1041 W. Montclaire Ave.
Glendale, WI 53217
May 6, 2003

City Clerk
Attn: Claims
200 E. Wells St. - Room 205
Milwaukee, WI 53202-3567

Subject: Filing of Claim

To Whom It May Concern:

Description of Incident

I was dispatched to the scene by WITI-Channel 6 on 8/27/02 for a 9:00 p.m. news story. At the time it was very dark and raining heavily. I parked at the location across from 8569 W. Lancaster Avenue adjacent to Vogel Park. After exiting the van, just before I got to the curb, I stepped upon a metal object that snapped up and struck me in the back of my right leg. The metal kept my feet from moving and caused me to fall on both knees and arms.

The back of my leg was bleeding profusely and I discovered what I had stepped on was the window frame of a van that had burned on that spot several days before. I attempted to control the bleeding with whatever I had in the truck and did my best to complete my job.

I was told the Dodge van that burned there had been witnessed by neighbors who told me a large amount of debris remained at the scene because the heat from the fire had blown out the windows and completely incinerated the car.

When I returned to WITI late that night, a co-engineer, Tom Nielsen, observed my injuries and was concerned about their extent. I was in pain and reported the next day to the Work Injury Clinic for a tetanus shot and exam. No x-rays were taken or MRI were done and I was given physical therapy which did not improve the pain in my knee. I then sought a second opinion from Dr. Michael Anderson who, with the help of an MRI, diagnosed my meniscus had been severely torn and knee surgery was done to repair the damage.

COLUMBIA HOSPITAL INC
BIN 503
MILWAUKEE, WI 53288-0503

RECORD OF SERVICE

414 961-3770

DATE: 04/08/03
ACCT TYPE: O

PATIENT NAME: REICHARD ,SCOTT A PATIENT NUMBER: 7643280001 FC: J
ADMIT DATE: 10/15/02 DISCHARGE DATE: BIRTH DT: 09/16/1959 PT: H

GUARANTOR: SCOTT A REICHARD
NAME AND : 1041 W MONTCLAIRE
ADDRESS :
GLENDALE WI 53217

TOTAL CHARGES: 10154.51
ACCOUNT BAL: .00
PATIENT BAL: .00

DATE	SVC	CD	DESC	BAL:	INS1: K59	INS2: H70	INS3:	PATIENT
					.00	.00		.00
101502	1	6530568	CISATRACURIUM 2		35.06	0.00	0.00	0.00
101502	1	6590049	BUPIVACAINE W/E		13.55	0.00	0.00	0.00
101502	1	6590057	CEFAZOLIN 1GM/D		32.24	0.00	0.00	0.00
101502	1	6590146	EPHEDRINE SO4 5		29.76	0.00	0.00	0.00
101502	2	6590207	GLYCOPYRROLATE		26.32	0.00	0.00	0.00
101502	1	6590260	LACTATED RINGER		29.76	0.00	0.00	0.00
101502	2	6590331	METOCLOPRAMIDE-		78.56	0.00	0.00	0.00
101502	1	6590331	METOCLOPRAMIDE-		39.28	0.00	0.00	0.00
101502	1	6590334	MIDAZOLAM-VERSE		24.01	0.00	0.00	0.00
101502	3	6590359	NEOSTIGMINE-PRO		39.48	0.00	0.00	0.00
101502	2	6590378	ONDANSETRON-ZOF		61.02	0.00	0.00	0.00
101502	1	6590426	PROPOFOL 10MG/M		31.89	0.00	0.00	0.00
101502	1	6590508	SUCCINYCHOLINE		14.85	0.00	0.00	0.00
101502	1	6590510	SUFENTANIL 50MC		41.30	0.00	0.00	0.00
101502	1	6590525	THIOPENTAL-PENT		32.97	0.00	0.00	0.00
101502	1	6590536	TRIAMCINOLONE A		19.43	0.00	0.00	0.00
101502	1	6590556	KETOROLAC INJ 6		25.74	0.00	0.00	0.00
101502	1	4230005	PACU SUPPLIES A		67.65	0.00	0.00	0.00
101502	1	4020001	ARTHROSCOPY		6997.18	0.00	0.00	0.00
101502	4	4420004	ANESTHESIA 15 M		187.44	0.00	0.00	0.00
101502	1	4420017	ANES-ORTHOPEDIC		980.38	0.00	0.00	0.00
101502	4	6590342	MORPHINE SULFAT		52.64	0.00	0.00	0.00
101502	1	4210004	PACU RECOVERY R		648.31	0.00	0.00	0.00
101502	1	4310001	AMBULATORY SURG		27.50	0.00	0.00	0.00
101502	1	4320001	AS ASSESSMENT F		396.75	0.00	0.00	0.00
101502	1	5600005	EKG 12 LEAD		120.14	0.00	0.00	0.00
101502	1	6526329	PERCOCET 5/325		2.11	0.00	0.00	0.00
101502	1	7080052	VENIPUNCTURE		16.96	0.00	0.00	0.00
101502	1	7110150	CBC PLT COMP DI		82.23	0.00	0.00	0.00
121802	-1	1011799	COMMERCIAL/OTH		-10154.51	0.00	0.00	0.00

