ll Slides	1	11	0	0
ne rectus stretch	1	0	0	5
mstring stretch in doorway	1	0	0	5
KE	1	0	0	10
ANDING ER	1	0	0	5

4/2002

atment	Sets	Reps	Weight	Duration
ne rectus stretch	1	0	0	5
stroc Stretch	1	0	0	5
ntar Fascia Stretch	1	0	0	5
LF RAISES	1	15	0	0
all Slides	1	11	0	0
mstring stretch in doorway	1	0	0	5
ANDING ER	1	0	0	5
KE	1	0	0	10
tensor Retinaculum Stretch	1	0	0	5
eadmill walking	1	0	0	5
ie-footed hopping on trampoline	1	20	0	0

29/2002

eatment	Sets	Reps	Weight	Duration
one rectus stretch	1	0	0	5
astroc Stretch	1	0	0	5
antar Fascia Stretch	1	0	0	5
ALF RAISES	1	15	0	0
all Slides	1	11	0	0
amstring stretch in doorway	1	0	0	5
TANDING ER	1	0	0	5
IKE	1	0	0	10
ctensor Retinaculum Stretch	1	0	0	5
ne-footed hopping on trampoline	1	20	0	0
eadmill walking	1	0	0	5

31/2002

reatment	Sets	Reps	Weight	Duration
antar Fascia Stretch	1	0	0	5
astroc Stretch	1	0	0	5
xtensor Retinaculum Stretch	1	0	0	5
ALF RAISES	1	15	0	0
/all Slides	1	11	0	0
rone rectus stretch	1	0	0	5
unning with directional changes	1	0	0	5
amstring stretch in doorway	1	0	0	5
IKE	1	0	0	10
TANDING ER	1	0	0	5
readmill walking	1	0	0	5
ne-footed hopping on trampoline	1	20	0	0

Ed Welch - P&G -

MARK A. PIASIO, M.D.
145 HOSPITAL AVENUE, SUITE 311
DUBOIS, PA 15801

(814) 375-9617
DEA # ____________
LIC. # MD 043778-E

NAME [illegible] AGE [illegible]

ADDRESS ____________ DATE 5/6

℞ PT: [illegible]
[illegible]
[illegible]
[illegible]
etc.

REFILL ______ TIMES

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Wed 5/8 @ 3:00

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100 Hospital Ave, DuBois, PA 15801

FAIRMAN,SEAN
RD 1 BOX 391
DUBOIS PA 15801

DIS - REF
Age 13Y

Unit # 000453177
Acct # D0204500751

Date:02/14/02 Time:1639

CHANDRASEKHAR,SUNDAR
635C MAPLE AVENUE
DUBOIS PA 15801

SIAR,W J
635C MAPLE AVENUE
DUBOIS PA 15801

Chk-in #	Order	Exam	
518200	0001	72724	CT-HEAD UNENHANCED

Ord Diag: 784.0-HEADACHE

UNENHANCED CT OF BRAIN:

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 OF THE BRAIN.

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

02/26/02 1158
RAW

Complete Duplicate

FAIRMAN,SEAN PED-4080-02 Unit # 000453177
RD 1 BOX 391
DUBOIS PA 15801 Age 13Y Acct # D0203100677

Date:02/01/02 Time:1526

PIASIO,MARK
145 HOSPITAL AVE MED ARTS
DUBOIS PA 15801

SIAR,W J
DRMC EAST
DUBOIS PA 15801

Chk-in #	Order	Exam	
515559	0009	44022	XR-TIBIA FIBULA 2 VIEWS*R

Ord Diag: ;FX TIB/FIB

RIGHT TIBIA AND FIBULA:

AP and lateral views of the tibia and fibula, incorporated in a fiberglass cast, again identify the fractured tibia showing minimal bowing medially. Alignment appears to be satisfactory.

/READ BY/ ROBERT J BORON
/Released By/ ROBERT J BORON

02/02/02 1216
RAW

Complete

FAIRMAN,SEAN DIS - REF Unit # 000453177
RD 1 BOX 391
DUBOIS PA 15801 Age 13Y Acct # D0203800467

Date:02/07/02 Time:1241

PIASIO,MARK
145 HOSPITAL AVE MED ARTS
DUBOIS PA 15801

SIAR,W J
635C MAPLE AVENUE
DUBOIS PA 15801

Chk-in #	Order	Exam	
516749	0001	45514	PI-TIBIA FIBULA 2 VIEWS*R
			Ord Diag: TIB FIB FX

AP AND LATERAL RIGHT TIB-FIB:

Tib-fib fracture is seen mid shaft, fibula nondisplaced. Tibia shows minimal valgus and acceptable alignment of a green-stick type fracture. Of note is nonossifying fibroma in distal tibia.

/READ BY/ MARK PIASIO M.D.
/Released By/ MARK PIASIO M.D.

02/12/02 1604
JAH

Complete

100 Hospital Ave, DuBois, PA 15801

FAIRMAN,SEAN
RD 1 BOX 391
DUBOIS PA 15801

DIS - REF
Age 13Y

Unit # 000453177
Acct # D0204500767

Date:02/14/02 Time:0825

PIASIO,MARK
145 HOSPITAL AVE MED ARTS
DUBOIS PA 15801

SIAR,W J
635C MAPLE AVENUE
DUBOIS PA 15801

Chk-in #	Order	Exam	
518692	0001	45514	PI-TIBIA FIBULA 2 VIEWS*R Ord Diag: 823.22-FX SHAFT FIB W TIB-CLOS
518692	0001	45536	PI-HUMERUS, MIN 2*L Ord Diag: 812.00-FX UP END HUMERUS NOS-C

AP AND LATERAL - RIGHT TIBIA FIBULA:

A mid shaft tibia fibula fracture is seen. There is acceptable alignment. No change from prior study.

LEFT HUMERUS:

Healing minimal linear fracture of the proximal humerus is seen, totally non-displaced. He remains skeletally juvenile.

/READ BY/ MARK PIASIO, Orthopaedic Surgeon
/Released By/ MARK PIASIO, Orthopaedic Surgeon

02/25/02 1612
JLB

Complete Duplicate

100 Hospital Ave, DuBois, PA 15801

FAIRMAN,SEAN *REF Unit # 000453177
RD 1 BOX 391
DUBOIS PA 15801 Age 13Y Acct # D0205300524

Date:02/22/02 Time:1538

PIASIO,MARK
145 HOSPITAL AVE MED ARTS
DUBOIS PA 15801

SIAR,W J
635C MAPLE AVENUE
DUBOIS PA 15801

Chk-in #	Order	Exam	
519857	0001	45514	PI-TIBIA FIBULA 2 VIEWS*R

Ord Diag: 823.22-FX SHAFT FIB W TIB-CLOS

RIGHT TIB-FIB - AP AND LATERAL:

Healing midshaft tibia fracture is seen. No change in alignment from prior studies noted. Non-ossifying fibroma distal tibia. Overlying cast shadow seen.

/READ BY/ MARK PIASIO, Orthopaedic Surgeon
/Released By/ MARK PIASIO, Orthopaedic Surgeon

03/12/02 1554
RAW

Complete Duplicate

100 Hospital Ave, DuBois, PA 15801

FAIRMAN,SEAN *REF Unit # 000453177
RD 1 BOX 391
DUBOIS PA 15801 Age 13Y Acct # D0207300865

Date:03/14/02 Time:0855

PIASIO,MARK
145 HOSPITAL AVE MED ARTS
DUBOIS PA 15801

SIAR,W J
635C MAPLE AVENUE
DUBOIS PA 15801

Chk-in #	Order	Exam	
524166	0001	45514	PI-TIBIA FIBULA 2 VIEWS*L

Ord Diag: 823.22-FX SHAFT FIB W TIB-CLOS

AP AND LATERAL RIGHT TIB-FIB:

Mid shaft tibial and fibular fractures are seen. Periosteal new bone formation is seen, mostly laterally at both fracture sites. No change in alignment, near anatomic. Minimal callus is noted medially. Nonossifying fibroma again noted in distal tibia.

/READ BY/ MARK PIASIO, Orthopaedic Surgeon
/Released By/ MARK PIASIO, Orthopaedic Surgeon

05/01/02 1417
JAH

Complete Duplicate

100 Hospital Ave, DuBois, PA 15801

FAIRMAN,SEAN *REF Unit # 000453177
RD 1 BOX 391
DUBOIS PA 15801 Age 13Y Acct # D0210100380

Date:04/11/02 Time:0923

PIASIO,MARK
145 HOSPITAL AVE MED ARTS
DUBOIS PA 15801

SIAR,W J
635C MAPLE AVENUE
DUBOIS PA 15801

Chk-in #	Order	Exam	
529323	0001	45514	PI-TIBIA FIBULA 2 VIEWS*R

Ord Diag: 823.22-FX SHAFT FIB W TIB-CLOS

AP AND LATERAL - RIGHT TIBIA:

No non-ossifying fibroma distal tibia is seen. The mid shaft fracture appears to be healing uneventfully. There is a soft tissue mass noted over the medial aspect of the tibia suspicious for very immature callus. Non-displaced fibular fracture healing uneventfully.

/READ BY/ MARK PIASIO, Orthopaedic Surgeon
/Released By/ MARK PIASIO, Orthopaedic Surgeon

05/01/02 1416
JLB

Complete Duplicate

. Department of Health & Human Services
alth Care Financing Admin.

IFICATE OF MEDICAL NECESSITY
MANUAL WHEELCHAIRS

Form Approved
OMB NO. 0938-0679
DMERC 02.03B

CTION A: Certification Type/Date: INITIAL 02/02/02 REVISED __/__/__

TIENT NAME,ADDRESS,TELEPHONE and HIC NO.	SUPPLIER NAME,ADDRESS,TELEPHONE and NSC NUMBER
FAIRMAN, SEAN RD 1 BOX 391 DUBOIS , PA 15801 814-375-1019 HICN: AU02778088W	MEDI HOME HEALTH CARE 225 MAIN ST BROOKVILLE PA 15825 814-849-8278 NSC:

ACE OF SERVICE: 12 ME and ADDRESS OF FACILITY applicable (See Reverse) N/A	HCPCS CODE K0195 K0002	PT DOB10/20/1988Sex M HT. 59(in) WT. 115 (lbs) PHYSICIAN NAME,ADDRESS (Printed or Typed) DR MARK A PIASIO 145 HOSPITAL AVENUE DUBOIS PA 15801 814 375-9617 UPIN:A14232

:TION B Information in this Section May NOT be Completed by the Supplier of the Items/Supplies.

.LENGTH OF NEED (# of months): 1-2 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): 833.22 _____ _____ _____

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1,5,8 AND 9 FOR MANUAL WHEELCHAIR BASE; 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)
nual Whlchr Base And l Accessories	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?
clining Back	Y (N) D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
evating Leg Rest	Y N D	3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
justable Height mrest	Y (N) D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
clining Back; justable HT. Armrest; y Type Ltwt. Whlchr	(2-5)	5. How many hours per day does the patient usually spend in the wheelchair? (1-24) (Round up to the next hour)
y Type Ltwt. Whlchr	Y N D	8. Is the patient able to adequately self-propel (without being pushed) in a standard weight manual wheelchair?
y Type Ltwt. Whlchr	Y N D	9. If the answer to question #8 is "No", would the patient be able to adequately self-propel (without being pushed) in the wheelchair which has been ordered?

FEB 25 2002

E OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print): ENTERED 2/25/02 ja

E: _____ TITLE: _____ EMPLOYER: _____ ROUTED TO file BY _____

CTION C Narrative Description of Equipment and Cost

Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory and option. *(See Instructions On Back)* If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on HCFA Form 854.

PC	Description		Quantity	Suppliers Charge	Medicare Fee Allowed
195	SA ELEV LEGREST PAIR K0195	W025010	1	44.00 /MONTH	44.00 /MONTH
002	W/C HEMI DET ARMS K0002	W111125	1	100.00 /MONTH	100.00 /MONTH

| | Check here if additional options/accessories are listed on attached HCFA Form 854

CTION D Physician Attestation and Signature/Date

rtify that I am the treating physician identified in Section B of this form. I have received Sections A, B and C of the tificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been ated and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete to the t of my knowledge and I understand that any falsification, omission, or concealment of material fact in that section may

'SICIANS SIGNATURE _____ DATE 2/14/02 (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

m HCFA-844 (5/97) LOC: 29 INS: 8544 CMN #: 1 SEQ #: 000002

MEDI HOME HEALTH CARE
225 MAIN ST
BROOKVILLE PA 15825

INS: 8544

SEQ # 00004
CMN # 2

FAIRMAN, SEAN LOC # 29 AU02778088

02/02/02 INDEFINITE

		02/02/02	LIFETIME	FAIR
E928.9	ACCIDENT NOS			
818.0	FX ARM MULT/NOS-CLOSED			
827.0	FX LOWER LIMB NEC-CLOSED			
812.00	FX UP END HUMERUS NOS-CL			

E0163NU COMMODE ALL-IN-ONE (4) D011015
IS PATIENT PHYSICALLY INCAPABLE OF UTILIZING
REGULAR TOILET FACILITIES? [X] YES [ ] NO

I CERTIFY THAT I HAVE ORDERED THE EQUIPMENT AND OR SUPPLIES
LISTED ABOVE.

2/14/02
DATE

PHYSICIAN SIGNATURE/UPIN

RECEIVED FEB 25 2002
ENTERED 2/25/02 BY
FILED BY

DR MARK A PIGOTT
145 HOSPITAL AVENUE
DUBOIS PA 15801

814 375 0611

0271 80886

Gatti Health Care, Inc.
1228 Wayne Avenue, Indiana, PA 15701

Joint Commission
on Accreditation of Healthcare Organizations

☐ 1228 Wayne Ave.
Indiana, PA 15701
(724) 463-4500

☐ 68 W. Washington St.
Bradford PA 16701
[redacted]) 368-8890

☐ 213 Beaver Drive
Dubois, PA 15801
(814) 375-9650

☐ New Patient ☐ Current Patient

PATIENT NAME: Shaun Fairman

FEB 15 2002 [redacted]

S.S. NUMBER:
ADDRESS:

DELIVERY DATE: 2/8/02
PHONE NUMBER:
PHYSICIAN:
DIAGNOSIS:

QUANTITY DEL	QUANTITY PU	EQUIPMENT DESCRIPTION	SERIAL#	RENT/ PURCHASE	CO-PAY	ADDITIONAL INFORMATION
1		DMI - 6584	long leg			
			Cast Protector			25.00
						X 80%
					Paid	CK# 2669
						PD 2/19/02
						#83333670

20•00 +
8•48 +
28•48 ∗

OXYGEN:
After Delivery: ____
Before Delivery: ____
Difference: ____
Total: ____
Liter Flow: ____

OK to Pay Insds
Lorae C. Fairman (Mother Insd is a minor)
RR1 Box 391
Du Bois, PA 1580
2/18/02

COMMENTS:

15801 zipcode

X____________________
(Individual Accepting or Returning Equipment)

X____________________
(Gatti Health Care, Inc., Representative)

DuBOIS MEDICAL SUPPLY CO., INC.
320 Liberty Boulevard
DuBOIS, PENNSYLVANIA 15801
(814) 375-1100 or 1-(800) 222-2023

CUSTOMER'S ORDER NO. | PHONE | DATE 2-2-02

NAME [redacted]

ADDRESS

FEB 18 2002

SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RET'D.	PAID OUT

QTY.	DESCRIPTION	PRICE	AMOUNT
1	Cast Prot		10 —
	02778088W		
	Pd CK#		
	Insds mitlex		
	OK to Pay X 80%		
	Total due $8.48		
		TAX	60
		TOTAL	10 60

RECEIVED BY

PRODUCT 610 All claims and returned goods must be accompanied by this bill.

9821

Thank You

MEDICAL SERVICES OF AMERICA, INC.

AND AFFILIATED COMPANIES

HOME PATIENT INSTRUCTION CHECKLIST

FEB 18 2002

Patient's Name: Sean Fairman [redacted]

Others receiving instruction: Mrs Fairman (mother)

Equipment: Wheelchair, Commode chair

Objectives:

- ☑ Comprehends use of prescribed equipment.
- ☑ Demonstrates the safe use of the equipment.
- ☑ Comprehends use of all safety features.
- ☑ Comprehends the cleaning and maintenance of the equipment.
- ☑ Understands how to resolve common problems associated with the use of the equipment.
- ☑ Understands how to obtain service should the device need it during use.

General:

- ☑ Additional support network who will be working with the patient is present during the instruction.
- ☑ Operating instructions and goals are left with the patient.
- ☑ Patient/caregiver understands never to attempt any repairs.
- ☑ Patient/caregiver received safety statement.
- ☑ Patient/caregiver received patient's rights and responsibilities brochure.
- ☑ Patient/caregiver received patient complaint policy.
- ☑ Patient's home has been accessed for practical use of prescribed equipment. List any discrepancy below:

Home is OK for equip use.

I agree to use the above stated equipment, set up by Med-Home Health. I have received instructions from the home care specialist and agree to comply with these instructions. I have also received a description of my rights and responsibilities as a patient, and agree to read and comply with these.

