To: City of Milwaukee

I SHERALDINE C. WILKERSON had A ACCdinet AT 2905 A. N 21th St ON A SUNDAY Night ON 2-27-2000 AROUND 9:00 P.M OR 10:00 P.M that Night I ~~TOOK~~ FALL down the STAIR AND I BROKE My ANKLE AND NOW I CAN'T WORK At ALL AND I don't HAVE A INCOME

2631 N 8th St Mil WIS 53206
I CAN Be Reach A (414)-933-1280
Above Adds is Temp

SHERALDINE C. WILKERSON
03-21-2000

CITY OF MILWAUKEE
'00 MAR 21 PM 1:16
RONALD D. LEONHARDT
CITY CLERK

CITY OF MILWAUKEE
RECEIVED
'00 MAR 21 PM 3:10
OFFICE OF
CITY ATTORNEY

12129 W. Feerick Street
Milwaukee, WI 53222-2106
Tel: 414/527-6000

239-001001170
Sheraldine Wilkerson
1727 N. 17th St.
Milwaukee, WI 53205

June 29, 2000

Dear Sheraldine Wilkerson,

This letter is in regard to anesthesia services provided to you on 03/01/2000 by Dr Su-Ryong Hur M.D. at St. Michael's Hospital. We submitted this claim directly to your insurance company but have not received payment. We are now asking for your assistance in obtaining their payment.

Enclosed is a completed health insurance claim form. Please sign the claim on line 13 and send to your insurance company along with any other forms they may require. If you are unable to do this, or if any of the information on the claim is incorrect, please phone our office toll free at (414) 527-6000.

Thank you for your cooperation in this matter.

Respectfully,

Michael B Lattos

Michael B. Lattos

*** For proper credit 239-001001170
Include account number ***

361F

DETACH AND ENCLOSE WITH YOUR REMITTANCE

PL/NAHTAN

Statements may not reflect all payments that have been received within the last twenty working days. For your convenience, you may use your Master or Visa Card to pay full balances of fifty dollars or more.

Amount	Card Number	Expires	Signature

Sheraldine Wilkerson
St. Michael's Hospital
Anesthesia Service 03/01/2000

Account: 239-001001170
Make Check Payable To:
Su-Ryong Hur, M.D., Ltd.

Su-Ryong Hur, M.D., Ltd.
Box 68-6217
Milwaukee WI 53268-6217

Total	730.00
Payments	0.00
Balance	730.00

Should you have any questions, please call us at (414) 527-6000.

PLEASE DO NOT STAPLE IN THIS AREA

Family Health Plan Cooperative
P.O. Box 2490
Brookfield, WI 53008-2490

FOR PROPER CREDIT
** 239-001001170 **
** Include account Number **

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: GROUP HEALTH PLAN

1a INSURED'S I.D. NUMBER: 325585352

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Wilkerson, Sheraldine

3 PATIENT'S BIRTH DATE MM DD YY: 06 19 1958 — SEX: F X

4 INSURED'S NAME (Last Name, First Name, Middle Initial): Wilkerson, Sheraldine

5 PATIENT'S ADDRESS (No., Street): 1727 N. 17th St.

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

7 INSURED'S ADDRESS (No., Street): 1727 N. 17th St.

CITY: Milwaukee — STATE: WI

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

CITY: Milwaukee — STATE: WI

ZIP CODE: 53205 — TELEPHONE (Include Area Code): ( )

ZIP CODE: 53205 — TELEPHONE (INCLUDE AREA CODE): (262) 787-2300

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: 036144090 FHP6

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

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: Patrick Cudahy Inc.

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:

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Dr. S. Kaplan

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 853746

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

19. RESERVED FOR LOCAL USE: St. Michael's Hospital

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. 733.16 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 ID. QUAL.	J RENDERING PROVIDER ID. #
				ANESTHESIA SERVICES							
03 01 00		22	7	27814 AA 1 Hrs 45 Mins		1	730.00	3 7			

25. FEDERAL TAX I.D. NUMBER: 39-1260459 SSN EIN: X

26. PATIENT'S ACCOUNT NO.: 239-001001170

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

28. TOTAL CHARGE: $ 730.00

29. AMOUNT PAID: $ 730.00

30. BALANCE DUE:

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

Su-Ryong Hur M.D.

SIGNED 06/29/2000 DATE

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

St. Michael's Hospital
2400 W. Villard Avenue
Milwaukee, WI 53209

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

Su-Ryong Hur, M.D., Ltd.
Box 68-6217
Milwaukee WI 53268-6217

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8 88)

PLEASE PRINT OR TYPE

F N 361P HH/NAHTAN

Telephone (414) 527-6000

1500-0116 (12-90) (OCR) 1 pt.