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BIN 503
MILWAUKEE, WI 53288-0503

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NAME AND : 1041 W MONTCLAIRE
ADDRESS :
GLENDALE WI 53217

ACCOUNT BAL: .00
PATIENT BAL: .00

TOTAL CHARGES: 10154.51 INS1: K59 .00 INS2: H70 .00
INS3: INS4:

1	PAYMENTS	-10154.51	-10154.51	0.00
2	LABORATORY	99.19	99.19	0.00
3	OR SERVICES	6997.18	6997.18	0.00
4	ANESTHESIA	1167.82	1167.82	0.00
5	SELF ADMIN DRUG	2.11	2.11	0.00
6	MED/SURG SUPPLI	67.65	67.65	0.00
7	PHARMACY	627.86	627.86	0.00
8	RCVRY RM PROC C	1072.56	1072.56	0.00
9	EKG/ECG	120.14	120.14	0.00

Chart #99845 SSN# 390606267 BLOUNT ORTHOPAEDIC CLINIC
Reichard,Scott A DOB 09-16-59 625 E ST PAUL AVE
1041 W Montclaire Avenue
From
Glendale, WI 53217 To 03/24/03 Milwaukee, WI 53202-5907
Home-(414)963-1890 Office-(414)355-6666 (414) 223-2727