[redacted] Kim Fairman — Rose Lee

Patient/Primary Caregiver — Homecare Specialist

2-2-02

(MSA01 Rev. 8/92) #40052 WHITE - REFERRAL COPY YELLOW - FILE COPY PINK - PATIENT COPY

FEB 15 2002

DUBOIS REGIONAL MEDICAL CENTER

WEST UNIT
371-2200

EAST UNIT
375 4321

DUBOIS, PENNSYLVANIA 15801

Patient's Name [redacted] Date 2/2

Address

℞ Wheelchair c elev. leg
Folding Commode
Crutches

REFILL ______ TIMES

SUBSTITUTION PERMISSABLE

DR PRINT NAME

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW

DEA NO. ______ STATE LIC. NO. ______

KK D 0604

Patient's Name

℞

REFILL

SUBSTITUTION P

DR PRINT NAME

IN ORDER FOR
NECESSARY OF

DEA NO

DUBOIS REGIONAL MEDICAL CENT

WEST UNIT
371-2200

EAS
375

DUBOIS, PENNSYLVANIA 15801

Patient's Name

BOIS PA 15801 | FED. TAX NO. 251490707 | 6 STATEMENT COVERS PERIOD FROM 013102 THROUGH 020202 | 7 CC 2 | 8 N-C-D. | 9 C-H-D. | 10 L-R-D. | 11

43712200

8/2012

IENT NAME: IRMAN, SEAN

13 PATIENT ADDRESS: RD 1 BOX 391 DUBOIS PA 15801

ITHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	CONDITION CODES 26	28	30	31
201988	M	S	013102	16	1	1	11	01	000453177					

OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
013102							A B C

FAIRMAN, LORAE C
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801
(814) 375-1019

39	CODE	VALUE CODES AMOUNT	41	CODE	VALUE CODES AMOUNT
a	01	520 00			
b					
c					
d					

V. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
)	R/B (SP) GEN	520.00		2	1040 00		
)	PHCY GEN				26 50		
3	PHCY IV SOLUTIONS				40 00		
)	PHCY DRUGS/OTHER				39 00		
)	M/S/C GEN				27 00		
5	L/C HEMATOLOGY				34 00		
)	R/D GEN				384 00		
)	OR SVC GEN				1934 00		
)	P/T GEN				50 00		
)	ER GEN				330 00		
)	RECOVERY GEN				450 00		
					PALMER CLAIMS		
					MAR 04 2002		
					RECEIVED		
	Claim# 02778088W						
1	TOTAL			2	4354 50		

PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
AUTO INSURANCE		Y	Y		4354 50	
0 CIGNA		Y	Y			
COMMERCIAL PROF COMP		Y	Y			

DUE FROM PATIENT

INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
AIRMAN LORAE C	3	CLM AU02778088W	AUTO	999999
AIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999
AIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999

TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
	1	INVENSYS ENERGY METE	
	8	NONE	
	8	NONE	

67 PRIN. DIAG. CD.	68 CODE	69	70 CODE	OTHER DIAG. CODES 71 CODE	72 CODE	73	74 CODE	75	76 ADM. DIAG. CD.	77 E-CODE	78
82382	81200	E8495							82382	E8261	

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9	7906	020102				
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: A14232 PIASIO, MARK

83 OTHER PHYS. ID: A14232 PIASIO, MARK

OTHER PHYS. ID:

84 REMARKS

85 PROVIDER REPRESENTATIVE: MEASEY, TARESA

86 DATE: 02/27/02

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

790-0208

OCR/ORIGINAL

FEDERAL I.D. NO. 25-1490707

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SEAN FAIRMAN	02031-00677	M	13Y	01/31/02	02/02/02	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER	PAYMENT AMOUNT
350001 AUTO INSURANCE	999999	CLM AU02778088W	
350002 AUTO INSURANCE PROF C	999999	CLM AU02778088W	
302755 CIGNA	999999	17748422803	
300005 COMMERCIAL PROF COMP	999999	17748422803	

GUARANTOR NAME AND ADDRESS
LORAE C FAIRMAN
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801

☐ 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
1/31/02	123	ROOM 4080 7	120	3	1	520.00	520.00
2/01/02	123	ROOM 4080 7	120	16	1	520.00	520.00
		TOTAL SEMIPRIVATE ROOM - MEDICAL					1,040.00
1/31/02	94190	0.9% NS 1000 ML 7983-09	258	11	1	20.00	20.00
1/31/02	94190	0.9% NS 1000 ML 7983-09	258	12	1	20.00	20.00
		TOTAL PHARMACY					40.00
1/31/02	66621	ACETAMINOPHEN TAB 325MG	253	2	10	0.75	7.50
2/01/02	59807	ACETAMINOPHEN 325MG TAB	253	7	2	0.75	1.50
2/01/02	59810	ACETAMINOPHEN/CODEINE 300/30 TAB	253	8	1	2.00	2.00
2/02/02	59810	ACETAMINOPHEN/CODEINE 300/30 TAB	253	9	1	2.00	2.00
2/02/02	66621	ACETAMINOPHEN TAB 325MG	253	2	-10	0.75	-7.50
2/02/02	66621	ACETAMINOPHEN TAB 325MG	253	2	4	0.75	3.00
		TOTAL pharmacy-self administered					8.50
2/01/02	58527	PROPFOL 200MG/20ML VIAL	259	5	1	39.00	39.00
		TOTAL injectable drugs/other					39.00
1/31/02	96697	STAY DRY ICE PACK SMALL	270	13	1	7.00	7.00
2/01/02	95883	TUBING SUCTION 1264-02	270	21	1	2.00	2.00
2/01/02	95962	STOPCOCK 3-WAY MX531	270	20	1	2.00	2.00
2/01/02	96696	ICE PACE SECURE-ALL LARGE	270	22	1	9.00	9.00
2/01/02	96697	STAY DRY ICE PACK SMALL	270	23	1	7.00	7.00
		TOTAL SUPPLIES					27.00
1/31/02	24004	HEMOGLOBIN	305	2	1	17.00	17.00
1/31/02	24005	HEMATOCRIT (HCT)	305	2	1	17.00	17.00
		TOTAL Lab-hematology					34.00
1/31/02	44004	XR-SHOULDER MIN 2	320	1	1	101.00	101.00
1/31/02	44022	XR-TIBIA FIBULA 2 VIEWS	320	1	1	93.00	93.00
2/01/02	44022	XR-TIBIA FIBULA 2 VIEWS	320	9	1	93.00	93.00
2/01/02	49001	FLUOROSCOPY TO 1 HR	320	5	1	97.00	97.00
2/01/02	49012	BEDSIDE/OR RADIOGRAPHY	320	5	1	0.00	0.00
		TOTAL RADIOLOGY					384.00

PATIENT NUMBER	*PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.*	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	CONTINUED
02031-00677				

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

[redacted]

FEDERAL I.D. NO. 25-1490707

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SEAN FAIRMAN	02031-00677	M	13Y	01/31/02	02/02/02	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
350001 AUTO INSURANCE	999999	CLM AU02778088W
350002 AUTO INSURANCE PROF C	999999	CLM AU02778088W
302755 CIGNA	999999	17748422803
300005 COMMERCIAL PROF COMP	999999	17748422803

PAYMENT AMOUNT

GUARANTOR NAME AND ADDRESS
LORAE C FAIRMAN
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801

☐ 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
/01/02	4037	OR ROOM UP TO 1 HR	360	6	1	1800.00	1,800.00
/01/02	4253	SCOTCH CAST - LONG LEG	360	7	1	134.00	134.00
		TOTAL OPERATING ROOM					1,934.00
/01/02	70522	SELF CARE/HOME MGMT&ADLS 15 MIN	420	15	1	50.00	50.00
		TOTAL PHYSICAL THERAPY					50.00
/31/02	16213	EMERGENCY DEPARTMENT VISIT L4	450	18	1	200.00	200.00
/31/02	16297	IV MEDS	450	17	2	65.00	130.00
		TOTAL EMERGENCY ROOM					330.00
/31/02	58585	HYDROMORPHONE HCL 2MG/ML	636	1	1	6.00	6.00
/01/02	58933	MORPHINE SULFATE 4MG/ML INJ	636	6	2	6.00	12.00
		TOTAL Drugs w/ detail coding					18.00
/01/02	6115	RECOVERY ROOM 30 MIN TO 1 HR	710	14	1	450.00	450.00
		TOTAL RECOVERY ROOM					450.00
/31/02	1613	PC EMERGENCY DEPARTMENT VISIT L4	980	19	1	175.00	175.00
		TOTAL Professional fee-general					175.00
		TOTAL CHARGES					4,529.50
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PATIENT NUMBER
02031-00677

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT DUE 4,529.50

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

INPATIENT AUTO INSURANCE CLAIM " EXPECTED PAYMENT" WORKSHEET

DuBois Regional Medical Center
Po Box 447
Dubois, PA 15801

Patient: Sean Faigman

DRMC Account #: 2031-00677

Medicare Provider # 390086

Dates of Service: 1/31/02 - 2/2/02

Total Charges: $ 4354.50

DRG: 255 $ 1095.59

X 110%

Subtotal: $ 1205.15

Total Expected Payment: $ 1205.15

PLEASE NOTE: PROFESSIONAL FEES ARE BILLED SEPARATE: ENCLOSED PROFESSIONAL CHARGES $ 175.00

IN THIS AREA [redacted]

MAR 0 4 2002

XXX PICA

HEALTH INSURANCE CLAIM FORM

PICA XXXX

CARRIE

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)	CLMAU02778088W
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN ,SEAN	3. PATIENT'S BIRTH DATE MM DD YY: 10 20 1988 SEX: M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN ,LORAE C	
5. PATIENT'S ADDRESS (No., Street): RD 1 BOX 391	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child X Other
7. INSURED'S ADDRESS (No., Street): RD 1 BOX 391	
CITY: DUBOIS STATE: PA	8. PATIENT STATUS: Single X Married Other
CITY: DUBOIS STATE: PA	
ZIP CODE: 15801 TELEPHONE (Include Area Code): (814)3751019	Employed Full-Time Student Part-Time Student
ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814)3751019	
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 X
a. INSURED'S DATE OF BIRTH MM DD YY: 01 04 1957 SEX: M F X	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F	b. AUTO ACCIDENT? YES X NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME: INVENSYS ENERGY METE	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME: AUTO INSURANCE	
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.	

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.
SIGNATURE ON FILE
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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: RIN A MCKINLEY

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B34287

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: 01 31 02 TO: 02 02 02

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. 82382 FX TIBIA W FIBULA NOS-CL 3. L___
2. E8261 PEDAL CYCLE ACCIDENT INJU 4. L___

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
01 31 02	01 31 02	23		99284		1	175 00	1				036110GY8

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 251490707 X

26. PATIENT'S ACCOUNT NO.: 0203100677

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

28. TOTAL CHARGE: $ 175 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $ 175 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.)
US
AMERON
SIGNED 02/12/02 DATE

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# 02465

(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

[redacted] CASUALTY GROUP
2640 WYCLIFF ROAD
RALEIGH NC 27607

APPROVED OMB

DECA... APP...

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CA...

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)	CLM#02778088W
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN	3. PATIENT'S BIRTH DATE: 10 20 88 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN, ERNIE	
5. PATIENT'S ADDRESS (No., Street): RR1 BOX 391	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]
7. INSURED'S ADDRESS (No., Street): HEMLOCK HEIGHTS	
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) -375-1019	
ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814) -375-1019	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN, LORAE	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 17748422803	a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH: 01 07 53 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	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
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 18 02

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

PATIENT AND INSURED INFORMATION

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
01 31 02		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PIASIO, MARK	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 01 31 02 TO 02 02 02
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. 812.00 FX HUMERUS UPPER 2. 823.22 FX FIBULA W/TIBIA 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 01 31 02	21		23600		1	600.00	1				58186197
2 01 31 02	21		99223	25 57	2	200.00	1				58186197
3											
4											
5											
6											

RALEIGH ... FEB 25 2002

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
58-1861978 [ ] [ ]	7580		$ 800.00	$	$ 800.00

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 #
PIASIO, MARK A., M.D.	DUBOIS REGIONAL MEDICAL C PO BOX 447 DUBOIS, PA 15801	MARK A. PIASIO, M.D. 145 HOSPITAL AVE, SUITE 311 DUBOIS, PA 15801
SIGNED 02 18 02 DATE		PIN# 581861978 GRP# 581861978

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

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

STAPLE IN THIS AREA

[redacted]

RALEIGH NC 27607

PICA

HEALTH INSURANCE CLAIM FORM

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): CLM#02778088W

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN

3. PATIENT'S BIRTH DATE MM DD YY: 10 20 88 — SEX: M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN, ERNIE

5. PATIENT'S ADDRESS (No., Street): RR1 BOX 391

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

7. INSURED'S ADDRESS (No., Street): HEMLOCK HEIGHTS

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)-375-1019

ZIP CODE: 15801 — TELEPHONE (INCLUDE AREA CODE): (814)-375-1019

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 17748422803

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

a. INSURED'S DATE OF BIRTH MM DD YY: 01 07 53 — SEX: M ☒ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — 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

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 18 02

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: 01 31 02 — 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: PIASIO, MARK

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 01 31 02 TO 02 02 02

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. 823.22 FX FIBULA W/TIBIA
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 01 02		21		27752	79	1	1100.00	1				58186197
2												
3												
4												
5												
6												

RALEIGH PA

FEB 25 2002

RECEIVED

25. FEDERAL TAX I.D. NUMBER SSN EIN: 58-1861978 ☐

26. PATIENT'S ACCOUNT NO.: 7580

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

28. TOTAL CHARGE: $ 1100.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 1100.00

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.)

PIASIO, MARK A., M.D.

SIGNED 02 18 02 DATE

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

DUBOIS REGIONAL MEDICAL C
PO BOX 447
DUBOIS, PA 15801

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

MARK A. PIASIO, M.D.
145 HOSPITAL AVE, SUITE 311
DUBOIS, PA 15801

PIN# 581861978 GRP# 581861978

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIE

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

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

IN THIS AREA

[redacted]

RALEIGH NC 27607

HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRI

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)	CLM#02778088W
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN	3. PATIENT'S BIRTH DATE: 10 20 88 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN, ERNIE	
5. PATIENT'S ADDRESS (No., Street): RR1 BOX 391	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]
7. INSURED'S ADDRESS (No., Street): HEMLOCK HEIGHTS	
CITY: DUBOIS STATE: PA	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
CITY: DUBOIS STATE: PA	
ZIP CODE: 15801 TELEPHONE (Include Area Code): (814)-375-1019	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814)-375-1019	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN, LORAE	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 17748422803	a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO
a. INSURED'S DATE OF BIRTH: 01 07 53 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 [ ] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] 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 18 02

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

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 01 31 02	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: PIASIO, MARK	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 $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 823.22 FX FIBULA W/TIBIA 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 07 02	11		73590	26	1	25.00	1				58186197

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
58-1861978 [ ]	7580	[X] YES [ ] NO	$ 25.00	$	$ 25.00

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 #
PIASIO, MARK A., M.D.	MARK A. PIASIO, M.D. 145 HOSPITAL AVE, STE 311 DUBOIS, PA 15801	MARK A. PIASIO, M.D. 145 HOSPITAL AVE, SUITE 311 DUBOIS, PA 15801
SIGNED 02 18 02 DATE		PIN# 581861978 GRP# 581861978

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

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

IN THIS AREA [redacted]

RALEIGH NC 27607

PICA

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)	CLM#02778088W
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN	3. PATIENT'S BIRTH DATE: 10 20 88 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN, ERNIE	
5. PATIENT'S ADDRESS (No., Street): RR1 BOX 391	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]
7. INSURED'S ADDRESS (No., Street): HEMLOCK HEIGHTS	
CITY: DUBOIS STATE: PA	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
CITY: DUBOIS STATE: PA	
ZIP CODE: 15801 TELEPHONE (Include Area Code): (814)-375-1019	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814)-375-1019	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN, LORAE	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 17748422803	a. EMPLOYMENT? (CURRENT OR PREVIOUS) [X] YES [ ] NO
a. INSURED'S DATE OF BIRTH: 01 07 53 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	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [ ] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] 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 18 02

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)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY: 01 31 02	MM DD YY	FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PIASIO, MARK	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. 812.00 FX HUMERUS UPPER 3. [ ]

2. 823.22 FX FIBULA W/TIBIA 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 14 02		11		73060	26	1	26 00	1				58186197
02 14 02		11		73590	26	2	25 00	1				58186197

RAIMOND PIASIO, M.D.

FEB 25 2002

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
58-1861978 [ ] [ ]	7580	[X] YES [ ] NO	$ 51.00	$	$ 51.00

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 #
PIASIO, MARK A., M.D.	MARK A. PIASIO, M.D.	MARK A. PIASIO, M.D.
SIGNED 02 18 02 DATE	145 HOSPITAL AVE, STE 311	145 HOSPITAL AVE, SUITE 311
	DUBOIS, PA 15801	DUBOIS, PA 15801
		PIN# 581861978 GRP# 581861978

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

CASUALTY GROUP
[illegible] WYCLIFF ROAD
RALEIGH NC 27607

MAR 13 2002

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

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): CLM#02778088W

RECEIVED

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
FAIRMAN SEAN	10 20 88 M ☒ F ☐	FAIRMAN, ERNIE
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
RR1 BOX 391	Self ☐ Spouse ☐ Child ☒ Other ☐	HEMLOCK HEIGHTS
CITY: DUBOIS / STATE: PA	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐	CITY: DUBOIS / STATE: PA
ZIP CODE: 15801 / TELEPHONE (Include Area Code): (814)-375-1019	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE: 15801 / TELEPHONE (INCLUDE AREA CODE): (814)-375-1019
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN, LORAE	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 17748422803	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH / SEX: 01 07 53 M ☒ F ☐
b. OTHER INSURED'S DATE OF BIRTH / SEX: MM DD YY 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
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 03 06 02

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)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
01 31 02	MM DD YY	MM DD YY FROM — MM DD YY TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PIASIO, MARK	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM — MM DD YY 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. 823.22 FX FIBULA W/TIBIA
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 22 02		11		73590	26	1	25.00	1				58186197

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
58-1861978 ☐	7580	☒ YES ☐ NO	$ 25.00	$	$ 25.00

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 #
PIASIO, MARK A., M.D.	MARK A. PIASIO, M.D. 145 HOSPITAL AVE, STE 311 DUBOIS, PA 15801	MARK A. PIASIO, M.D. 145 HOSPITAL AVE, SUITE 311 DUBOIS, PA 15801
SIGNED 03 06 02 DATE		PIN# 581861978 GRP# 581861978

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

STAPLE IN THIS AREA

[redacted]

RALEIGH NC 27607

PICA

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): CLM#02778088W

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN

3. PATIENT'S BIRTH DATE MM DD YY: 10 20 88 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN, ERNIE

5. PATIENT'S ADDRESS (No., Street): RR1 BOX 391

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

7. INSURED'S ADDRESS (No., Street): HEMLOCK HEIGHTS

CITY: DUBOIS STATE: PA

8. PATIENT STATUS: Single | Married | Other

CITY: DUBOIS STATE: PA

ZIP CODE: 15801 TELEPHONE (Include Area Code): (814)-375-1019

Employed | Full-Time Student | Part-Time Student

ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814)-375-1019

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 17748422803

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

a. INSURED'S DATE OF BIRTH MM DD YY: 01 07 53 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

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

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 03 19 02

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): 01 31 02

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: PIASIO, MARK

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. 823.22 FX FIBULA W/TIBIA 3.

2. 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 03 14 02		11		73590	26	1	25.00	1				58186197
2 03 14 02		11		A4649		1	26.00	1				58186197
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 58-1861978

26. PATIENT'S ACCOUNT NO.: 7580

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

28. TOTAL CHARGE: $ 51.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 51.00

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.)