ST MICHAEL HOSPITAL
BOX 68-9505
MILWAUKEE, WI 53268-9505
Statement on: 07/13/00 at 09:32 AM

Guarantor: WILKERSON SHERALDINE C
1727 N 17TH ST
MILWAUKEE, WI 53205-0000

Patient: WILKERSON SHERALDINE C
Acct No: 5449613
AR Per: 03/01/00 to 03/02/00

Date	Svc Code	Description	Units	Debits	Credits
03/01/00	5115621	IV CASSETTE/PUMP/MAIN	1	169.25	
03/01/00	5145788	CASE CART #24 PLASTIC	1	467.75	
03/01/00	6003561	PLATE IMPLANT C<200	1	294.75	
03/01/00	6015770	TOURNIQUET	1	129.25	
03/01/00	6015881	BASIC ORTHO II INSTRU	1	269.25	
03/01/00	6015883	MINI/SMALL FRAG INSTR	1	257.00	
03/01/00	6015976	SURGICAL AIR DRILL	1	366.00	
03/01/00	6030007	OPERATING ROOM USE CH	1	116.75	
03/01/00	6032012	O.R. TIME-STAFF B-1/4	2	400.50	
03/01/00	6032013	O.R. TIME-STAFF B PER	1	791.75	
03/01/00	6036020	HOLDING ROOM CHARGE/H	1	151.25	
03/01/00	6042610	SUTURE PACK A	4	216.00	
03/01/00	6043604	CAST D	1	200.75	
03/01/00	6115100	PACU ADMISSION EQUIPM	1	110.25	
03/01/00	6179003	PACU PRE-OP HOLDING	1	118.50	
03/01/00	6179023	PACU PER MINUTE-LEVEL	65	357.50	
03/01/00	6430001	DS BASE FACILITY FEE	1	105.00	
03/01/00	6615208	PULSE OXIMETER	1	54.00	
03/01/00	6615229	BLOOD PRES MONITOR	1	55.00	
03/01/00	6615231	E.K.G. MONITOR	1	49.75	
03/01/00	6615234	VENTILATOR	1	81.00	
03/01/00	6615236	OXYGEN ANALYZER	1	61.50	
03/01/00	6615248	ANES. EQUIP USE MD/HR	1	101.25	
03/01/00	6615251	HUMIDIFIER	1	32.00	
03/01/00	6615252	CO2 MONITOR	1	80.50	
03/01/00	6615258	ANES EQUIP USE MD-1/4	2	59.50	
03/01/00	6615263	LARYNGEAL MASK AIRWAY	1	197.75	
03/01/00	6653201	GENERAL ANESTHESIA	1	207.25	
03/01/00	7056429	OR FLUORO UP TO ONE H	1	324.50	
03/01/00	7059414	ANKLE PORTABLE LT	1	187.25	
03/01/00	10812059	CEFAZOLIN SOD 1GM VIA	3	160.59	
03/01/00	12808082	MORPHINE INJ 8MG SDV	1	37.10	
03/01/00	14020026	D5W INJ 50ML BAG	3	131.01	
03/01/00	19400006	EMPTY IV BAG 1000ML	3	143.73	
03/02/00	2022001	OBSERVATION BASE RATE	1	150.25	
03/02/00	2022002	OBSER FACILITY CHARGE	16	288.00	
03/02/00	5601016	PT-GAIT TRAINING/15 M	2	113.50	
03/02/00	5601051	PT-EVALUATION 15 MIN	1	73.50	
03/02/00	10812059	CEFAZOLIN SOD 1GM VIA	2	107.06	
03/02/00	12804008	THIOPENTAL INJ 500MG	1	44.63	
03/02/00	12808080	MORPHINE INJ 10MG SDV	1	37.10	
03/02/00	12808127	PERCOCET TAB UD	6	23.52	

- Continue -

ST MICHAEL HOSPITAL
BOX 68-9505
MILWAUKEE, WI 53268-9505
Statement on: 07/13/00 at 09:32 AM

Guarantor: WILKERSON SHERALDINE C
1727 N 17TH ST
MILWAUKEE, WI 53205-0000

Patient: WILKERSON SHERALDINE C
Acct No: 5449613
AR Per: 03/01/00 to 03/02/00

Date	Svc Code	Description	Units	Debits	Credits
03/09/00	9848191	ALLOW FHP CAP CONTRAC	-1		3059.97-
03/16/00	9848191	ALLOW FHP CAP CONTRAC	-1		15.58-
05/23/00	9900610	PAY FAMILY HEALTH PLA	-2		8472.82-
				Balance:	4225.63-

* - Not posted