T	Date	Code	Diagnosis	Prov	AmountR	IB	Paid	Balance/ Susp. Amt	Carr
C	09-13-02	99204	836 0	MJA02	193.00N	NY	193.00	0.00	
C	09-18-02	20610	836 0	MJA00	141.00N	NY	141.00	0.00	
C	09-18-02	J3301	836 0	MJA00	12.00N	NY	12.00	0.00	
C	09-23-02	99213	836 0	MJA00	88.00N	NY	88.00	0.00	
C	09-27-02	97110TI	836 0	MSDZ0	72.00N	NY	72.00	0.00	
C	09-27-02	97035	836 0	MSDZ0	61.00N	NY	61.00	0.00	
C	10-04-02	97110TE	836 0	MSWS0	88.00N	NY	88.00	0.00	
C	10-07-02	99213	836 0	MJA00	88.00N	NY	88.00	0.00	
C	10-07-02	97110TI	836 0	MSMA0	144.00N	NY	144.00	0.00	
C	10-11-02	97110TE	836 0	MSTS0	88.00N	NY	88.00	0.00	
C	10-14-02	97110TI	836 0	MSMA0	144.00N	NY	144.00	0.00	
C	10-15-02	29881	836 0	MJA01	2930.00N	NY	2930.00	0.00	
P	10-21-02	PWC		MJA00	-128.66N		0.00	0.00	GBS01
CA	10-21-02	CFOC		MJA00	-24.34N		0.00	0.00	
P	10-21-02	PWC		MJA02	-173.70N		0.00	0.00	GBS01
CA	10-21-02	CFOC		MJA02	-19.30N		0.00	0.00	
C	10-30-02	99024	836 0	MJA00	0.00N	NN	0.00	0.00	
C	11-11-02	97110TI	836 0	MSMA0	144.00N	NY	144.00	0.00	
C	11-13-02	97110TI	836 0	CMDB0	144.00N	NY	144.00	0.00	
C	11-18-02	97110TE	836 0	MSMA0	88.00N	NY	88.00	0.00	
C	11-20-02	97110TI	836 0	CMDB0	72.00N	NY	72.00	0.00	
C	11-20-02	97032	836 0	CMDB0	61.00N	NY	61.00	0.00	
P	11-22-02	PWC		MSMA0	-127.74N		0.00	0.00	GBS01
CA	11-22-02	CWC		MSMA0	-16.26N		0.00	0.00	
P	11-22-02	PWC		MJA00	-79.20N		0.00	0.00	GBS01
CA	11-22-02	CFOC		MJA00	-8.80N		0.00	0.00	
C	11-25-02	99024	836 0	MJA00	0.00N	NN	0.00	0.00	
P	11-26-02	PWC		MSMA0	-127.74N		0.00	0.00	GBS01
CA	11-26-02	CWC		MSMA0	-16.26N		0.00	0.00	
P	11-26-02	PWC		MJA00	-79.20N		0.00	0.00	GBS01
CA	11-26-02	CWC		MJA00	-8.80N		0.00	0.00	
C	12-02-02	97110TI	836 0	CMMA0	72.00N	NY	72.00	0.00	
C	12-02-02	97014	836 0	CMMA0	55.00N	NY	55.00	0.00	
P	12-03-02	PWC		MJA01	-2637.00N		0.00	0.00	GBS01
CA	12-03-02	CWC		MJA01	-293.00N		0.00	0.00	
P	12-03-02	PWC		MSTS0	-79.20N		0.00	0.00	GBS01
CA	12-03-02	CWC		MSTS0	-8.80N		0.00	0.00	
P	12-03-02	PWC		MSWS0	-79.20N		0.00	0.00	GBS01
CA	12-03-02	CWC		MSWS0	-8.80N		0.00	0.00	
P	12-03-02	PWC		MSDZ0	-103.88N		0.00	0.00	GBS01
CA	12-03-02	CWC		MSDZ0	-29.12N		0.00	0.00	
C	12-09-02	97110TI	836 0	CMMA0	72.00N	NY	72.00	0.00	
C	12-09-02	97014	836 0	CMMA0	55.00N	NY	55.00	0.00	
P	12-17-02	PWC		CMDB0	-127.74N		0.00	0.00	GBS01
CA	12-17-02	CWC		CMDB0	-16.26N		0.00	0.00	

Chart #99845 SSN# 390606267 BLOUNT ORTHOPAEDIC CLINIC
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Home-(414)963-1890 Office-(414)355-6666 (414) 223-2727

T	Date	Code	Diagnosis	Prov	Amount	R	IB	Paid	Balance/ Susp. Amt	Carr
P	12-18-02	PWC		MSMA0	-127.74	N		0.00	0.00	GBS01
CA	12-18-02	CWC		MSMA0	-16.26	N		0.00	0.00	
P	12-23-02	PWC		MSMA0	-79.20	N		0.00	0.00	GBS01
CA	12-23-02	CWC		MSMA0	-8.80	N		0.00	0.00	
P	12-23-02	PWC		CMDB0	-104.58	N		0.00	0.00	GBS01
CA	12-23-02	CWC		CMDB0	-28.42	N		0.00	0.00	
C	12-23-02	99024	836 0	MJA00	0.00	N	NN	0.00	0.00	
P	01-07-03	PWC		CMMA0	-86.17	N		0.00	0.00	GBS01
CA	01-07-03	CWC		CMMA0	-40.83	N		0.00	0.00	
C	01-27-03	99213	836 0	MJA00	88.00	N	NY	88.00	0.00	
P	02-19-03	PWC		CMMA0	-92.22	N		0.00	0.00	GBS01
CA	02-19-03	CWC		CMMA0	-34.78	N		0.00	0.00	
P	02-25-03	PWC		MJA00	-79.20	N		0.00	0.00	GBS01
CA	02-25-03	CWC		MJA00	-8.80	N		0.00	0.00	
C	03-03-03	99213	836 0	MJA00	88.00	N	YY	0.00	88.00	GBS01