PIASIO, MARK A., M.D.

SIGNED 03 19 02 DATE

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

MARK A. PIASIO, M.D.
145 HOSPITAL AVE, STE 311
DUBOIS, PA 15801

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

MARK A. PIASIO, M.D.
145 HOSPITAL AVE, SUITE 311
DUBOIS, PA 15801

PIN# 581861978 GRP# 581861978

RECEIVED APR 09 2002

PAID APR 19 2002

OHIO CASUALTY Raleigh NC MAR 26 2002

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

8/29/03

RECEIVED HT CASUALTY GROUP
261 WYCLIFF ROAD
RALEIGH NC 27607
APR 2 4 2002

APPROVED OMB-0938-0008

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 (ID) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CLM#02778008W

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN

3. PATIENT'S BIRTH DATE: 10 20 88 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN, ERNIE

5. PATIENT'S ADDRESS (No., Street): RR1 BOX 391

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

7. INSURED'S ADDRESS (No., Street): HEMLOCK HEIGHTS

CITY: DUBOIS STATE: PA

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

CITY: DUBOIS STATE: PA

ZIP CODE: 15801 TELEPHONE (Include Area Code): (814) -375-1019

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

ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814) -375-1019

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 17748422803

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

a. INSURED'S DATE OF BIRTH: 01 07 53 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

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

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 04 16 02

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: 01 31 02

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: PIASIO, MARK

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

APR 24 2002

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

1. 823.22 FX FIBULA W/TIBIA
2.
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 04 11 02		11		73590	26	1	25.00	1				58186197
2 04 11 02		11		L2112		1	800.00	1				58186197
3												
4												
5												
6												

RECEIVED APR 22 2002

25. FEDERAL TAX I.D. NUMBER SSN EIN: 58-1861978 [ ]

26. PATIENT'S ACCOUNT NO.: 7580

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

28. TOTAL CHARGE: $ 825.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 825.00

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.)

PIASIO, MARK A., M.D.

SIGNED 04 16 02 DATE

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

MARK A. PIASIO, M.D.
145 HOSPITAL AVE, STE 311
DUBOIS, PA 15801

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

MARK A. PIASIO, M.D.
145 HOSPITAL AVE, SUITE 311
DUBOIS, PA 15801

PIN# 581861978 GRP# 581861978

(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

[redacted]

Unmet

OHIO CA[illegible]ALTY GROUP
510 WYCLIFF ROAD
RALEIGH NC 27607

APPROVED OMB-0938-0008

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): CLM#02778088W

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)
FAIRMAN SEAN	10 20 88 M ☒ F ☐	FAIRMAN, ERNI MAY 20 2002
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
RR1 BOX 391	Self ☐ Spouse ☐ Child ☒ Other ☐	HEMLOCK HEIGHTS RECEIVED
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) -375-1019		15801 (814) -375-1019
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
FAIRMAN, LORAE		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
17748422803	☐ YES ☒ NO	01 07 53 M ☒ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
M ☐ F ☐	☒ YES ☐ NO	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	☐ YES ☐ NO	
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 05 13 02

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 / MM DD YY TO
01 31 02		
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 / MM DD YY TO
PIASIO, MARK		
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1: 823.22 FX FIBULA W/TIBIA 3: ___ 2: ___ 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
05 06 02	11		99212	1	50.00	1				58186197
05 06 02	11		73590 / 26	1	25.00	1				58186197

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
58-1861978 ☐☐	7580	☒ YES ☐ NO	$ 75.00	$	$ 75.00

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 #
PIASIO, MARK A., M.D.	MARK A. PIASIO, M.D. 145 HOSPITAL AVE, STE 311 DUBOIS, PA 15801	MARK A. PIASIO, M.D. 145 HOSPITAL AVE, SUITE 311 DUBOIS, PA 15801
SIGNED 05 13 02 DATE		PIN# 581861978 GRP# 581861978

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

DUBOIS REGIONAL MEDICAL CENTER
P O BOX 447
DUBOIS PA 15801
8143712200

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
		0204400547	131

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7	8 N-C D.	9 C-I D.	10 L-R D.	11
251490707	021402	021402					

12 PATIENT NAME	13 PATIENT ADDRESS
FAIRMAN, SEAN	RD 1 BOX 391 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.	24	26	28	30	31
10201988	M	S	021402	00	3	1	23	57	000453177	CONDITION CODES				

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37 A B C

FAIRMAN, LORAE C
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801
(814) 375-1019

	39 CODE	39 VALUE CODES AMOUNT	40	41 CODE	41 VALUE CODES AMOUNT
a					
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
420	P/T GEN	97116 GP	021402	1	50 00	10.58	
01	TOTAL			1	50 00		

MAR 12 2002
RECEIVED

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
AUTO INS	390086	Y	Y		50 00	
00 CIGNA		Y	Y			
COMMERCIAL PROF COMP		Y	Y			

DUE FROM PATIENT

57 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
AIRMAN LORAE C	3	CLM AU02778088W	AUTO	999999
AIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999
AIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
	1	INVENSYS ENERGY METE	
	8	NONE	
	8	NONE	

67 PRIN. DIAG. CD.	68 CODE	69	70 CODE	71	72 CODE	73	74 CODE	75	76 ADM. DIAG. CD.	77 E-CODE	78
2382											

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

82 ATTENDING PHYS. ID	
F88128	CHANDRASEKHA, S

83 OTHER PHYS. ID

OTHER PHYS. ID

REMARKS

85 PROVIDER REPRESENTATIVE	86 DATE
KORBY, ROBYN L	02/20/02

92 HCFA-1450 OCR/ORIGINAL 790-0208

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

PLEASE DO NOT STAPLE IN THIS AREA

OHIO CASUAL[illegible] GROUP
2610 WYCLIF[illegible] ROAD
RALEIGH, NC 27607

RECEIVED
JUN 19 2002
N.H.R.

Under

8515

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): 02778088W

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)
FAIRMAN SEAN	10201988 M X F	FAIRMAN ERNIE

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
RD 1 BOX 391	Self / Spouse / Child X / Other	RD 1 BOX 391

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

JUN 14 2002

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (INCLUDE AREA CODE)
15801	(814) 375-1019	Employed / Full-Time Student / Part-Time Student X	15801	(814) 375-1019

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
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? YES X / NO / 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: OHIO CASUALTY GROUP
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: 06012002

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
01302002		

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
MARK PIASIO	A14232	

19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES / NO X — $ CHARGES: 0 00	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 823.20 2. 3. 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
05082002	05082002	11	09	97140	59	1	40.00	1				
05082002	05082002	11	09	97530		1	40.00	1				
05082002	05082002	11	09	97001		1	75.00	1				
05102002	05102002	11	09	97140	59	1	40.00	1				
05102002	05102002	11	09	97110		1	60.00	1				
05102002	05102002	11	09	97530	59	1	120.00	3				

REC'D JUN 19 2002 OCG RALEIGH

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
25-1802909	EIN X	FAISEA	X YES / NO	$ 375.00	$ 0.00	$ 375.00

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#
EDWARD WELCH PT-008866-L 06012002 SIGNED DATE		P & G Physical Therapy, Inc. 602-1 West DuBois Ave DuBois, PA 15801 (814) 375-6830

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

OHIO CASUALTY GROUP
2610 WYCLIFF ROAD
RALEIGH, NC 27607

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) X	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 02778088W

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN	3. PATIENT'S BIRTH DATE MM DD YY: 10201988 SEX M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN ERNIE	
5. PATIENT'S ADDRESS (No., Street): RD 1 BOX 391	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child X Other	7. INSURED'S ADDRESS (No., Street): RD 1 BOX 391	
CITY: DUBOIS	STATE: PA	8. PATIENT STATUS: Single X Married Other	CITY: DUBOIS / STATE: PA
ZIP CODE: 15801	TELEPHONE (Include Area Code): (814) 375-1019	Employed Full-Time Student Part-Time Student X	ZIP CODE: 15801 / TELEPHONE (INCLUDE AREA CODE): (814) 375-1019
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
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? YES X NO 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: OHIO CASUALTY GROUP
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: 06012002

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: 01302002	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: MARK PIASIO	17a. I.D. NUMBER OF REFERRING PHYSICIAN: A14232	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO: JUN 14 2002
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. 823.20 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.: RECEIVED
		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
05132002	05132002	11	09	97530	59	1	80.00	2				
05132002	05132002	11	09	97140	59	1	40.00	1				
05132002	05132002	11	09	97110		1	90.00	3				
05142002	05142002	11	09	97530	59	1	120.00	3				
05142002	05142002	11	09	97140	59	1	40.00	1				
05142002	05142002	11	09	97110		1	60.00	2				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 25-1802909 X	26. PATIENT'S ACCOUNT NO.: FAISEA	27. ACCEPT ASSIGNMENT? (For govt. claims see back) X YES NO	28. TOTAL CHARGE: $ 430.00	29. AMOUNT PAID: $ 0.00	30. BALANCE DUE: $ 430.00

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.) EDWARD WELCH PT-008866-L 06012002 SIGNED DATE	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 P&HG Physical Therapy, Inc. 602-1 West DuBois Ave DuBois, PA 15801 (814) 375-6830 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)

PLEASE DO NOT STAPLE IN THIS AREA

OHIO CASUALTY GROUP
2610 WYCLIFF ROAD
RALEIGH, NC 27607

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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)
				X			02778088W

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)
FAIRMAN SEAN	10201988 M X F	FAIRMAN ERNIE

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
RD 1 BOX 391	Self / Spouse / Child X / Other	RD 1 BOX 391

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) 375-1019	Employed / Full-Time Student / Part-Time Student X	15801	(814) 375-1019

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
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? YES X / NO / 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: OHIO CASUALTY GROUP
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: 06012002

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
01302002		

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
MARK PIASIO	A14232	

19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES / NO X $ CHARGES	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
	0 00	

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

1. 823.20 3. 2. 4.

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
05172002	05172002	11	09	97110		1	60.00	2				
05172002	05172002	11	09	97140	59	1	40.00	1				
05172002	05172002	11	09	97530	59	1	120.00	3				
05222002	05222002	11	09	97530	59	1	120.00	3				
05222002	05222002	11	09	97140	59	1	40.00	1				
05222002	05222002	11	09	97110		1	60.00	2				

RECEIVED JUN 12 2002 OCG WC CLAIMS RALEIGH

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 $
25-1802909 X	FAISEA		440.00	0.00	440.00

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 PH#
EDWARD WELCH PT-008866-L 06012002 SIGNED DATE		P & G Physical Therapy, Inc. 602-1 West DuBois Ave DuBois, PA 15801 (814)375-6830 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)

PLEASE DO NOT STAPLE IN THIS AREA

OHIO CASUALTY GROUP
2610 WYCLIFF ROAD
RALEIGH, NC 27607

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): 02778088W

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN

3. PATIENT'S BIRTH DATE MM DD YY: 10201988 SEX M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN ERNIE

5. PATIENT'S ADDRESS (No., Street): RD 1 BOX 391

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

7. INSURED'S ADDRESS (No., Street): RD 1 BOX 391

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) 375-1019

ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814) 375-1019

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:

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 M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 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: OHIO CASUALTY GROUP

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: 06012002

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

JUN 14 2002

SIGNED: Signature on File

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 01302002

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: MARK PIASIO

17a. I.D. NUMBER OF REFERRING PHYSICIAN: A14232

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. 823.20
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
05242002	05242002	11	09	97530	59	1	120.00	3				
05242002	05242002	11	09	97140	59	1	40.00	1				
05242002	05242002	11	09	97110		1	30.00	1				
05292002	05292002	11	09	97530	59	1	80.00	2				
05292002	05292002	11	09	97140	59	1	40.00	1				
05292002	05292002	11	09	97110		1	90.00	3				

25. FEDERAL TAX I.D. NUMBER: 25-1802909 SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: FAISEA

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

28. TOTAL CHARGE: $ 400.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 400.00

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.)

EDWARD WELCH PT-008866-L

SIGNED 06012002 DATE

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

P & G Physical Therapy, Inc.
602-1 West DuBois Ave
DuBois, PA 15801

PIN# (814) 375-6830 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

OHIO CASUAL[illegible] GROUP
2610 WYCLIF[illegible] ROAD
RALEIGH, NC 27607

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): 027780888W

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN

3. PATIENT'S BIRTH DATE: MM DD YY 10201988 — SEX: M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN ERNIE

5. PATIENT'S ADDRESS (No., Street): RD 1 BOX 391

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

7. INSURED'S ADDRESS (No., Street): RD 1 BOX 391

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) 375-1019

ZIP CODE: 15801 — TELEPHONE (INCLUDE AREA CODE): (814) 375-1019

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:

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: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — 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: OHIO CASUALTY GROUP

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.

RALEIGH CLAIMS OCG

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: 06012002

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

JUN 14 2002

SIGNED: Signature on File

14. DATE OF CURRENT: MM DD YY 01302002 — 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: MARK PIASIO

17a. I.D. NUMBER OF REFERRING PHYSICIAN: A14232

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 ☒ — $ CHARGES: 0 00

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

1. 823.20 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
05312002	05312002	11	09	97110		1	60.00	2				
05312002	05312002	11	09	97140	59	1	40.00	1				
05312002	05312002	11	09	97530	59	1	80.00	2				

RECEIVED JUN 17 2002 OCG WC CLAIMS RALEIGH

25. FEDERAL TAX I.D. NUMBER: 25-1802909 — SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: FAISEA

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

28. TOTAL CHARGE: $ 180.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 180.00

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.)

EDWARD WELCH PT-008866-L

SIGNED — DATE: 06012002

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#

P & G Physical Therapy, Inc.
602-1 West DuBois Ave
DuBois, PA 15801

(814) 375-6830

PIN# — GRP#

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED 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)

UBOIS REGIONAL MEDICAL CENTER
O BOX 447
UBOIS PA 15801
145712200

2

3 PATIENT CONTROL NO. 04500751 | OF BILL 131

FED. TAX NO. 251490707 | 6 STATEMENT COVERS PERIOD FROM 021402 THROUGH 021402 | 7 | 8 N-C-D. | 9 L-R-D. | 10 L-R-D. | 11

80333

PATIENT NAME: AIRMAN, SEAN

13 PATIENT ADDRESS: RD 1 BOX 391 DUBOIS PA 15801

BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	26	28	30	31
0201988	M	S	021402	15	3	1	23	57	000453177					

OCCURRENCE CODE	OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
1	013102										A
											B
											C

FAIRMAN, LORAE C
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801
(814) 375-1019

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
50	CT SCANNER GENERAL CLAS	70450	021402	1	528 00	224 77	
01	TOTAL			1	528 00		

PATIENT CHARGES
MAR 06 2002
RECEIVED

PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
AUTO INS	390086	Y	Y		528 00	
00 CIGNA		Y	Y			
COMMERCIAL PROF COMP		Y	Y			

DUE FROM PATIENT

INSURED'S NAME	59 P REL	60 CERT. SSN. HIC. ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
AIRMAN LORAE C	3	CLM AU02778088W	AUTO	999999
AIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999
AIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999

TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
	1	INVENSYS ENERGY METE	
	8	NONE	
	8	NONE	

PRIN. DIAG. CD.	68 CODE	69	OTHER DIAG. CODES 70 CODE	71	72 CODE	73	74 CODE	75	76 ADM. DIAG. CD.	77 E-CODE	78
840	95901										

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

82 ATTENDING PHYS. ID: F88128 CHANDRASEKHA, S

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: CORBY, ROBYN L | 86 DATE: 02/21/02

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

(814) 375-4200
FEDERAL I.D. NO. 25-1490707

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SEAN FAIRMAN	02045-00751	M	13Y	02/14/02	02/14/02	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
350001 OHIO CASUALTY	999999	CLM AU02778088W
350002 AUTO INSURANCE PROF C	999999	CLM AU02778088W
302755 CIGNA	999999	17748422803
300005 COMMERCIAL PROF COMP	999999	17748422803

PAYMENT AMOUNT

RECEIVED
MAR 04 2002

GUARANTOR NAME AND ADDRESS
LORAE C FAIRMAN
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801

☐ 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
02/14/02	44 (60) 72724	CT HEAD, NO CONTRAST	350	1	1	528.00	528.00
		TOTAL CT SCAN					528.00
		TOTAL CHARGES					528.00
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PATIENT NUMBER	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	528.00
02045-00751			

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

STAPLE IN THIS AREA

RALEIGH NC 27620-0621

PICA

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 (ID)
						X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): AU027780888W

APR 04 2002

RECEIVED

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)
Fairman Sean	10 20 1988 / X M / F	Fairman Lorae C

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
RD 1 Box 391	Self / Spouse / Child X / Other	RD 1 Box 391

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) 375-1019	Employed / Full-Time Student / Part-Time Student	15801	(814) 375-1019

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
Lorae C Fairman		
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 17748422803	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / X NO	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: Invevsys Energy Mete
c. EMPLOYER'S NAME OR SCHOOL NAME: Invevsys Energy Mete	c. OTHER ACCIDENT? YES / X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA	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 032902
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	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
Russell E Cameron		FROM 01 31 02 TO 01 31 02

19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES / X 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. 9592 3. ____
2. 82320 4. ____

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

RECEIVED APR 12 2002

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	EMG	COB	I RESERVED FOR LOCAL USE	J	K
1													
01 31 02	21	4	73030	26lt	1	28 00	1						
2 01 31 02	21	4	73590	26rt	2	28 00	1						
3													
4													
5													
6													

PHYSICIAN OR SUPPLIER INFORMATION

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		fairse517644	X YES / NO	$ 56 00	$ 0 00	$ 56 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 #
G Kosco MD	DuBois Reg Medical Ctr DuBois, PA 15801 DU390086	DuBois Radiologists Inc. PO Box 1106 DuBois PA 15801
SIGNED 25-1715230 DATE 032902		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

STAPLE IN THIS AREA

RALEIGH NC 27620-0621

PICA

HEALTH INSURANCE CLAIM FORM

APR 04 2002

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): AU02778088W

RECEIVED

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Fairman Sean

3. PATIENT'S BIRTH DATE (MM DD YY) / SEX: 10 20 1988 / M X / F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Fairman Lorae C

5. PATIENT'S ADDRESS (No., Street): RD 1 Box 391

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

7. INSURED'S ADDRESS (No., Street): RD 1 Box 391

CITY: DuBois **STATE:** PA

8. PATIENT STATUS: Single X / Married / Other

CITY: DuBois **STATE:** PA

ZIP CODE: 15801 **TELEPHONE (Include Area Code):** (814) 375-1019

Employed / Full-Time Student / Part-Time Student

ZIP CODE: 15801 **TELEPHONE (INCLUDE AREA CODE):** (814) 375-1019

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Lorae C Fairman

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 17748422803

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? YES X / NO / PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: Invevsys Energy Mete

c. EMPLOYER'S NAME OR SCHOOL NAME: Invevsys Energy Mete

c. OTHER ACCIDENT? YES / NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA

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 032902

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: 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:

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Mark A Piasio MD

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM: 02 01 02 **TO:** 02 01 02

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. 82380 82380
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 01 02		21	4	73590	26rt	1	28 00	1				
2												
3												
4												
5												
6												

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

26. PATIENT'S ACCOUNT NO.: fairse517801

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

28. TOTAL CHARGE: $ 28 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 28 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.)