	Charges	Receipts	Debits	Credits	Balance
Patient:	0.00	0.00	0.00	0.00	0.00
Insurance:	4988.00	-4312.37	0.00	-587.63	88.00
TOTALS:	4988.00	-4312.37	0.00	-587.63	88.00

City of Milwaukee

Police Department

Arthur L. Jones
Chief of Police

January 29, 2003

Lauris Reichard
3400 S. Indiana Avenue
Milwaukee, WI 53207

Dear Ms. Reichard:

This is in response to your request for information pursuant to the Wisconsin Open Records Law. In your letter dated January 10, 2003, you requested "Police Report # 022293051 dated 8/17/2002 concerning the burning of a van at 8570 W. Lancaster Ave., Milwaukee, WI", as well as "Tow Report #1132789".

Enclosed is a partial copy of the requested report on file with our department of an Arson of Property report 02-229-3051, and a partial copy of Fire Investigation Report #02-FF00967, as well as a complete Tow Record report #1132789.

Please be advised that your request for a copy of the complete Arson of Property report and complete Fire Investigation report is denied. This is a pending investigation and the request is denied per Wisconsin State Statutes 905.09, and Wisconsin Supreme Court decision Newspapers, Inc. v. Breier, 89 Wis. 2d 417 (1979).

Further be advised that in the event that all or part of your request is denied, that this determination is subject to review by mandamus, Wisconsin Statutes 19.37(1), or upon application to the District Attorney or Attorney General.

Sincerely,

ARTHUR L. JONES
CHIEF OF POLICE

ANTHONY R. HENDRICKS
CAPTAIN OF POLICE

ALJ:ARH:jd
Encl.
P01937

SCOTT REICHARD
MEDICAL BILLS INVENTORY

Dated April 15, 2003

	Charges	Mileage
Work Injury Clinic Includes some meds	$ 749.00	21 (7)
St Mary's/Ozaukee & Milwaukee		
Emergency Room & Hospital	$10,692.00	18 (1)
Dr. - Emergency	$ 134.00	40 (1)
Dr. - Surgery & Physical Therapy	$ 4,988.00	480 (20)
Prescriptions	$ 80.00	28 (7)
Mileage @ $.34/mi.	$ 206.38	20 (1)
TOTAL	$16,849.38	607 Miles

PLEASE DO NOT STAPLE IN THIS AREA

WITI FOX 6 TV
ATTN: MARCIA MICKICH
9001 N. GREEN BAY ROAD
MILWAUKEE, WI 53209

APPROVED OMB-0938-0008

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): 390606267

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REICHARD, SCOTT A

3. PATIENT'S BIRTH DATE: 09 | 18 | 59 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REICHARD, SCOTT A

5. PATIENT'S ADDRESS (No., Street): 1041 W MONTCLAIRE AVE

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

7. INSURED'S ADDRESS (No., Street): ATTN: MARCIA MICICH

CITY: GLENDALE | STATE: WI

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

CITY: MILWAUKEE | STATE: WI

ZIP CODE: 53217 | TELEPHONE (Include Area Code): (414) 963-1890

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

ZIP CODE: 53209 | TELEPHONE (INCLUDE AREA CODE): ( ) -

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 09 | 18 | 59 SEX: M [X] F [ ]