R Boron MD

SIGNED 25-1715230 DATE 032902

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

DuBois Reg Medical Ctr
DuBois, PA 15801
DU390086

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: 8145711784

DuBois Radiologists Inc.
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

1 PROVIDER
UBOIS REGIONAL MEDICAL CENTER
O BOX 447
UBOIS PA 15801
143712200

2

3 PATIENT CONTROL NO.
203800467

4 TYPE OF BILL
131

FED. TAX NO.
251490707

6 STATEMENT COVERS PERIOD FROM THROUGH
020702 020702

8 N-C-D. | 9 C-I-D. | 10 L-R-D. | 11

PATIENT NAME
AIRMAN, SEAN

13 PATIENT ADDRESS
RD 1 BOX 391 DUBOIS PA 15801

BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24–30 CONDITION CODES	31
0201988	M	S	020702	09	3	1	23	57	000453177		

32–35 OCCURRENCE CODE / DATE	34–35 OCCURRENCE CODE / DATE	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37 A B C

FAIRMAN, LORAE C
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801
(814) 375-1019

	39–40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
a		
b		
c		
d		

REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
320	R/D GEN	73590	020702	1	93 00	37.94	
	[redacted]						
	MAR 04 2002						
	Received						
	Claim# 027780880						
001	TOTAL			1	93 00		

PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
AUTO INS	390086	Y	Y		93 00	
00 CIGNA		Y	Y			
COMMERCIAL PROF COMP		Y	Y			

DUE FROM PATIENT

INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
AIRMAN LORAE C	3	177484228		999999
AIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999
AIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999

TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
	1	INVENSYS ENERGY METE	
	8	NONE	
	8	NONE	

PRIN. DIAG. CD.	68 CODE	69 CODE	OTHER DIAG. CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
2382											

P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE

OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS. ID
A14232 PIASIO, MARK

83 OTHER PHYS. ID

OTHER PHYS. ID

REMARKS

85 PROVIDER REPRESENTATIVE
KORBY, ROBYN L

86 DATE
02/16/02

PRINTED:02/18/02 PAGE: 4

92 HCFA-1450 OCR/ORIGINAL 790-0208

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

FEDERAL I.D. NO. 25-1490707

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SEAN FAIRMAN	02038-00467	M	13Y	02/07/02	02/07/02	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
350001 AUTO INSURANCE	999999	177484228
350002 AUTO INSURANCE PROF C	999999	177484228
302755 CIGNA	999999	17748422803
300005 COMMERCIAL PROF COMP	999999	17748422803

PAYMENT AMOUNT

GUARANTOR NAME AND ADDRESS
LORAE C FAIRMAN
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801

MAR 04 2002

☐ 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
02/07/02 44	345514	PI-TIBIA FIBULA 2 VIEWS	320	1	1	93.00	93.00
		TOTAL RADIOLOGY					93.00
		TOTAL CHARGES					93.00
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PATIENT NUMBER
02038-00467

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT DUE 93.00

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

143712200 | 251490707 | 021402 | 021402

PATIENT NAME	13 PATIENT ADDRESS		
AIRMAN, SEAN	RD 1 BOX 391	DUBOIS	PA 15801

BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	CONDITION CODES 26	28	30	31
0201988	M	S	021402	16	3	1	23	57	000453177					

32 OCCURRENCE DATE	33 OCCURRENCE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								A B C

FAIRMAN, LORAE C
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801
(814) 375-1019

39 VALUE CODES CODE	AMOUNT	40	41 VALUE CODES CODE	AMOUNT
a				
b				
c				
d				

MAR 06 2002

REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
20	R/D GEN	73060 LT	021402	1	98 00	38.68	1
20	R/D GEN	73590 RT	021402	1	93 00	38.68	2
							3
							4
							5
							6
							7
							8
							9
							10
							11
							12
							13
							14
							15
							16
							17
							18
							19
							20
							21
							22
01	TOTAL			2	191 00		

Worked

PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
AUTO INS	390086	Y	Y		191 00	
00 CIGNA		Y	Y			
COMMERCIAL PROF COMP		Y	Y			

DUE FROM PATIENT

INSURED'S NAME	59 P REL	60 INSD'S GRP - SGN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
AIRMAN LORAE C	3	CLM AU02778088W	AUTO	999999
AIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999
AIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999

TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
	1	INVENSYS ENERGY METE	
	8	NONE	
	8	NONE	

PRIN. DIAG. CD.	68 CODE	69 CODE	OTHER DIAG. CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
1200	82322								81200		

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

82 ATTENDING PHYS. ID: A14232 PIASIO, MARK

83 OTHER PHYS. ID

OTHER PHYS. ID

REMARKS

85 PROVIDER REPRESENTATIVE: KORBY, ROBYN L

86 DATE: 02/22/02

FEDERAL I.D. NO. 25-1490707

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SEAN FAIRMAN	02045-00767	M	13Y	02/14/02	02/14/02	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER	PAYMENT AMOUNT
350001 OHIO CASUALTY	999999	CLM AU02778088W	
350002 AUTO INSURANCE PROF C	999999	CLM AU02778088W	
302755 CIGNA	999999	17748422803	
300005 COMMERCIAL PROF COMP	999999	17748422803	

GUARANTOR NAME AND ADDRESS
LORAE C FAIRMAN
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801

☐ 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
2/14/02	44 34 45514	PI-TIBIA FIBULA 2 VIEWS	320	1	1	93.00	93.00
2/14/02	44 34 45536	PI-HUMERUS, MIN 2	320	1	1	98.00	98.00
		TOTAL RADIOLOGY					191.00
		TOTAL CHARGES					191.00
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PATIENT NUMBER
02045-00767

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT DUE 191.00

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

STATE IN THIS AREA

RALEIGH NC 27626-0621

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRI

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): XXU027780888W

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)
Fairman Sean	10 20 1980 ☒ M ☐ F	Fairman Lorae C
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
RD 1 Box 391	Self ☐ Spouse ☐ Child ☒ Other ☐	RD 1 Box 391
CITY: DuBois / STATE: PA	8. PATIENT STATUS: Single ☒ Married ☐ Other ☐	CITY: DuBois / STATE: PA
ZIP CODE: 15801 / TELEPHONE (Include Area Code): (814) 375-1019	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE: 15801 / TELEPHONE (INCLUDE AREA CODE): (814) 375-1019
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Lorae C Fairman	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 17748422803	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 DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) ☒ YES ☐ NO ( )	b. EMPLOYER'S NAME OR SCHOOL NAME: Invevsys Energy Mete
c. EMPLOYER'S NAME OR SCHOOL NAME: Invevsys Energy Mete	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA	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: 022202

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: Sundar ChandraSekhar	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 / $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 7840 7840
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											
2 02 14 02	22	4	70450	26	1	96 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 ☐ ☐	Fairse520218	☒ YES ☐ NO	$ 96 00	$ 0 00	$ 96 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 DU390086	DuBois Radiologists IncMD PO Box 1106 DuBois PA 15801 8143711784
SIGNED 25-1715230 DATE 022202		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

143712200. 251490707 022202 022202

PATIENT NAME: AIRMAN, SEAN
13 PATIENT ADDRESS: RD 1 BOX 391 DUBOIS PA 15801

BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24 CONDITION CODES	31
0201988	M	S	022202	14	3	1	23	57	000453177		

32 OCCURRENCE CODE	32 OCCURRENCE DATE	33	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
									A B C

FAIRMAN, LORAE C
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801
(814) 375-1019

	39 CODE	VALUE CODES AMOUNT		41 CODE	VALUE CODES AMOUNT
a					
b					
c					
d					

REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
20	R/D GEN	73590 RT	022202	1	93 00	39.51	
01	TOTAL			1	93 00		

Claim # 027780888W
Verified
Rec'd 10-2002

PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
AUTO INS 00 CIGNA COMMERCIAL PROF COMP	390086	Y Y Y	Y Y Y		93 00	

DUE FROM PATIENT

INSURED'S NAME			59 P REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
AIRMAN	LORAE	C	3	CLM AU027780888W	AUTO	999999
AIRMAN	SEAN		1	17748422803	CIGNA HEALTHCA	999999
AIRMAN	SEAN		1	17748422803	CIGNA HEALTHCA	999999

TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
	1	INVENSYS ENERGY METE	
	8	NONE	
	8	NONE	

PRIN. DIAG. CD.	68 CODE	70 CODE	OTHER DIAG. CODES 72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
1200	82322						

P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE			82 ATTENDING PHYS. ID
							A14232 PIASIO, MARK
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
							OTHER PHYS. ID

REMARKS

85 PROVIDER REPRESENTATIVE: ASHMAN, CHERYL A
86 DATE: 02/28/02

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

FEDERAL I.D. NO. 25-1490707

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SEAN FAIRMAN	02053-00524	M	13Y	02/22/02	02/22/02	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER	PAYMENT AMOUNT
350001 OHIO CASUALTY	999999	CLM AU02778088W	
350002 AUTO INSURANCE PROF C	999999	CLM AU02778088W	
302755 CIGNA	999999	17748422803	
300005 COMMERCIAL PROF COMP	999999	17748422803	

GUARANTOR NAME AND ADDRESS
LORAE C FAIRMAN
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801

☐ 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
02/22/02 44	34/45514	PI-TIBIA FIBULA 2 VIEWS	320	1	1	93.00	93.00
		TOTAL RADIOLOGY					93.00
		TOTAL CHARGES					93.00
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PAID BY INS CO
MAR 18 2002
RECEIVED

PATIENT NUMBER	*PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.*	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	93.00
02053-00524				

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

3143712200 | 251490707 | 031402 | 031402 | | | | $340

PATIENT NAME	13 PATIENT ADDRESS
FAIRMAN, SEAN	RD 1 BOX 391 DUBOIS PA 15801

BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	CONDITION CODES 26	28	30	31
0201988	M	S	031402	15	3	1	23	57	000453177					

OCCURRENCE CODE	OCCURRENCE DATE	OCCURRENCE	34 OCCURRENCE CODE	OCCURRENCE DATE	OCCURRENCE	36 OCCURRENCE CODE	OCCURRENCE SPAN FROM	THROUGH	37
									A
									B
									C

RECEIVED
MAY 0 8 2002
AHH

FAIRMAN, LORAE C
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801
(814) 375-1019

39 CODE	VALUE CODES AMOUNT		40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a						
b						
c						
d						

REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	MO. SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
320	R/D GEN	73590 LT	031402	1	93 00	30.50	
001	TOTAL			1	93 00		

Claim #
027780888W
Verified

MAY 06 2002
RECEIVED

PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
AUTO INS	390086	Y	Y		93 00	
100 CIGNA		Y	Y			
COMMERCIAL PROF COMP		Y	Y			

DUE FROM PATIENT

INSURED'S NAME	59 P REL	60 CERT. SSN. HIC. ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
FAIRMAN LORAE C	3	CLM AU02778088W	AUTO	999999
FAIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999
FAIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999

TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
	1	INVENSYS ENERGY METE	
	8	NONE	
	8	NONE	

PRIN. DIAG. CD.	68 CODE	70 CODE	OTHER DIAG. CODES 72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
2322						E9289	

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

82 ATTENDING PHYS. ID	
A14232	PIASIO, MARK
83 OTHER PHYS. ID	
OTHER PHYS. ID	

REMARKS

85 PROVIDER REPRESENTATIVE	86 DATE
OLIVER, CHERYL A	04/27/02

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

1-92 HCFA-1450 OCR/ORIGINAL 790-0208

FEDERAL I.D. NO. 25-1490707

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SEAN FAIRMAN	02073-00865	M	13Y	03/14/02	03/14/02	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
350001 OHIO CASUALTY	999999	CLM AU02778088W
350002 AUTO INSURANCE PROF C	999999	CLM AU02778088W
302755 CIGNA	999999	17748422803
300005 COMMERCIAL PROF COMP	999999	17748422803

PAYMENT AMOUNT

GUARANTOR NAME AND ADDRESS
LORAE C FAIRMAN
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801

☐ 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
03/14/02 LL	3445514	PI-TIBIA FIBULA 2 VIEWS	320	1	1	93.00	93.00
		TOTAL RADIOLOGY					93.00
		TOTAL CHARGES					93.00
04/23/02	I1130	8 COMMERCIAL INS OUTPATIENT					0.00
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PATIENT NUMBER	*PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.*	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	93.00
02073-00865				

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

:143712200	251490707	041102	041102	

PATIENT NAME	13 PATIENT ADDRESS		
'AIRMAN, SEAN	RD 1 BOX 391	DUBOIS	PA 15801

BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	26	28	30	31
.0201988	M	S	041102	07	3	1	23	57	000453177					

DE	OCCURRENCE DATE	32 CODE	33 OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37 A B C

FAIRMAN,LORAE C
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801
(814) 375-1019

RECEIVED
MAY 0 8 2002

39 CODE	VALUE CODES AMOUNT		41 CODE	VALUE CODES AMOUNT
a				
b				
c				
d				

REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
320	R/D GEN	73590	041102	1	93 00	36 30	

Claim # 02778088W

Received

PATIENT CLAIMS
MAY 06 2002
RECEIVED

001	TOTAL		1	93 00	

PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
AUTO INS	390086	Y	Y		93 00	
200 CIGNA		Y	Y			
COMMERCIAL PROF COMP		Y	Y			

DUE FROM PATIENT

INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
'AIRMAN LORAE C	3	CLM AU02778088W	AUTO	999999
'AIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999
'AIRMAN SEAN	1	17748422803	CIGNA HEALTHCA	999999

TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
	1	INVENSYS ENERGY METE	
	8	NONE	
	8	NONE	

PRIN. DIAG. CD.	68 CODE	70 CODE	OTHER DIAG. CODES 72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
2322					32322		

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

82 ATTENDING PHYS. ID: A14232 PIASIO, MARK

83 OTHER PHYS. ID:

OTHER PHYS. ID:

REMARKS

85 PROVIDER REPRESENTATIVE: OLIVER, CHERYL A 86 DATE: 04/27/02

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

FEDERAL I.D. NO. 25-1490707

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SEAN FAIRMAN	02101-00380	M	13Y	04/11/02	04/11/02	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
350001 OHIO CASUALTY	999999	CLM AU02778088W
350002 AUTO INSURANCE PROF C	999999	CLM AU02778088W
302755 CIGNA	999999	17748422803
300005 COMMERCIAL PROF COMP	999999	17748422803

PAYMENT AMOUNT

GUARANTOR NAME AND ADDRESS
LORAE C FAIRMAN
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801

☐ 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
4/11/02	44 34 45514	PI-TIBIA FIBULA 2 VIEWS	320	1	1	93.00	93.00
		TOTAL RADIOLOGY					93.00
		TOTAL CHARGES					93.00
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PATIENT NUMBER
02101-00380

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT DUE 93.00

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

STAPLE IN THIS AREA

JUN 18 2002

N.H.D.

RALEIGH NC 27620-0621

JUN 11 2002

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): AU027780888W

RECEIVED

PATIENT AND INSURED INFORMATION

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)
Fairman Sean	10 20 1988 M X F	Fairman Lorae C
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
RD 1 Box 391	Self Spouse Child X Other	RD 1 Box 391
CITY: DuBois / STATE: PA	8. PATIENT STATUS: Single X Married Other	CITY: DuBois / STATE: PA
ZIP CODE: 15801 / TELEPHONE (Include Area Code): (814) 375-1019	Employed Full-Time Student Part-Time Student	ZIP CODE: 15801 / TELEPHONE (INCLUDE AREA CODE): (814) 375-1019
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Lorae C Fairman	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 17748422803	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES X NO	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: Invevsys Energy Mete
c. EMPLOYER'S NAME OR SCHOOL NAME: Invevsys Energy Mete	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA	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 060702

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: Mark A Piasio MD	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 X 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. 82322 2. V674 3. 82322 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 05 28 02	22	4	73590	26rt	1 2	28 00	1				
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
25-1715230	fairse539472	X YES NO	$ 28 00	$ 0 00	$ 28 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#
R Boron MD	DuBois Reg Medical Ctr DuBois, PA 15801 DU390086	DuBois Radiologists Inc. PO Box 1106 DuBois PA 15801
SIGNED 25-1715230 DATE 060702		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

IN THIS AREA [redacted]

HUNT VALLEY MD 2103-1 INV # K335853

PICA

HEALTH INSURANCE CLAIM FORM

PRIMARY

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)
		006				

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): AU02778088W

PATIENT AND INSURED INFORMATION

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)
FAIRMAN, SEAN	10 20 1988 M [X] F [ ]	SAME
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
Rd 1 Box 391	Self [ ] Spouse [ ] Child [X] Other [ ]	SAME
CITY: DUBOIS	STATE: PA	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
ZIP CODE: 15801	TELEPHONE (Include Area Code): (814) 375-1019	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY	STATE	ZIP CODE	TELEPHONE (INCLUDE AREA CODE)
			( )

MAR 0 5 2002 BALTIMORE MAR 15 2002 RECEIVED

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
SAME		NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 177484228	a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO	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? [ ] YES [X] NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME: PO BOX 5200 SCRANTON PA 185055200	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA
d. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA	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 — SIGNED _____ DATE 02/02/02

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: DR MARK A PIASIO	17a. I.D. NUMBER OF REFERRING PHYSICIAN: A14232	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. E92 89 — 3. 827 0
2. 818 0 — 4. 812 00

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
02 02 02	03 01 02	12		K0002		E928.9	100 00	1				
02 02 02	03 01 02	12		K0195	RR	E928.9	44 00	1				

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
540950139	[ ] [X]	188708934	[X] YES [ ] NO	$ 144 00	$	$ 144 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 #
SIGNED [signature] DATE 2/26/02	MEDI HOME HEALTH CARE 225 MAIN ST BROOKVILLE PA 15825 814 849-8278	MEDICAL SERVICES OF AMERICA I PO BOX 890412 CHARLOTTE NC 28289-0412 PIN# GRP# 303 957-0500

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** CO. # 1

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

IN THIS AREA [redacted]

EXECUTIVE PLAZA STE 800 (8544)
HUNT VALLEY MD 21093-1 INV # K335854

PICA

HEALTH INSURANCE CLAIM FORM PRIMARY [H90] PICA

CARRII

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): AU027780088W

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN, SEAN

3. PATIENT'S BIRTH DATE MM DD YY: 10 20 1938 SEX M [X] F [ ]

MAR 15 2002

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

5. PATIENT'S ADDRESS (No., Street): Rd.1 Box 391

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

7. INSURED'S ADDRESS (No., Street): SAME

CITY: DUBOIS STATE: PA

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

CITY STATE

ZIP CODE: 15801 TELEPHONE (Include Area Code): (814) 375-1019

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 1774844228

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? PLACE (State) YES [ ] NO [X]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME: PO BOX 65200 SCRANTON PA 185055200

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA

d. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA

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 SIGNED _____ DATE 02/02/02

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: DR MARK A PIASIO

17a. I.D. NUMBER OF REFERRING PHYSICIAN: A142J2

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. E92 89
2. 818 0
3. 827 0
4. 812 00

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 02 02	02 02 02	12		E0163	NU	E928.9	145 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 540950139 [X]

26. PATIENT'S ACCOUNT NO.: 1.887088934

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

28. TOTAL CHARGE $ 145 00

29. AMOUNT PAID $

30. BALANCE DUE $ 145 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 [signature] DATE 02/26/02

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
MEDI HOME HEALTH CARE
225 MAIN ST
BROOKVILLE PA 15825
814 849-8278

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
MEDICAL SERVICES OF AMERICA I
PO BOX 890412
CHARLOTTE NC 28289-0412
PIN# GRP# 803 957-0500

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE CO. # 1 FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

P & G Physical Therapy, Inc.