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME: WITI FOX 6 TV

c. EMPLOYER'S NAME OR SCHOOL NAME

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: WITI FOX 6 TV

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. Signature On File

SIGNED _____ DATE 08/22/02

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: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 08 | 21 | 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: No Referred Services

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. 891.0
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 08 22 02	08 22 02	11	1	99203		1	146 00	1				
2 08 22 02	08 22 02	11	1	J0C3459145800 Smz V 90718		1	25 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 39-1772507 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 13154-1

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

28. TOTAL CHARGE: $ 171 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 171 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 D. SETER, M.D.

03/24/03

SIGNED DATE

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

WORK INJURY CARE CENTER
1720 W FLORIST AVE
GLENDALE CORPORATE CENTER
MILWAUKEE, WI 53209

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

WORK INJURY CARE CENTER I
PO BOX 78422 ANDREW J. SETER MD
MILWAUKEE, WI 53278-0422

PIN# GRP# 39-1772507

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

Fold

Fold

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
Mfd. by Medical Arts Press

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

WITI FOX 6 TV
ATTN: MARCIA MICKICH
9001 N. GREEN BAY ROAD
MILWAUKEE, WI 53209

PICA

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PICA

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3. PATIENT'S BIRTH DATE: 09 16 59 — SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REICHARD, SCOTT A

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

7. INSURED'S ADDRESS (No., Street): ATTN: MARCIA MICICH

CITY: GLENDALE — STATE: WI

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

CITY: MILWAUKEE — STATE: WI

ZIP CODE: 53217 — TELEPHONE (Include Area Code): (414)963-1890

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

ZIP CODE: 53209 — TELEPHONE (INCLUDE AREA CODE): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 09 16 59 — 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: WITI FOX 6 TV

c. EMPLOYER'S NAME OR SCHOOL NAME

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: WITI FOX 6 TV

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. Signature On File — DATE 08/22/02

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

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

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17a. I.D. NUMBER OF REFERRING PHYSICIAN

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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. 891 0
2. 844 9
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 08 30 02	08 30 02	11	1	99213		12	93 00	1				
2 08 30 02	08 30 02	11	1	99070		12	11 00	1				
3												
4												
5												
6												

RX IBUPROFEN 600MG#40 NDC#0976273792

25. FEDERAL TAX I.D. NUMBER: 39-1772507 — SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 13154-2

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

28. TOTAL CHARGE: $ 104 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 104 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.)
CYNTHIA BUONO, M.D.
03/24/03
SIGNED — DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
WORK INJURY CARE CENTER
1720 W FLORIST AVE
GLENDALE CORPORATE CENTER
MILWAUKEE, WI 53209

33. PHYSICIAN'S & SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
WORK INJURY CARE CENTER I
PO BOX 78422 ANDREW J. SETER MD
MILWAUKEE, WI 53278-0422

PIN# — GRP# 39-1772507

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

Mfd. by Medical Arts Press
Call toll-free: 1-800-328-2179

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

WITI FOX 6 TV
ATTN: MARCIA MICKICH
9001 N. GREEN BAY ROAD
MILWAUKEE, WI 53209

APPROVED OMB-0938-0008

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 [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 390606267

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REICHARD, SCOTT A

3. PATIENT'S BIRTH DATE: 09 | 18 | 59 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REICHARD, SCOTT A

5. PATIENT'S ADDRESS (No., Street): 1041 W MONTCLAIRE AVE

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

7. INSURED'S ADDRESS (No., Street): ATTN: MARCIA MICICH

CITY: GLENDALE | STATE: WI

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

CITY: MILWAUKEE | STATE: WI

ZIP CODE: 53217 | TELEPHONE (Include Area Code): (414) 963-1890

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

ZIP CODE: 53209 | TELEPHONE (INCLUDE AREA CODE): ( ) -

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 09 | 18 | 59 SEX: M [X] F [ ]