07/18/2003 Statement

602-1 West DuBois Ave
DuBois, PA 15801

(814)375-6830 ID # 25-1802909

Patient SEAN FAIRMAN
Account # FAIRSE
Acct Type SELF PAY
Referral MARK PIASIO
Provider EDWARD WELCH
Injured 01/30/2002
Employer
Pri Ins CIGNA HEALTHCARE

Diagnosis:
719.46 JOINT PAIN-L/LEG

ERNIE FAIRMAN
RD 1 BOX 391
DUBOIS, PA 15801

Date	CPT	Name	Charge Amount	Patient Amount	Patient Payment	Patient Credit	Insurance Payment	Insurance Credit	Open Balance
10/15/2002	99202	PT EVALUATION	75.00	15.00	-	-	60.00	-	15.00
10/15/2002	97530	FUNCTIONAL	80.00	24.00	-	-	56.00	-	24.00
10/16/2002	97530	FUNCTIONAL	80.00	24.00	-	-	56.00	-	24.00
10/16/2002	97140	MANUAL THERAPY TECHNIQUE	30.00	6.00	-	-	24.00	-	6.00
10/16/2002	97110	THERAPEUTIC	75.00	15.00	-	-	60.00	-	15.00
10/21/2002	97530	FUNCTIONAL	80.00	24.00	-	-	56.00	-	24.00
10/21/2002	97140	MANUAL THERAPY TECHNIQUE	30.00	6.00	-	-	24.00	-	6.00
10/21/2002	97110	THERAPEUTIC	75.00	15.00	-	-	60.00	-	15.00
10/25/2002	97530	FUNCTIONAL	80.00	24.00	-	-	56.00	-	24.00
10/25/2002	97140	MANUAL THERAPY TECHNIQUE	30.00	6.00	-	-	24.00	-	6.00
10/25/2002	97110	THERAPEUTIC	50.00	10.00	-	-	40.00	-	10.00
10/28/2002	97110	THERAPEUTIC	75.00	15.00	-	-	60.00	-	15.00
10/28/2002	97140	MANUAL THERAPY TECHNIQUE	30.00	6.00	-	-	24.00	-	6.00
10/28/2002	97530	FUNCTIONAL	80.00	24.00	-	-	56.00	-	24.00
10/30/2002	97530	FUNCTIONAL	80.00	24.00	-	-	56.00	-	24.00
10/30/2002	97140	MANUAL THERAPY TECHNIQUE	30.00	6.00	-	-	24.00	-	6.00
10/30/2002	97110	THERAPEUTIC	50.00	10.00	-	-	40.00	-	10.00
11/11/2002	97530	FUNCTIONAL	80.00	24.00	-	-	56.00	-	24.00
11/11/2002	97140	MANUAL THERAPY TECHNIQUE	30.00	6.00	-	-	24.00	-	6.00
11/11/2002	97110	THERAPEUTIC	75.00	15.00	-	-	60.00	-	15.00
11/13/2002	97530	FUNCTIONAL	80.00	24.00	-	-	56.00	-	24.00
11/13/2002	97140	MANUAL THERAPY TECHNIQUE	30.00	0.03	-	-	29.97	-	0.03
11/13/2002	97110	THERAPEUTIC	75.00	-	-	-	75.00	-	-

Continued on next page

P & G Physical Therapy, Inc.

07/18/2003 Statement

602-1 West DuBois Ave
DuBois, PA 15801

(814)375-6830 ID # 25-1802909

P & G Billing & Collection
Mary Lou Hanson
(740) 450-2905

Patient SEAN FAIRMAN
Account # FAIRSE
Acct Type SELF PAY
Referral MARK PIASIO
Provider EDWARD WELCH
Injured 01/30/2002
Employer
Pri Ins CIGNA HEALTHCARE

Diagnosis:
719.46 JOINT PAIN-L/LEG

ERNIE FAIRMAN
RD 1 BOX 391
DUBOIS, PA 15801

Date	CPT	Name	Charge Amount	Patient Amount	Patient Payment	Patient Credit	Insurance Payment	Insurance Credit	Open Balance
11/18/2002	97530	FUNCTIONAL	80.00	24.00	-	-	56.00	-	24.00
11/18/2002	97140	MANUAL THERAPY TECHNIQUE	30.00	6.00	-	-	24.00	-	6.00
11/18/2002	97110	THERAPEUTIC	75.00	15.00	-	-	60.00	-	15.00
11/20/2002	97530	FUNCTIONAL	80.00	24.00	-	-	56.00	-	24.00
11/20/2002	97140	MANUAL THERAPY TECHNIQUE	30.00	6.00	-	-	24.00	-	6.00
11/20/2002	97110	THERAPEUTIC	75.00	15.00	-	-	60.00	-	15.00
11/25/2002	97530	FUNCTIONAL	80.00	24.00	-	-	56.00	-	24.00
11/25/2002	97140	MANUAL THERAPY TECHNIQUE	30.00	6.00	-	-	24.00	-	6.00
11/25/2002	97110	THERAPEUTIC	75.00	39.00	-	-	36.00	-	39.00
11/26/2002	97530	FUNCTIONAL	80.00	44.00	-	-	36.00	-	44.00
11/26/2002	97140	MANUAL THERAPY TECHNIQUE	30.00	6.00	-	-	24.00	-	6.00
11/26/2002	97110	THERAPEUTIC	75.00	39.00	-	-	36.00	-	39.00
Account Totals			2140.00	571.03	-	-	1568.97	-	571.03

*** COMMENT ***

Amount Due **571.03**

[Please detach and remit with payment]

P & G Physical Therapy, Inc.
602-1 West DuBois Ave
DuBois, PA 15801
(814)375-6830
ID # 25-1802909

Patient SEAN FAIRMAN
Account # FAIRSE

07/18/2003 Statement

(Please check one of the following)
[ ] MasterCard [ ] Visa [ ] Cash [ ] Check
[ ] Money Order

Card # _____ Amount: $_____

Signature _____ Exp. ___/___/___

Account Balance	571.03
Patient Balance	571.03
Amount Due	571.03

P & G Physical Therapy, Inc.

07/18/2003 Statement

602-1 West DuBois Ave
DuBois, PA 15801

(814)375-6830 ID # 25-1802909

Patient SEAN FAIRMAN
Account # FAISEA
Acct Type SELF PAY
Referral MARK PIASIO
Provider EDWARD WELCH
Injured 01/30/2002
Employer
Pri Ins CIGNA HEALTHCARE

Diagnosis:
823.20 FX SHAFT TIBIA-CLOSED

ERNIE FAIRMAN
RD 1 BOX 391
DUBOIS, PA 15801

Date	CPT	Name	Charge Amount	Patient Amount	Patient Payment	Patient Credit	Insurance Payment	Insurance Credit	Open Balance
05/08/2002	97140	Manual tech --plus	40.00	-	-	-	26.06	13.94	-
05/08/2002	97530	FUNCTIONAL	40.00	-	-	-	34.60	5.40	-
05/08/2002	97001	PT EVAL	75.00	-	-	-	71.06	3.94	-
05/10/2002	97140	Manual tech --plus	40.00	-	-	-	26.06	13.94	-
05/10/2002	97110	THERAPEUTIC	60.00	-	-	-	55.80	4.20	-
05/10/2002	97530	Functional ex plus	120.00	-	-	-	51.42	68.58	-
05/13/2002	97530	FUNCTIONAL	80.00	16.00	-	-	64.00	-	16.00
05/13/2002	97140	MANUAL THERAPY TECHNIQUE	40.00	8.00	-	-	32.00	-	8.00
05/13/2002	97110	THERAPEUTIC	30.00	6.00	-	-	24.00	-	6.00
05/14/2002	97110	THERAPEUTIC	60.00	12.00	-	-	48.00	-	12.00
05/14/2002	97140	MANUAL THERAPY TECHNIQUE	40.00	8.00	-	-	32.00	-	8.00
05/14/2002	97530	FUNCTIONAL	40.00	12.00	-	-	28.00	-	12.00
05/17/2002	97530	FUNCTIONAL	40.00	12.00	-	-	28.00	-	12.00
05/17/2002	97140	MANUAL THERAPY TECHNIQUE	40.00	12.00	-	-	28.00	-	12.00
05/17/2002	97110	THERAPEUTIC	60.00	12.00	-	-	48.00	-	12.00
05/22/2002	97110	THERAPEUTIC	60.00	12.00	-	-	48.00	-	12.00
05/22/2002	97140	MANUAL THERAPY TECHNIQUE	40.00	12.00	-	-	28.00	-	12.00
05/22/2002	97530	FUNCTIONAL	40.00	8.00	-	-	32.00	-	8.00
05/24/2002	97530	FUNCTIONAL	40.00	12.00	-	-	28.00	-	12.00
05/24/2002	97140	MANUAL THERAPY TECHNIQUE	40.00	12.00	-	-	28.00	-	12.00
05/24/2002	97110	THERAPEUTIC	60.00	12.00	-	-	48.00	-	12.00
05/29/2002	97110	THERAPEUTIC	60.00	12.00	-	-	48.00	-	12.00
05/29/2002	97140	MANUAL THERAPY TECHNIQUE	40.00	8.00	-	-	32.00	-	8.00

Continued on next page

P & G Physical Therapy, Inc.

07/18/2003 Statement

602-1 West DuBois Ave
DuBois, PA 15801

(814)375-6830 ID # 25-1802909
P & G Billing & Collection
Mary Lou Hanson
(740) 450-2905

Patient SEAN FAIRMAN
Account # FAISEA
Acct Type SELF PAY
Referral MARK PIASIO
Provider EDWARD WELCH
Injured 01/30/2002
Employer
Pri Ins CIGNA HEALTHCARE

Diagnosis:
823.20 FX SHAFT TIBIA-CLOSED

ERNIE FAIRMAN
RD 1 BOX 391
DUBOIS, PA 15801

Date	CPT	Name	Charge Amount	Patient Amount	Patient Payment	Patient Credit	Insurance Payment	Insurance Credit	Open Balance
05/29/2002	97530	FUNCTIONAL	40.00	12.00	-	-	28.00	-	12.00
05/31/2002	97530	FUNCTIONAL	40.00	12.00	-	-	28.00	-	12.00
05/31/2002	97140	MANUAL THERAPY TECHNIQUE	40.00	8.00	-	-	32.00	-	8.00
05/31/2002	97110	THERAPEUTIC	60.00	12.00	-	-	48.00	-	12.00
Account Totals			1365.00	230.00	-	-	1025.00	110.00	230.00

*** COMMENT ***

Amount Due **230.00**

[Please detach and remit with payment]

P & G Physical Therapy, Inc.
602-1 West DuBois Ave
DuBois, PA 15801
(814)375-6830
ID # 25-1802909

Patient SEAN FAIRMAN
Account # FAISEA

OCG CLAIMS
JUL 25 2003
P. VERISH

07/18/2003 Statement

(Please check one of the following)
[ ] MasterCard [ ] Visa [ ] Cash [ ] Check
[ ] Money Order

Card # _____ Amount: $_____

Signature _____ Exp. ___/___/___

Account Balance	230.00
Patient Balance	230.00
Amount Due	230.00

ACCOUNT NO. 188-70-8934 STATEMENT DATE 06/05/03

AMOUNT ENCLOSED $_____

MEDICAL SERVICES OF AMERICA
P.O. BOX 1928 171 MONROE LANE
LEXINGTON, SC 29071-1928

MASTERCARD/VISA PAYMENTS

ACCOUNT NO. _____ EXP. DATE _____

SIGNATURE OF CARDHOLDER X _____

MAKE CHECK PAYABLE TO: MEDI HOME HEALTH CARE 01-29

SEAN FAIRMAN
C/O LORAE FAIRMAN
RR 1 BOX 391
DU BOIS PA 15801-8747

MEDICAL SERVICES OF AMERICA
P.O. BOX 890412
CHARLOTTE, NC 28289-0412

PLEASE DETACH AND RETURN THIS PORTION WITH PAYMENT

ACCOUNT NO. 188-70-8934 MAKE CHECK PAYABLE TO: MEDI HOME HEALTH CARE 01-29

DATE	DESCRIPTION	CHARGE	CREDIT
	OUR RECORDS REFLECT THAT THE BELOW LISTED BALANCE IS STILL OUTSTANDING. THIS BALANCE IS FOR YOUR MEDICAL EQUIPMENT AND/OR SUPPLIES. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR LOCAL SERVICE PROVIDER		

PAYMENT DUE UPON RECEIPT OF THIS STATEMENT

STATEMENT DATE	PREVIOUS BALANCE	FINANCE CHARGE	TOTAL CHARGE	TOTAL CREDITS	NEW BALANCE
06/05/03	46.56	0.00	0.00	0.00	$46.56

ID:

JUN 27'03 6:41 NO.002 P.04

Raintree MRI Service
PO Box 1106
109 N Brady St
DuBois,PA 15801
814-371-1784

FOR X RAY INTERPRETATION

Account No.	Amount Due
Fairle-05	200.00
Date	**Amount Enclosed**
04/03/03	

Lorae Fairman
RD 1 Box 391
Hemlock Heights

DuBois,PA 15801

Remit Payment To: Raintree MRI Service

IF ANY QUESTIONS CALL (814) 371-1784

Fairman,Sean E

PLEASE REMIT PAYMENT BY
MAY 1, 2003.

Please remove and return this portion with your payment

Date	Dr	Procedure Code	Description	Diagnosis	Chrgs./Credits	Item Balance
01/13/03	o	73721	MRI ANY LOWER JOINT EXTR	71946	1000.00	200.00
02/17/03			Plan Payment: OHIO CASUALT		0.00	
			BENEFITS EXHAUSTED			
03/06/03			Plan Payment: CIGNA (CONNE		800.00-	
			Raintree MRI Service			
			PO Box 1106 109 N Brady St		e002	
Tax Id:25-1762010			DuBois,PA 15801		Phone: 814-371-1784	

Patient Name: Sean E Fairman

PLEASE RETAIN THIS PORTION OF STATEMENT FOR YOUR RECORDS

PAY THIS AMOUNT → 200.00

Account Analysis	Total	Current	30 - 60	61 - 90	91 - 120	120 +
Insurance Balance	0.00	0.00	0.00	0.00	0.00	0.00
Patient Balance	200.00	200.00	0.00	0.00	0.00	0.00
Account Balance	200.00					

PATIENT BALANCE AMOUNT DUE ↑

PLEASE DO NOT STAPLE IN THIS AREA

ATTEN RUTH ULMER
PO BOX 29621
RALEIGH NC 27626

003609 Ulmer

CARRIER

PICA [X][X]

HEALTH INSURANCE CLAIM FORM

PICA [X][X][X]

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): FPW25350369 PAID OUT CLAIM

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN E

3. PATIENT'S BIRTH DATE MM DD YY: 10 20 88 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN E

5. PATIENT'S ADDRESS (No., Street): RD 1 BOX 391

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

7. INSURED'S ADDRESS (No., Street): RD 1 BOX 391

FEB 19 2002

CITY: HEMLOCK HEIGHTS / DUBOIS — STATE: PA

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

CITY: DUBOIS — STATE: PA

RECEIVED

ZIP CODE: 15801 — TELEPHONE (Include Area Code): (814) 375 1019

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

ZIP CODE: 15801 — TELEPHONE (INCLUDE AREA CODE): (814) 375 1019

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN E

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 17748422803

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

a. INSURED'S DATE OF BIRTH MM DD YY: 10 20 88 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 10 20 88 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: OHIO CASUALITY

d. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA HEALTHCARE

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.

SIGNATURE ON FILE — SIGNED _____ DATE 021402

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

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 [X] $ CHARGES: 50 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. E814.7
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 027780880

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 12 02	02 12 02	3	35	99213		1 2	50 00	1				

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

26. PATIENT'S ACCOUNT NO.: 5233 1

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

28. TOTAL CHARGE: $ 50 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 50 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.)