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME: WITI FOX 6 TV

c. EMPLOYER'S NAME OR SCHOOL NAME

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: WITI FOX 6 TV

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. Signature On File

SIGNED _____ DATE 08/22/02

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 09 | 21 | 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 MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: No Referred Services

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. 891.0
2. 844.9
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 09 03 02	09 03 02	11	1	97010 HOT/COLD/HOT	12	31 00	1				
2 09 03 02	09 03 02	11	1	97750 PHY TEST/MEASMNT PER	12	140 00	2				
3 09 03 02	09 03 02	11	1	97140 SOFT TISSUE MOBIL ZA	12	70 00	1				
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER: 39-1772507 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 13154- 3

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

28. TOTAL CHARGE: $ 241 00

29. AMOUNT PAID: $ 241 00 (414) 355-2000

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.)

CANNOT BE BILLED 03/24/03

SIGNED _____ DATE

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

WORK INJURY CARE CENTER
1720 W FLORIST AVE
GLENDALE CORPORATE CENTER
MILWAUKEE, WI 53209

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

WORK INJURY CARE CENTER I
PO BOX 78422 ANDREW J. SETER MD
MILWAUKEE, WI 53278-0422

PIN# GRP# 39-1772507

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

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WITI FOX 6 TV
ATTN: MARCIA MICKICH
9001 N. GREEN BAY ROAD
MILWAUKEE, WI 53209

APPROVED OMB-0938-0008

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 [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 390606267

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REICHARD, SCOTT A

3. PATIENT'S BIRTH DATE: 09 16 59 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REICHARD, SCOTT A

5. PATIENT'S ADDRESS (No., Street): 1041 W MONTCLAIRE AVE

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

7. INSURED'S ADDRESS (No., Street): ATTN: MARCIA MICICH

CITY: GLENDALE STATE: WI

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

CITY: MILWAUKEE STATE: WI

ZIP CODE: 53217 TELEPHONE (Include Area Code): (414)963-1890

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

ZIP CODE: 53209 TELEPHONE (INCLUDE AREA CODE): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 09 16 59 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: WITI FOX 6 TV

c. EMPLOYER'S NAME OR SCHOOL NAME

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: WITI FOX 6 TV

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. Signature On File

SIGNED _____ DATE 08/22/02

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 08 21 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 MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: No Referred Services

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

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

1. 891 0
2. 344 9
3. 727 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 09 05 02	09 05 02	11	1	99213	EXP PROB	123	93 00	1				
2 09 05 02	09 05 02	11	1	J9070	METHYLPREDNSLN#40MG#21 NDC 59762332721	123	20 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 39-1772507 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 13154-- 4

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

28. TOTAL CHARGE: $ 113 00

29. AMOUNT PAID: $ 113 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.)

EDWARD GUENET, Ph.D.
03/24/03
SIGNED DATE

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

WORK INJURY CARE CENTER
1720 W FLORIST AVE
GLENDALE CORPORATE CENTER
MILWAUKEE, WI 53209

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

WORK INJURY CARE CENTER I
PO BOX 78422 ANDREW J. SETER MD
MILWAUKEE, WI 53278-0422

PIN# GRP# 39-1772507

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

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WITI FOX 6 TV
ATTN: MARCIA MICKICH
9001 N. GREEN BAY ROAD
MILWAUKEE, WI 53209

APPROVED OMB-0938-0008

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): 390606267

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REICHARD, SCOTT A

3. PATIENT'S BIRTH DATE: 09 | 18 | 59 SEX: M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REICHARD, SCOTT A

5. PATIENT'S ADDRESS (No., Street): 1041 W MONTCLAIRE AVE

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

7. INSURED'S ADDRESS (No., Street): ATTN: MARCIA MICICH

CITY: GLENDALE STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒

CITY: MILWAUKEE STATE: WI

ZIP CODE: 53217 TELEPHONE (Include Area Code): (414) 963-1890

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

ZIP CODE: 53209 TELEPHONE (INCLUDE AREA CODE): ( ) -

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 09 | 18 | 59 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: WITI FOX 6 TV