SUNDAR CHANDRASEKHAR 021402

SIGNED DATE

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

GATEWAY OFFICE
M635 C MAPLE AVENUE
DUBOIS PA 15801

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

AREA MEDICAL ASSOC INC
635 C MAPLE AVE
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)

SERVICE LIMITED
BOX 8
DIANA, PA 15701
888-463-3488

Federal I.D.# 25-1638713 MEMBER: N

CALL NUMBER	BILLING DATE
4300190	02/06/02

PATIENT NAME
FAIRMAN, SEAN

DESCRIPTION OF SERVICES		
OM: LIBERTY BLVD	719.41	PAIN, SHOULDER
TO: DUBOIS REG MEDICAL CTR - WEST	729.5	PAIN, LEG
	780.0	Loss of Consciousnes
LLER: Police/Fire/911	E819.9	Motor Vehicle Accident

CHARGES/MEMO		
/01/02	ALS 1 E 01/01	445.00
	ALS MILEAGE - ALS	18.00
	Oxygen Administration	55.00
	CARDIAC MONITOR 01/01	85.00
	ALS - C-COLLAR	35.00

FEB 15 2002

Attn: Ruth Ulmer
Ext. 2618

TOTAL CREDITS TO DATE - 0.00

Thank You For Using AMSERV LIMITED. If insurance coverage is available to cover these cost, please complete & return the enclosed form. Thank you!

NET DUE → [illegible]

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

INVOICE

DATE	AMOUNT PAID
02/06/02	
CALL NUMBER	**ACCOUNT NUMBER**
4300190	3724

MAKE CHECKS PAYABLE TO:
AM SERV LIMITED
PO BOX 10
DIANA, PA 15701

FROM:
SEAN FAIRMAN
RD 1 BOX 351
DUBOIS, PA 15801

AMOUNT ENCLOSED $ _____

APPROVED OMB-0938-0008

OHIO CASUALTY INSURANCE
2510 WYCLIFF ROAD

RALEIGH, NC 27607

8D313

Jimer

RECEIVED MAY 05 2002

PICA

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)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): FPW25350369
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FAIRMAN, SEAN	3. PATIENT'S BIRTH DATE: 10 20 1988 SEX: M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): FAIRMAN SEAN	
5. PATIENT'S ADDRESS (No., Street): RD 1 BOX 391	6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child X / Other
7. INSURED'S ADDRESS (No., Street): RD 1 BOX 391	
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) 375-1019	
ZIP CODE: 15801 TELEPHONE (INCLUDE AREA CODE): (814) 375-1019	
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: 027780B8W	
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 10 20 1988 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: OHIO CASUALTY INSURANCE	
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.	

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: 02/08/2002

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 01 31 2002 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: MVA/LF SHOULDER AND RT LEG PAIN/LO C/02-4LPM	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. 719 41 PAIN, SHOULDER; 2. 729 5 PAIN, LEG; 3. 780 09 Loss of Cons; 4. E819 9 Motor Vehicl	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 01312002	01312002	41	9	A0427	SH	1,2,3,4	565 00	1			$53.35	
2 01312002	01312002	41	9	ALS MILEAGE - ALS A0390	SH	1,2,3,4	15 00	2			15.92	
3 01312002	01312002	41	9	Oxygen Administration A0422	SH	1,2,3,4	55 00	1			45.19	
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 25-1630713 SSN / EIN X	26. PATIENT'S ACCOUNT NO.: 4300190#A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES / NO	28. TOTAL CHARGE: $ 638 00
29. AMOUNT PAID: $ 0 00	30. BALANCE DUE: $ 638 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.)
KATHLEEN SCHAFFER
SIGNED 02/27/2002 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
FROM: LIBERTY BLVD
TO: DUBOIS REG MEDICAL CTR
DUBOIS, PA 15801

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
AM SERV LIMITED
PO BOX 8
INDIANA PA 15701
PIN# GRP# 1-888-463-3488

PHYSICIAN OR SUPPLIER INFORMATION

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

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)

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.
D1-OPW	02/21/03	1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SEAN FAIRMAN	03045-00134	M	14Y	02/14/03	02/14/03	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
302755 CIGNA	999999	17748422803
300005 COMMERCIAL PROF COMP	999999	17748422803

PAYMENT AMOUNT

GUARANTOR NAME AND ADDRESS
LORAE C FAIRMAN
RD 1 BOX 391
HEMLOCK HEIGHTS
DUBOIS PA 15801

☐ ☐ ☐

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
		402 ULTRASOUND					303.00
		TOTAL CHARGES					303.00
03/05/03	I1130	3 COMMERCIAL INS OUTPATIENT					-242.40
		TOTAL PAYMENTS/ADJUSTMENTS					-242.40

FINAL NOTICE

PATIENT NUMBER	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	60.60
03045-00134			

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.
D1-REF	10/11/02	1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SEAN FAIRMAN	02280-00591	M	14Y	10/07/02	10/07/02	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER	PAYMENT AMOUNT
350001 AUTO INSURANCE	999999	CLM#20020237777	
350002 AUTO INSURANCE PROF C	999999	CLM#20020237777	
350001 OHIO CASUALTY	999999	CLM AU02778088W	
350002 AUTO INSURANCE PROF C	999999	CLM AU02778088W	

GUARANTOR NAME AND ADDRESS: LORAE C FAIRMAN, RD 1 BOX 391, HEMLOCK HEIGHTS, DUBOIS PA 15801

☐ 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
		320 RADIOLOGY					271.00
		TOTAL CHARGES					271.00
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

FINAL NOTICE

PATIENT NUMBER	TOTAL AMOUNT DUE	271.00
02280-00591		

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

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

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.
D1-REF	05/10/02	1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SEAN FAIRMAN	02126-00861	M	14Y	05/06/02	05/06/02	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
350001 AUTO INSURANCE	999999	CLM#20020237777
350002 AUTO INSURANCE PROF C	999999	CLM#20020237777
350001 OHIO CASUALTY	999999	CLM AU02778088W
350002 AUTO INSURANCE PROF C	999999	CLM AU02778088W

PAYMENT AMOUNT

GUARANTOR NAME AND ADDRESS: LORAE C FAIRMAN, RD 1 BOX 391, HEMLOCK HEIGHTS, DUBOIS PA 15801

☐ 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
		320 RADIOLOGY					93.00
		TOTAL CHARGES					93.00
08/21/02	I1130	2 COMMERCIAL INS OUTPATIENT					-74.40
		TOTAL PAYMENTS/ADJUSTMENTS					-74.40

FINAL NOTICE

You must start making payments to keep these accts from going to collections.

PATIENT NUMBER	PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	18.60
02126-00861				

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

SETTLEMENT AGREEMENT AND RELEASE

This Settlement Agreement and Release (the "Settlement Agreement") is made and entered into this 11th day of December, 2003, by and between [among]:

"Petitioners" Sean Fairman, a minor, by and through his natural parents and guardians, Ernest and Lorae Fairman

"Insurer" Ohio Casualty Group

Recitals

A. On or about January 31, 2002, was injured in a bicycle accident which occurred on Liberty Boulevard, State Route 19, Clearfield County, Pennsylvania. Claimants allege that the accident and resulting physical and personal injuries arose out of certain alleged negligent acts or omissions of Barrett Johnston and have made a claim seeking monetary damages on account of those injuries. Barrett Johnston was insured through a policy of automobile liability insurance issued by Ohio Casualty Group which provided underinsured motorist benefits and coverage for medical bills.

B. Insurer is the liability insurer of Barrett Johnston, and as such, would be obligated to pay underinsured motorist benefits and outstanding medical bills which are covered by its policy with Barrett Johnston.

C. The parties desire to enter into this Settlement Agreement in order to provide for any certain payments in full settlement and discharge of all claims which have, or might be made, by reason of the incident described in Recital A above, upon the terms and conditions set forth below.

Agreement

The parties agree as follows:

1.0 Release and Discharge

1.1. In consideration of the payments set forth in Section 2, Petitioners hereby completely release and forever discharge Insurer from any and all past, present of future claims, demands, obligations, actions, causes of action, wrongful death claims, rights, damages, costs, losses of services, expenses and compensation of any nature whatsoever, whether based on a tort, contract or other theory of recovery, which the Petitioners now have, or which may hereafter accrue or otherwise be acquired, on account of, or may in any way grow out of the incident described in Recital A above including, without limitation, any and all known or unknown claims for bodily and personal injuries

EXHIBIT

C

to Petitioners, or any future wrongful death claim of Petitioners' representatives or heirs, which have resulted or may result from the alleged acts or omissions of the Insurer.

1.2 This release and discharge shall also apply to Insurer's past, present and future officers, directors, stockholders, attorneys, agents, servants, representatives, employees, subsidiaries, affiliates, partners, predecessors and successors in interest, and all other persons, firms or corporations with whom any of the former have been , are now, or may hereafter be affiliated.

1.3 This release, on the part of the Petitioners, shall be a fully binding and complete settlement among the Petitioners, the Insurer, and their heirs, assigns and successors.

1.4 The Petitioners acknowledge and agree that the release and discharge set forth above is a general release. Petitioners expressly waive and assume the risk of any and all claims for damages which exist as of this date, but of which the Petitioners do not know or suspect to exist, whether through ignorance, oversight, error, negligence, or otherwise, and which, if known, would materially affect Petitioners' decision to enter into this Settlement Agreement. All outstanding medical bills or liens, to the extent required to be paid in accordance with law, will be satisfied out of the proceeds of the within settlement. The Petitioners further agree that Petitioners have accepted payment of the sums specified herein as a complete compromise of matters involving disputed issues of law and fact. Petitioners assume the risk that the facts or law may be other than Petitioners believe.

2.0 Payments

In consideration of the release set forth above, the Insurer on behalf of the Decedent's automobile liability policy agrees to pay to the individuals named below ("Payees") the sums outlined in this Section 2 below:

2.1 Payments due at the time of settlement as follows:

Payee: Sean Fairman, by and through his natural parents and guardians, Ernest and Lorae Fairman

Amount: Twenty-Two Thousand One Hundred and No/100 ($22,100.00) Dollars, including Twenty Thousand and No/100 ($20,000.00) Dollars for underinsured motorist benefits and Two Thousand One Hundred and No/100 ($2,100.00) Dollars for outstanding medical bills.

All sums set forth herein constitute damages on account of personal injuries and sickness, within the meaning of Section 104(a)(2) of the Internal Revenue Code of 1986, as amended.

3.0 Representation of Comprehension of Document

In entering into this Settlement Agreement, Petitioners represent the Petitioners have completely read all terms hereof and that such terms are fully understood and voluntarily accepted by Petitioners and that Petitioners have been adequately represented, or had opportunity to seek representation by counsel of Petitioners' choice.

4.0 Warranty of Capacity to Execute Agreement

Petitioners represent and warrant that no other person or entity has, or has had, any interest in the claims, demands, obligations, or causes of action referred to in this Settlement Agreement, except as otherwise set forth herein; that Petitioners have the sole right and exclusive authority to execute this Settlement Agreement and receive the sums specified in it; and that Petitioners have not sold, assigned, transferred, conveyed or otherwise disposed of any of the claims, demands, obligations or causes of action referred to in this Settlement Agreement.

5.0 Confidentiality

The parties agree that neither they nor their attorneys nor representatives shall reveal to anyone, other than as may be mutually agreed to in writing, any of the terms of this Settlement Agreement or any of the amounts, numbers or terms and conditions of any sums payable to Payee hereunder.

6.0 Governing Law

This Settlement Agreement shall be construed and interpreted in accordance with the laws of the Commonwealth of Pennsylvania.

7.0 Additional Documents

All parties agree to cooperate fully and execute any and all supplementary documents and to take all additional actions which may be necessary or appropriate to give full force and effect to the basic terms and intent of this Settlement Agreement.

8.0 Entire Agreement and Successors in Interest

This Settlement Agreement contains the entire agreement the Petitioners and the Insurer with regard to the matters set forth in it and shall be binding upon and enure to the benefit of the executors, administrators, personal representatives, heirs, successors and assigns of each.

9.0 Effectiveness

This Settlement Agreement shall become effective immediately following execution by each of the parties.

Petitioner:

By: _____
Ernest Fairman, Natural Parent and Guardian of Sean Fairman, a Minor

Date: 12/11/03

By: _____
Lorae Fairman, Natural Parent and Guardian of Sean Fairman, a Minor

Date: 12/11/03

Insurer:

Ohio Casualty Group

By: Patricia A Vasek
Title: Claims Representative
Date: 11-19-03

AFFIDAVIT

Before me, the undersigned authority, personally appeared Ernest and Lorae Fairman, Natural Parents and Guardians of Sean Fairman, a Minor, who being duly sworn according to the law, depose and state that they have read the foregoing Petition for Court Approval of Settlement of the Action of a Minor, and that the contents thereof are true and correct to the best of their knowledge, information and belief, that the terms of the foregoing Petition have been fully explained to them by counsel, and that they understand the terms thereof and agree that the settlement is in the best interest of their child, Sean Fairman.

By: _____
Ernest Fairman, Natural Parent and
Guardian of Sean Fairman, a Minor

By: _____
Lorae Fairman, Natural Parent and
Guardian of Sean Fairman, a Minor

SWORN to and SUBSCRIBED before me
this 11th day of December, 2003.

By: _____
Notary Public

NOTARIAL SEAL
Marlene E. Duttry, Notary Public
City of Du Bois, Clearfield County
My commission expires August 22, 2006

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

IN RE: SEAN FAIRMAN, a Minor, by and through his Natural Parents and Guardians, ERNEST and LORAE FAIRMAN,	)	CIVIL ACTION
	)	No: 03-1860-CD
Petitioner.	)	

FILED

DEC 26 2003

0/12:10/m

William A. Shaw

Prothonotary/Clerk of Courts

2 cert to Atty.

ORDER OF COURT

AND NOW, to wit, this 24 day of December, 2003, upon presentation in open court and it appearing that settlement between the parties is in the best interest of the Minor-Petitioner, said settlement is hereby approved pursuant to the following terms:

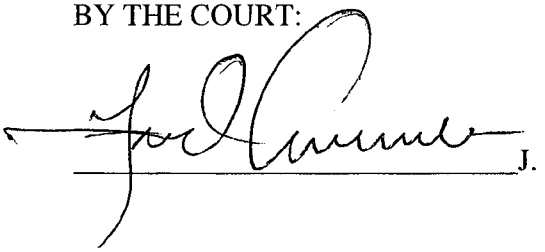
1. Minor-Petitioner, Sean Fairman, by and through his natural parents and guardians, Ernest and Lorae Fairman settled his claim for underinsured motorist benefits and outstanding medical bills with Ohio Casualty Group.

2. Ohio Casualty Group will make a lump sum payment of Twenty-Two Thousand One Hundred and No/100 ($22,100.00) Dollars to Minor Petitioner, by and through his natural parents and guardians, Ernest and Lorae Fairman. Said payment will be placed by Tina A Aracri, Esquire, in a federally insured interest-bearing account in the name of the Minor Petitioner, not to be withdrawn and/or transferred to another account until the Minor-Petitioner attains the age of 18, or by further Order of Court.

3. Proof of Placement of the settlement proceeds in an interest-bearing account shall be filed with Court within thirty (30) days of the date of this Order by Tina A. Aracri, Esquire.

4. All costs and fees associated with obtaining court approval of the herein settlement agreement shall be borne by Ohio Casualty Group.

BY THE COURT:



J.

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing PETITION FOR COURT APPROVAL OF SETTLEMENT OF THE ACTION OF A MINOR was mailed by postage prepaid, First Class mail, to the following counsel of record this 16th day of December, 2003:

Ernest and Lorae Fairman
R.D. #1, Box 391
Hemlock Heights, DuBois, PA 15801

Tina A. Aracri, Esquire

FILED Atty pd. 85.00
m 11:00 Bt No CC
DEC 19 2003

William A. Shaw
Prothonotary/Clerk of Courts

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

IN RE: SEAN FAIRMAN, a Minor, by and through his Natural Parents and Guardians, ERNEST and LORAE FAIRMAN,

Petitioners.

CIVIL ACTION

No: 03-1860-CD

PROOF OF DEPOSIT OF SETTLEMENT PROCEEDS

COUNSEL OF RECORD FOR THIS PARTY:

DANIEL L. RIVETTI, ESQUIRE
PA I.D. # 73015

TINA A. ARACRI, ESQUIRE
PA I.D. #85327

ROBB LEONARD MULVIHILL
FIRM #249
2300 One Mellon Center
Pittsburgh, PA 15219

(412) 281-5431

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

IN RE: SEAN FAIRMAN, a Minor, by and through his Natural Parents and Guardians, ERNEST and LORAE FAIRMAN,	)	CIVIL ACTION
	)	
	)	No: 03-1860-CD
	)	
	)	
Petitioner.	)	
	)	

PROOF OF DEPOSIT OF SETTLEMENT PROCEEDS

AND NOW, comes the Petitioners, SEAN FAIRMAN, a Minor, by and through his Natural Parents and Guardians, ERNEST and LORAE FAIRMAN, by and through their attorneys, ROBB LEONARD MULVIHILL and TINA A. ARACRI, ESQUIRE, and files the within Proof of Deposit of Settlement Proceeds, which is attached hereto.

Respectfully submitted,

ROBB LEONARD MULVIHILL

By: _____
Tina A. Aracri, Esquire
Counsel for Ohio Casualty Group

Time Certificate of Deposit

COPY

Financial Institution: The Farmers National Bank of Emlenton, DuBois Office
861 Beaver Drive, PO Box 292, DuBois, PA 15801

1133543

Account Name: SEAN FAIRMAN BY AND THROUGH HIS NATURAL PARENTS AND GUARDIANS ERNEST AND LOREA FAIRMAN **SSN/TIN:** 188-70-8934

OWNERSHIP TYPE: Trust (not to be withdrawn or transferred until ageof 18)

Account Number	Issue Date	Deposit Amount	Term	Maturity Date
1133543	January 16, 2004	$20,000.00	84 Months	January 16, 2011

Rate Information: This Account is an interest bearing account. The interest rate on the account is 4.14% with an annual percentage yield of 4.20%.

The interest rate and annual percentage yield will not change for the term of the account. The interest rate will be in effect until January 16, 2011. Interest begins to accrue on the business day you deposit noncash items (for example, checks). Interest will be compounded quarterly and will be credited to the account quarterly. Interest on your account will be credited by adding the interest to the principal. The annual percentage yield assumes interest will remain on deposit until maturity. A withdrawal will reduce earnings.

Balance Information: We use the daily balance method to calculate the interest on the account. This method applies a daily periodic rate to the principal in the account each day. We will use an interest accrual basis of 365 for each day in the year.

Limitations: You must deposit $500.00 to open this account. You may not make additional deposits into this account. You may not make withdrawals from your account until the maturity date.

Time Account Information: Your account will mature on January 16, 2011. If you withdraw any of the principal before the maturity date, we may impose a penalty of the loss of three (3) months interest. This account will automatically renew. You will have ten (10) calendar days after the maturity date to withdraw funds without penalty.

Account Fees: The following fees apply to this account: Replacement/Interim Statements: $5.00; Account Research: $20/hr ($20 minimum); and Levys/Writs/Garnishments: $40.00.

NON TRANSFERABLE - NON NEGOTIABLE | Member FDIC | Signature and Title of Authorized Financial Institution Signer CSR

TIME DEPOSIT AGREEMENT - 84 MONTH CERTIFICATE OF DEPOSIT (NP)

We appreciate your decision to open a time deposit account with us. This Agreement sets forth certain conditions, rates, and rules that are specific to your Account. Each signer acknowledges that the Account Holder named has placed on deposit with the Financial Institution the Deposit Amount indicated, and has agreed to keep the funds on deposit until the Maturity Date. As used in this Agreement, the words "you", "your" or "yours" mean the Account Holder(s), the word "Account" means this Time Deposit Account and the word "Agreement" means this Time Deposit Agreement, and the words "we", "us" and "our" mean the Financial Institution. This Account is effective as of the Issue Date and is valid as of the date we receive credit for noncash items (such as checks drawn on other financial institutions) deposited to open the Account. Deposits of foreign currency will be converted to U.S. funds as of the date of deposit and will be reflected as such on our records.

ISSUE DATE. If you open a time deposit account with us after 4:00 PM on a business day that we are open, we will consider that the transaction was made at the opening of the next business day for issue date and effective date purposes.

INTEREST RATE. The interest rate is the annual rate of interest paid on the Account which does not reflect compounding ("Interest Rate"), and is based upon the interest accrual basis described above.

AUTOMATIC RENEWAL POLICY. If the Account will automatically renew as described above, the principal amount and all paid earned interest that has not been withdrawn will automatically renew on each Maturity Date for the term described above in the Time Account Information section. Interest on renewed accounts will be calculated at the interest rate then in effect for time deposits of that Deposit Amount and term. If you wish to withdraw funds from your Account, you must notify us during the grace period after the Maturity Date.

EARLY WITHDRAWAL PENALTY. You have agreed to keep the funds on deposit until the Maturity Date of your Account. Any withdrawal of all or part of the funds from your Account prior to maturity may result in an early withdrawal penalty. We will consider requests for early withdrawal and, if granted, the penalty as specified above will apply.

Minimum Required Penalty. If you withdraw money within six (6) days after the date of deposit, the Minimum Required penalty is seven (7) days' simple interest on the withdrawn funds. If partial early withdrawal(s) are permitted, we are required to impose the Minimum Required Penalty on the amount(s) withdrawn within six (6) days after each partial withdrawal. The early withdrawal penalty may be more than the Minimum Required Penalty. You pay the early withdrawal penalty by forfeiting part of the accrued interest on the Account. If your Account has not earned enough interest, or if the interest has been paid, we take the difference from the principal amount of your Account.

Exceptions. We may let you withdraw money from your Account before the Maturity Date without an early withdrawal penalty: (1) when one or more of you dies or is determined legally incompetent by a court or other administrative body of competent jurisdiction; or (2) when the Account is an Individual Retirement Account (IRA) established in accordance with 26 USC 408 and the money is paid within seven (7) days after the Account is opened; or (3) when the Account is a Keogh Plan (Keogh), if you forfeit at least the interest earned on the withdrawn funds; or (4) if the Account is an IRA or a Keogh Plan established pursuant to 26 USC 408 or 26 USC 401, when you reach age 59 1/2 or become disabled; or (5) within an applicable grace period (if any).

RIGHT OF SETOFF. Subject to applicable law, we may exercise our right of setoff or security interest against any and all of your Accounts (except IRA, Keogh plan and Trust Accounts) without notice, for any liability or debt of any of you, whether joint or individual, whether direct or contingent, whether now or hereafter existing, and whether arising from overdrafts, endorsements, guarantees, loans, attachments, garnishments, levies, attorneys' fees, or other obligations. If the Account is a joint or multiple-party account, each joint or multiple-party account holder authorizes us to exercise our right of setoff against any and all Accounts of each Account Holder.

OTHER ACCOUNT RULES. The following rules also apply to the Account.

Surrender of Instrument. We may require you to endorse and surrender this Agreement to us when you withdraw funds, transfer or close your Account. If you lose this Agreement, you agree to sign any affidavit of lost instrument, or other Agreement we may require, and agree to hold us harmless from liability, prior to our honoring your withdrawal or request.

Death of Account Holder. Each Account Holder agrees to notify us immediately upon the death of any other Account Holder. You agree that we may hold the funds in your Account until we have received all required documentation and instructions.

Indemnity. If you ask us to follow instructions that we believe might expose us to any claim, liability or damages, we may refuse to follow your instructions or may require a bond or other protection, including your agreement to indemnify us.

Customer Copy

CUSTOMER RECEIPT

DuBois Office
1103 44 01/16/04
84 MO CD/ S FAIRMAN 12:04 PM
Acct# 1133543 $20,000.00

Serving this area from this area!

THE FARMERS NATIONAL BANK
OF EMLENTON

CERTIFICATE OF AUTHORITY

(for Deposit Accounts)

Account Holder:	**SEAN FAIRMAN BY AND THROUGH HIS NATURAL PARENTS AND GUARDIANS ERNEST AND LOREA FAIRMAN** **RR 1 BOX 391 HEMLOCK HEIGHTS** **DUBOIS, PA 15801**	**Financial Institution:**	**The Farmers National Bank of Emlenton** **DuBois Office** **861 Beaver Drive** **PO Box 292** **DuBois, PA 15801**

IN CONSIDERATION OF the existing or proposed banking relationship between SEAN FAIRMAN BY AND THROUGH HIS NATURAL PARENTS AND GUARDIANS ERNEST AND LOREA FAIRMAN and Financial Institution, the persons signing below jointly and severally and on behalf of SEAN FAIRMAN BY AND THROUGH HIS NATURAL PARENTS AND GUARDIANS ERNEST AND LOREA FAIRMAN represent to Financial Institution and certify to Financial Institution that:

Account Holder. SEAN FAIRMAN BY AND THROUGH HIS NATURAL PARENTS AND GUARDIANS ERNEST AND LOREA FAIRMAN is the complete and correct name of the Account Holder. The following is a complete list of all assumed business names, if any, under which SEAN FAIRMAN BY AND THROUGH HIS NATURAL PARENTS AND GUARDIANS ERNEST AND LOREA FAIRMAN does business. SEAN FAIRMAN BY AND THROUGH HIS NATURAL PARENTS AND GUARDIANS ERNEST AND LOREA FAIRMAN has filed assumed business name listings with the following governmental entities on the indicated dates:

Signature Authorization. The Financial Institution named above, at any one or more of its offices or branches, is designated as a depository for the funds of SEAN FAIRMAN BY AND THROUGH HIS NATURAL PARENTS AND GUARDIANS ERNEST AND LOREA FAIRMAN, which may be withdrawn on checks, drafts, advices of debit, notes or other orders for the payment of monies bearing the following appropriate number of signatures:

Any **one** (1) of the following named partners, employees or designated individuals of SEAN FAIRMAN BY AND THROUGH HIS NATURAL PARENTS AND GUARDIANS ERNEST AND LOREA FAIRMAN ("Agents"), whose actual signatures are shown below:

and that the Financial Institution shall be and is authorized to honor and pay the same whether or not they are payable to bearer or to the individual order of any Agent or Agents signing the same. The Financial Institution is hereby directed to accept and pay without further inquiry any item drawn against Account 1133543 with the Financial Institution bearing the signature or signatures of Agents, as authorized above or otherwise, even though drawn or endorsed to the order of any Agent signing the same or tendered by such Agent for cashing or in payment of the individual obligation of such Agent or for deposit to the Agent's personal account, and the Financial Institution shall not be required or be under any obligation to inquire as to the circumstances of the issue or use of any item signed in accordance with the resolutions contained herein, or the application or disposition of such item or the proceeds of the item.

Agent's Authority. Any one of such Agents is authorized to endorse all checks, drafts, notes, and other items payable to or owned by Account Holder for deposit with the Financial Institution, or for collection or discount by the Financial Institution; and to accept drafts and other items payable at the Financial Institution.

The above named Agents are authorized and empowered to execute such other agreements, including, but not limited to, special depository agreements and arrangements regarding the manner, conditions, or purposes for which funds, checks, or items of Account Holder may be deposited, collected, or withdrawn and to perform such other acts as they deem reasonably necessary to carry out the provisions of these resolutions. The other agreements and other acts may not be contrary to the provisions contained in this Certificate of Authority.

Duration. The authority hereby conferred upon the above named Agents shall be and remain in full force and effect until written notice of any amendment or revocation thereof shall have been delivered to and received by the Financial Institution at each location where an account is maintained. Financial Institution shall be indemnified and held harmless from any loss suffered or any liability incurred by it in continuing to act in accordance with this authorization. Any such notice shall not affect any items in process at the time notice is given.

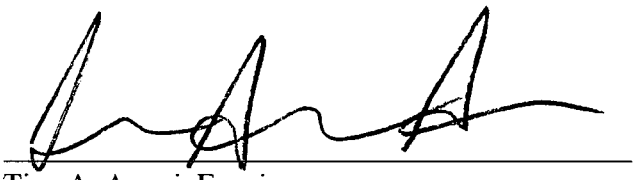
The rights of Financial Institution under this agreement are in addition to any other rights Financial Institution may have. Financial Institution need not accept this agreement for it to become effective. This agreement is dated: _____.

ACCOUNT HOLDER:

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing PROOF OF DEPOSIT OF SETTLEMENT PROCEEDS was mailed by postage prepaid, First Class mail, to the following counsel of record this 19th day of January, 2004:

Ernest and Lorae Fairman
R.D. #1, Box 391
Hemlock Heights
DuBois, PA 15801



Tina A. Aracri, Esquire

G.D. No.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

CIVIL DIVISION

IN RE: LORAE FAIRMAN, individually and as parent and natural guardian of SEAN FAIRMAN, a minor

G.D. No.

Issue No. 03-1860-CD

PETITION FOR LEAVE TO SETTLE CLAIMS OF MINOR, SEAN FAIRMAN

Code:

Filed on behalf of Defendant, Barrett Johnston

Counsel of record for this party:

DICKIE, McCAMEY & CHILCOTE, P.C.
Firm #067
Two PPG Place, Suite 400
Pittsburgh, PA 15222-5402

(412) 281-7272

G.D. No.

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

IN RE: LORAE FAIRMAN, individually and as parent and natural guardian of SEAN FAIRMAN, a minor)

PETITION FOR LEAVE TO SETTLE CLAIMS OF MINOR, SEAN FAIRMAN

AND NOW, comes the Defendant, Barrett Johnston, and his insurer, American Independent Insurance Company, petitions this Court for leave to settle and discontinue the minor's claims as against the Defendant, Barrett Johnston, and in support thereof sets forth as follows:

1. The above-captioned matter arises out of an automobile accident that occurred on or about January 31, 2002, in Dubois, Pennsylvania.

2. Sean Fairman was riding his friend's bicycle with the friend, Justin Zmitravich, riding on the back.

3. The two boys rode the bicycle out of the lower exit of the Dubois Middle School parking lot to cross Liberty Boulevard.

4. The boys proceeded to cross Liberty Boulevard, which is five lanes wide, two lanes southbound and two lanes northbound, with a center lane for turning.

5. The boys proceeded into the roadway, and when they got into the middle lane, a vehicle stopped in the left lane of the southbound traffic to wave them across.

6. Defendant, Barrett Johnston, was also traveling southbound on Liberty Boulevard, in the right, curb-side lane, at a speed of approximately 35 miles per hour.

7. After passing through the traffic light at Liberty Boulevard and Parkway Drive, the Defendant approached a large van or SUV in the left southbound lane, the same vehicle that waved the boys across Liberty Boulevard.

8. The boys on their bicycle came from in front of the van or SUV and the Defendant hit his brakes and swerved to the right to avoid the bicycle.

9. Justin Zmitravich jumped off the back of the bicycle, and the bicycle struck the left front corner of the Defendant's automobile.

10. Sean Fairman suffered a fractured leg and shoulder injuries.

11. The posted speed limit is 35 miles per hour, and there are no school warning signs or school zone signs in this area on the Boulevard, and the Defendant was not cited for any traffic violations.

12. Sean Fairman was treated for his injuries at Dubois Medical Center and received physical therapy through P & G Physical Therapy Inc.

13. The Defendant, Barrett Johnston is an insured of American Independent Insurance Company.

14. The insurer has tendered an offer of $15,000, the limits of the policy, to settle the claim of the minor, Sean Fairman. Lorae Fairman, the mother and legal guardian of the minor wishes to accept the offer as she believes it is reasonable.

15. Counsel for defendant is of the belief that this settlement is reasonable.

16. Lorae Fairman, on behalf of her son, Sean Fairman, signed a general release, whereby for the sole consideration of the sum of $15,000 paid by Defendant, Barrett Johnston, and his insurer, American Independent Insurance Company, releasing and discharging the Defendant and American Independent Insurance Company of and from any and all claims, demand, damages,

action, causes of action or suits at law or in equity of whatsoever kind or nature for any matter related to the accident occurring on or about January 31, 2002. The General Release was signed on August 4, 2003. A copy of the General Release is attached hereto, and made a part hereto marked Exhibit "A".

17. In signing this General Release on behalf of her son, Sean Fairman, Lorae Fairman acknowledged that she extinguished the rights of her son Sean Fairman, for any and all claims against the payers and agreed to hold payers harmless from any and all further claims of any type and agreed to indemnify payers for any future judgments and or costs arising from the accident on January 31, 2002.

18. The General Release includes any and all medical expenses arising from the alleged accident and any and all liens of any kind whatsoever. Lorae Fairman, acting on behalf of her son, Sean Fairman, expressly agreed to be responsible for paying such liens and medical expenses and that they would hold harmless the Defendant, Barrett Johnston, and American Independent Insurance Company for any claims by anyone for any expenses and or liens.

WHEREFORE, Your Petitioner, through counsel, respectfully petitions this Court to approve the minor's claims of Sean Fairman.

DICKIE, McCAMEY & CHILCOTE, P.C.

By: _____
Gregory R. Webber, Esquire

Claim #: 02-23777

GENERAL RELEASE

KNOW ALL MEN BY THESE PRESENTS THAT:

I/We, **Lorae Fairman, p/n/g of Sean Fairman**, for the sole consideration of the sum of **Fifteen thousand and 00/100 dollars ($15,000.00)** to Me/Us in hand paid by **Barrett Johnston and American Independent Ins. Company**, PAYERS, the receipt of which is hereby acknowledged, have released and discharged, and by these presents do for myself/ourselves my/our heirs, executors, administrators, and assigns release and forever discharge the said PAYERS and all other persons, firms, and corporation, both known and unknown, of and from any and all claims, demand, damages, action, causes of action or suits at law or in equity of whatsoever kind or nature, for or because of any matter or thing done, omitted or suffered to be done by anyone prior to and including the date hereof on account of all injuries both to person or property resulting, or to result, from any accident which occurred on or about **January 31st., 2002 at or near Liberty Blvd., Dubois, PA.** *

I/We understand the PAYERS, by reason of agreeing to this compromise payment, neither admits nor denies liability of any sort, and the PAYERS have made no agreement or promise to do or omit to do any act or thing not herein set forth and I/We further understand that this release is made as a compromise to avoid expense and to terminal all controversy and/or claims for the injuries or damages of whatsoever nature, known or unknown, including future developments thereof, in any way growing our of or connected with said accident.

Lorae Fairman is acting in his/her role as parent and natural guardian of **Sean Fairman** in the execution of this release. In doing so, he/she acknowledges that he/she is extinguishing the rights of **Sean Fairman** for any and all claims against PAYERS and he/she hereby agrees to hold PAYERS harmless from any and all further claims of any type and he/she agrees to indemnify PAYERS for any future judgments and or costs arising from the accident on **January 31st, 2002.**

This settlement includes any and all medical expenses arising from the alleged accident and any and all liens of any kind, whatsoever and I/We expressly agree that I/We shall be responsible for paying them and that I/We will indemnify and hold harmless the PAYERS for any claims by anyone for any expenses or liens.

I/We admit that no representation of fact or opinion has been made by the said PAYERS or anyone on her, his or their behalf to induce this compromise with respect to the extent, nature or permanency of said injuries or as to the likelihood of future complications or recovery therefrom and that the sum paid is solely by way of compromise of a disputed claim, and that in determining said sum there has been taken into consideration the fact that serious or unexpected consequences might result form the present injuries, known or unknown, from said accident, and it is therefore specifically agreed that this release shall be a complete bar to all claims or suit for injuries or damages of whatsoever nature resulting or to result from said accident. However, it is understood that by the execution of this release that I do not intend to give up any possible claim for malpractice by any medical provider who treated me for this accident.

Notarial Seal
Carl E. Reagle, Notary Public
Sandy Twp., Clearfield County
My Commission Expires Apr. 4, 2005
Member, Pennsylvania Association of Notaries

IN WITNESS WHEREOF I/We hereunto set my/our hand(s) this 4 day of August 2003.

In the presence of:

Carl Reagle

Lorae Fairman
Claimant

* THIS RELEASE DOES NOT COVER ANY ACTIONS FOR MEDICAL MAL PRACTICE AND/OR CLAIMS FOR UNDERINSURED COVERAGE OR ANY OTHER FIRST PARTY CLAIMS.

ALL-STATE LEGAL®
EXHIBIT
A

G.D. No.

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

IN RE: LORAE FAIRMAN, individually and as parent and natural guardian of SEAN FAIRMAN, a minor)

ORDER OF COURT

AND NOW, to-wit, this _____ day of _____, 2004, upon consideration of the foregoing Petition and representations of the Petitioner and his counsel, all claims of the minor Plaintiff, Sean Fairman are hereby settled and discontinued of record, and those claims of the minor Plaintiff identified above are dismissed with prejudice.

BY THE COURT:

_____ J.

G.D. No.

CERTIFICATE OF SERVICE

I, Gregory R. Webber, Esquire, hereby certify that a true and correct copy of the foregoing **PETITION FOR LEAVE TO SETTLE CLAIMS OF MINOR, SEAN FAIRMAN** was served this 27th day of February, 2004, by United States First Class Mail, postage prepaid, to:

Lorae Fairman
R.D. 1
Box 391
Dubois, PA 15801

Respectfully submitted,

DICKIE, MCCAMEY & CHILCOTE, P.C.

Gregory R. Webber, Esquire

FILED

m 3.39

MAR 1 6 2004

William A. Shaw
Prothonotary

CA

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

SEAN FAIRMAN, a Minor, by and through his Natural Parents and Guardians , ERNEST AND LORAE FAIRMAN	:	No. 03-1860-CD

ORDER

NOW, this 16th day of March, 2004, upon consideration of Attorney Webber's Petition for Leave to Settle Claims of a Minor, a Rule is hereby issued upon the parties to Appear and Show Cause why the Petition should not be granted. Argument is scheduled the 1 day of April, 2004, at 9:30 A.M. in Courtroom No. 1, Clearfield County Courthouse, Clearfield, PA.

BY THE COURT:

Fredric J. Ammerman

FREDRIC J. AMMERMAN
President Judge

FILED

MAR 16 2004

William A. Shaw
Prothonotary

FILED

0 3.40 BA 2 cc & Memo of Service to Atty Weaver

MAR 16 2004

William A. Shaw
Prothonotary

G.D. No.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

CIVIL DIVISION

G.D. No.

IN RE: LORAE FAIRMAN, individually and as parent and natural guardian of SEAN FAIRMAN, a minor

Issue No. 03-1860-CD

AFFIDAVIT OF SERVICE OF RULE TO SHOW CAUSE

Code:

Filed on behalf of Defendant, Barrett Johnston

Counsel of record for this party:

DICKIE, McCAMEY & CHILCOTE, P.C.
Firm #067
Two PPG Place, Suite 400
Pittsburgh, PA 15222-5402

(412) 281-7272

G.D. No.

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

IN RE: LORAE FAIRMAN, individually and as parent and natural guardian of SEAN FAIRMAN, a minor)

AFFIDAVIT OF SERVICE OF RULE TO SHOW CAUSE

Before me, the undersigned authority, personally appeared Gregory R. Webber, Esquire, who deposes and says that pursuant to Pa. R. Civ. P. 404 and 403 that he mailed a copy of the Rule to Show Causes filed in the above-referenced matter to Lorae Fairman, R.D. 1, Box 391, Dubois, PA 15801 by certified mail, return receipt requested.

Respectfully submitted,

DICKIE, McCAMEY & CHILCOTE, P.C.

By: _____
Gregory R. Webber

SWORN TO and subscribed before
me this 23rd day of March, 2004

_____
Notary Public

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Elaine Wapiennik, Notary Public
City Of Pittsburgh, Allegheny County
My Commission Expires Jan. 30, 2008
Member, Pennsylvania Association Of Notaries

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

SEAN FAIRMAN, a Minor, by and through his Natural Parents and Guardians , ERNEST AND LORAE FAIRMAN	:	No. 03-1860-CD

ORDER

NOW, this 16th day of March, 2004, upon consideration of Attorney Webber's Petition for Leave to Settle Claims of a Minor, a Rule is hereby issued upon the parties to Appear and Show Cause why the Petition should not be granted. Argument is scheduled the 1 day of April, 2004, at 9:30 A.M. in Courtroom No. 1, Clearfield County Courthouse, Clearfield, PA.

BY THE COURT:

/s/ Fredric J. Ammerman

FREDRIC J. AMMERMAN
President Judge

I hereby certify this to be a true and attested copy of the original statement filed in this case.

MAR 16 2004

Attest.

Prothonotary/
Clerk of Courts

CERTIFICATE OF SERVICE

I, Gregory R. Webber, Esquire, hereby certify that a true and correct copy of the foregoing **AFFIDAVIT OF SERVICE OF RULE TO SHOW CAUSE** was served this 23 day of March, 2004, by United States First Class Mail, postage prepaid, to:

Lorae Fairman
R.D. 1
Box 391
Dubois, PA 15801

Respectfully submitted,

DICKIE, MCCAMEY & CHILCOTE, P.C.

Gregory R. Webber, Esquire

IN THE COURT OF COMMON PLEAS

OF CLEARFIELD COUNTY, PENNSYLVANIA

CIVIL DIVISION

FILED

APR 06 2004

William A. Shaw
Prothonotary

SEAN FAIRMAN, a Minor, by :

and through his Parents : No. 03-1860-CD

and Natural Guardians, :

ERNEST AND LORAE FAIRMAN :

O R D E R

NOW, this 1st day of April, 2004, upon presentation in open court of the Petition for Leave to Settle Claims of Minor, Sean Fairman, with the Court further noting that the Juvenile's natural mother has appeared and that the parties appear to be entering into the settlement voluntarily, knowingly and intelligently and that the settlement is in the best interests of the minor; the said settlement is hereby approved pursuant to the following terms:

1. The Minor-Petitioner, Sean Fairman, by and through his natural parents and guardians, Ernest and Lorae Fairman, are settling his claim for insurance benefits with the American Independent Insurance Company;

2. American Independent Insurance Company will make a lump sum payment of Fifteen Thousand ($15,000.00) dollars to the Minor-Petitioner, by and through his natural parents and guardians, the said Ernest and Lorae Fairman.

Said payment to be placed by Gregory R. Webber, Esquire, in a federally insured, interest-bearing account in the name of the Minor-Petitioner, not to be withdrawn and/or transferred to another account until the Minor-Petitioner attains the age of twenty-five (25) or by further Order of Court;

3. Proof of placement of the said settlement proceeds in an interest-bearing account shall be filed with the Court within thirty (30) days of the date of this Order by Gregory R. Webber, Esquire;

4. All costs and fees associated with obtaining court approval of this portion of the settlement shall be borne by the American Independent Insurance Company.

BY THE COURT,

Judge J. Cummerman

President Judge

FILED

0 10:30 BA 2 cc to Atty Webber
2 cc atty Asaui

APR 06 2004

William A. Shaw
Prothonotary

G.D. No.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

IN RE: LORAE FAIRMAN, individually and as parent and natural guardian of SEAN FAIRMAN, a minor

CIVIL DIVISION

No. 03-1860 - CD

Issue No.

PROOF OF DEPOSIT

Code:

Counsel of record for this party:

Gregory R. Webber, Esq.
PA. I.D. #83749

DICKIE, McCAMEY & CHILCOTE, P.C.
Firm #067
Two PPG Place, Suite 400
Pittsburgh, PA 15222-5402

(412) 281-7272

G.D. No.

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

IN RE: LORAE FAIRMAN, individually and as parent and natural guardian of SEAN FAIRMAN, a minor	) No. 03-1860 - CD

PROOF OF DEPOSIT

AND NOW, comes the Defendant, American Independent Insurance Company, by and through its attorneys, Dickie, McCamey & Chilcote, P.C. and Gregory R. Webber, Esquire, and hereby files Proof of Deposit, averring as follows:

1. A settlement was entered into whereby Sean Fairman was to be paid $15,000.00 by and through his natural guardians.

2. American Independent Insurance Company received permission of Court to settle this claim by Order dated April 1, 2004. This Order, which is attached hereto as Exhibit A, instructed Gregory R. Webber to deposit $15,000.00 into an interest bearing federally insured account for Sean Fairman.

3. Gregory R. Webber engaged in communication with Earnest and Lorae Fairman, the parents and natural guardians of Sean Fairman, who had arranged for a ten year CD, which is interest bearing and federally insured, to be set up in the name of Sean Fairman through Farmers National Bank.

4. Farmers National Bank was informed of the restrictions placed on this account by the Court's Order.

5. On April 30, 2004, the sum of $15,000.00 was deposited into Sean Fairman's account pursuant to the Court's instructions. Correspondence of Farmers National Bank verifying this deposit is attached hereto as Exhibit B.

6. Accordingly, undersigned counsel certifies that the settlement proceeds have been deposited in the appropriate account.

Respectfully submitted,

DICKIE, McCAMEY & CHILCOTE, P.C.

By: _____
Gregory R. Webber

IN THE COURT OF COMMON PLEAS

OF CLEARFIELD COUNTY, PENNSYLVANIA

CIVIL DIVISION

SEAN FAIRMAN, a Minor, by :

and through his Parents : No. 03-1860-CD

and Natural Guardians, :

ERNEST AND LORAE FAIRMAN :

O R D E R

NOW, this 1st day of April, 2004, upon presentation in open court of the Petition for Leave to Settle Claims of Minor, Sean Fairman, with the Court further noting that the Juvenile's natural mother has appeared and that the parties appear to be entering into the settlement voluntarily, knowingly and intelligently and that the settlement is in the best interests of the minor; the said settlement is hereby approved pursuant to the following terms:

1. The Minor-Petitioner, Sean Fairman, by and through his natural parents and guardians, Ernest and Lorae Fairman, are settling his claim for insurance benefits with the American Independent Insurance Company;

2. American Independent Insurance Company will make a lump sum payment of Fifteen Thousand ($15,000.00) dollars to the Minor-Petitioner, by and through his natural parents and guardians, the said Ernest and Lorae Fairman.

Said payment to be placed by Gregory R. Webber, Esquire, in a federally insured, interest-bearing account in the name of the Minor-Petitioner, not to be withdrawn and/or transferred to another account until the Minor-Petitioner attains the age of twenty-five (25) or by further Order of Court;

3. Proof of placement of the said settlement proceeds in an interest-bearing account shall be filed with the Court within thirty (30) days of the date of this Order by Gregory R. Webber, Esquire;

4. All costs and fees associated with obtaining court approval of this portion of the settlement shall be borne by the American Independent Insurance Company.

BY THE COURT,

/s/ Fredric J. Ammerman

President Judge

I hereby certify this to be a true and attested copy of the original statement filed in this case.

APR 06 2004

Attest.

Prothonotary/
Clerk of Courts

Farmers National Bank

P.O. BOX 292 861 BEAVER DRIVE DUBOIS, PENNSYLVANIA 15801
Phone 814-371-2166 Fax 814-375-0646

April 30, 2004

Gregory Webber
Law Office of Vickie McCamey & Chilcote
Two PPG Place
Suite 400
Pittsburgh, PA 15222

RE: Sean Fairman account

Mr. Webber:

This letter is in reference to a 10 year certificate of deposit account that was opened for Sean Fairman.

I received a check in the amount of $15,000.00 from American Independent Insurance Company to open this interest bearing account, which is FDIC approved.

The funds deposited to the certificate of deposit are not to be moved or transferred until Sean Fairman reaches the age of 25 years old.

Sincerely,

Joanne M. Agosti
Customer Service Representative
Farmers National Bank

EXHIBIT
B

PENGAD-Bayonne, N. J.

CERTIFICATE OF SERVICE

I, Gregory R. Webber, Esquire, hereby certify that a true and correct copy of the foregoing **PROOF OF DEPOSIT** was served this 4th day of May, 2004, by United States First Class Mail, postage prepaid, to:

Mr. Earnest Fairman
Ms. Lorae Fairman
R.D. 1
Box 391
Dubois, PA 15801

Respectfully submitted,

DICKIE, MCCAMEY & CHILCOTE, P.C.

Gregory R. Webber, Esquire

FILED

M 11:04BA NO CC

MAY 05 2004

William A. Shaw
Prothonotary

G.D. No.

CA

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

CIVIL DIVISION

No. 03-1860 - CD

IN RE: LORAE FAIRMAN, individually and as parent and natural guardian of SEAN FAIRMAN, a minor

Issue No.

MOTION TO AMEND COURT ORDER/RELEASE FUNDS

Code:

Filed on behalf of Defendant, Barrett Johnston

Counsel of record for this party:

DICKIE, McCAMEY & CHILCOTE, P.C.
Firm #067
Two PPG Place, Suite 400
Pittsburgh, PA 15222-5402

(412) 281-7272

G.D. No.

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

IN RE: LORAE FAIRMAN, individually and as parent and natural guardian of SEAN FAIRMAN, a minor	) No. 03-1860 - CD

MOTION TO AMEND COURT ORDER/RELEASE FUNDS

AND NOW, comes the Defendant, Barrett Johnston, and his insurer, American Independent Insurance Company, and hereby files this Motion to Amend Court Order/Release Funds and in support thereof sets forth as follows:

1. Pursuant to an April 1, 2004 Order of Court, American Independent Insurance Company forwarded $15,000.00 to Farmers National Bank which was deposited into an account for Sean Fairman, a minor.

2. On the date of deposit, Lorea Fairman, mother of Sean Fairman, contacted Gregory R. Webber, the undersigned counsel for American Independent Insurance Company, to state that $3,500.00 of those funds needed to be utilized to satisfy outstanding medical bills of CIGNA. Further, Mrs. Fairman indicated that she brought this matter before the Court at the time of the argument on the Petition for Approval of Minor's Settlement and provided documentation attached as Exhibit "A".

3. Through communications with representatives of Farmers National Bank and Mrs. Fairman, it has been agreed that $3,500.00 will be removed from the fund and forwarded for payment to CIGNA. Thereafter, the remaining $11,500.00 will be placed into an interest bearing, federally insured CD for Sean Fairman.

4. Accordingly, the parties request that the Court amend the April 1, 2004 Order to indicate that the $15,000.00 deposited for Sean Fairman be allocated as $11,500.00 in a Certificate of Deposit for Sean Fairman and $3,500.00 to be utilized to satisfy outstanding bills to CIGNA.

Respectfully submitted,

DICKIE, McCAMEY & CHILCOTE, P.C.

By: _____
Gregory R. Webber, Esquire

Primax Recoveries Incorporated

P.O. Box 7135
Bloomfield, CT 06002-7135

May 30, 2003

Lorae C. Fairman
R D 1 Box 391 Hemlock Hgts
Dubois, PA 15801

Insured:	Lorae C. Fairman
Our Case ID:	3024952
Patient:	Sean E. Fairman
Date of Incident:	01/31/2002
Our Client:	CIGNA HealthCare-ES Proclaim Std

Dear Lorae C. Fairman:

Enclosed please find a list of benefits paid to date on behalf of Sean E. Fairman by CIGNA HealthCare-ES Proclaim Std. Because there may be additional benefits, please contact me prior to settlement of the claim so that the benefits can be updated. Should you have any questions, please contact me.

Very truly yours,

John W. Desmerais
Primax Recoveries Incorporated
(800) 442-2075 Ext. 6343

10% Reduction
owe
3,500.00

EXHIBIT
A

Insured: Lorae C. Fairman
Our Case ID: 3024952
Date of Accident: 01/31/2002
Our Client: CIGNA HealthCare-ES Proclaim Std

Claimant: Sean E. Fairman

Claim Number	CPT	Provider	Dates of Service	Claim Amount	Benefit Amount
0650216807754		MED SVC OF AMERICA INC	02/02/2002 - 02/02/2002	$289.00	$124.50
0650305105775		MED SVC OF AMERICA INC	03/02/2002 - 03/02/2002	$144.00	$69.12
0650305185775		MED SVC OF AMERICA INC	04/02/2002 - 05/02/2002	$244.00	$117.12
0650229006142		MED SVC OF AMERICA INC	05/02/2002 - 05/02/2002	$44.00	$21.12
7650221890516		DUBOIS REG MED CTR	05/06/2002 - 05/06/2002	$93.00	$74.40
7650221991379		P & O PHYS THRP INC	05/13/2002 - 05/31/2002	$990.00	$760.00
7650221890517		DUBOIS REG MED CTR	05/28/2002 - 05/28/2002	$93.00	$74.40
7650221091088		PIASO MD	05/28/2002 - 05/28/2002	$50.00	$36.00
7650229991333		PIASO MC	10/07/2002 - 10/07/2002	$129.00	$99.20
7650229695135		PIGIG PHYS THRP INC	10/15/2002 - 10/16/2002	$340.00	$256.00
7650230392130		P & O PHYS THRP INC	10/21/2002 - 10/25/2002	$345.00	$260.00
7650311592173		PIGIG PHYS THRP INC	10/28/2002 - 11/13/2002	$715.00	$560.97
7650231692848		PIASO MD	11/04/2002 - 11/04/2002	$50.00	$40.00
7650233301154		P & O PHYS THRP INC	11/18/2002 - 11/20/2002	$370.00	$280.00
7650233792821		PIGIG PHYS THRP INC	11/25/2002 - 11/26/2002	$370.00	$212.00
7650304295097		PIASO MD	01/09/2003 - 01/20/2003	$140.00	$104.00
7650305591828		RAINTREE MRI SVC INC	01/13/2003 - 01/13/2003	$1,000.00	$800.00
			Totals:	$5,406.00	$3,888.83

FILED

m 11:04 BA NO CC

MAY 05 2004

William A. Shaw
Prothonotary

G.D. No.

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

IN RE: LORAE FAIRMAN, individually and as parent and natural guardian of SEAN FAIRMAN, a minor	) No. 03-1860 - CD

ORDER OF COURT

AND NOW, to-wit, this 6 day of May, 2004, upon consideration of the Motion to Amend Order/Release Funds, it is hereby ORDERED, ADJUDGED and DECREED as follows:

1. Farmers National Bank is ORDERED to issue payment in the amount of $3,500.00 to CIGNA from the $15,000.00 which has previously been deposited in the account of Sean Fairman for satisfaction of bills incidental to the underlying accident.

2. It is further ORDERED that the remaining $11,500.00 of the $15,000.00 settlement shall remain in the existing federally insured interest bearing account, or be placed into a new federally insured interest bearing account, as directed by Earnest and Lorea Fairman, parents and natural guardians of Sean Fairman, which is not to be removed or transferred until Sean Fairman reaches the age of 25, except upon further Order of this Court.

BY THE COURT:

J.

FILED

MAY 07 2004

William A. Shaw
Prothonotary/Clerk of Courts

FILED 2cc
01:26/61 Atty Webber
MAY 07 2004

William A. Shaw
Prothonotary/Clerk of Courts

CERTIFICATE OF SERVICE

I, Gregory R. Webber, Esquire, hereby certify that a true and correct copy of the foregoing **MOTION TO AMEND COURT ORDER/RELEASE FUNDS** was served this 4th day of May, 2004, by United States First Class Mail, postage prepaid, to:

Earnest Fairman
Lorae Fairman
R.D. 1
Box 391
Dubois, PA 15801

Respectfully submitted,

DICKIE, MCCAMEY & CHILCOTE, P.C.

Gregory R. Webber, Esquire