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: WITI FOX 6 TV

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. Signature On File

SIGNED _____ DATE 08/22/02

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 09 | 21 | 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 MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: No Referred Services

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. 891 0
2.
3. 727 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 09 05 02	09 05 02	11	1	97110 ULTRASOUND PER 15min	123	70 00	1				
2 09 05 02	09 05 02	11	1	97035	123	50 00	1				
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN: 39-1772507 ☒

26. PATIENT'S ACCOUNT NO.: 13154- 5

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

28. TOTAL CHARGE $ 120 00

29. AMOUNT PAID $ 120 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.)

CANCELLED

SIGNED DATE 03/24/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)
WORK INJURY CARE CENTER
1720 W FLORIST AVE
GLENDALE CORPORATE CENTER
MILWAUKEE, WI 53209

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE
WORK INJURY CARE CENTER I
PO BOX 78422 ANDREW J. SETER MD
MILWAUKEE, WI 53278-0422
(414) 352-2800

PIN# GRP# 39-1772507

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
Mfd. by Medical Arts Press

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

MAKE CHECKS PAYABLE TO

INFINITY HEALTHCARE PHYSICIANS, S.C.
1251 W GLEN OAKS LANE
MEQUON, WI 53092-3378

DATE: 03/27/2003

ACCOUNT NO.: 9-2382858

PROFESSIONAL SERVICES
FOR SCOTT REICHARD
BY CHRIS FELTON M.D.
AT ST MARYS HOSPITAL - OZK

SCOTT REICHARD
1041 W MONTCLAIRE
MILWAUKEE, WI 53217

QUESTIONS REGARDING THIS STATEMENT?
PLEASE CALL 414-290-6720 OR TOLL FREE
888-290-6720, MONDAY THROUGH FRIDAY
8 AM to 4 PM.

☐ - CHANGE OF ADDRESS INFORMATION ON REVERSE SIDE

☐ - MASTERCARD / VISA PAYMENTS - SEE REVERSE SIDE

DETACH HERE AND RETURN UPPER PORTION WITH PAYMENT

DATE	DESCRIPTION	AMOUNT
09/06/2002	(CPT:99283) LEVEL 3: EVALUATION	$149.00
10/18/2002	UNITED HEALTHCARE OF WI/PC:CONTRACT ADJ	-$14.90
10/18/2002	UNITED HEALTHCARE OF WI/PC:PD PER CONTRACT	-$134.10
	THESE CHARGES ARE FOR EMERGENCY PHYSICIAN SERVICES ONLY. THEY ARE NOT INCLUDED IN YOUR HOSPITAL BILL.	
	PAYMENT DUE by 04/10/2003-------->	$0.00

INFINITY HEALTHCARE PHYSICIANS, S.C. 9-2382858
1251 W GLEN OAKS LANE
MEQUON, WI 53092-3378 TAX ID# 39-1861457

lgohde

ST.MARY'S HOSPITAL MILWAUKEE RECORD OF SERVICE PG# 1
DRAWER 78408 DATE: 04/08/03
MILWAUKEE, WI 53278-0408 414 961-3770 ACCT TYPE: O

PATIENT NAME: REICHARD ,SCOTT A PATIENT NUMBER: 505330307 FC: S
ADMIT DATE: 09/06/02 DISCHARGE DATE: BIRTH DT: 09/16/1959 PT: E

GUARANTOR NAME AND ADDRESS: SCOTT A REICHARD
1041 W MONTCLAIRE
GLENDALE WI 53217

TOTAL CHARGES: 537.49
ACCOUNT BAL: -247.24
PATIENT BAL: -25.00

DATE	SVC	CD	DESC	BAL:	INS1: R58	INS2: G31	INS3:	PATIENT
					.00	-222.24		-25.00
090602	2		VICODIN 5/500 T	65575612	3.88	0.00	0.00	0.00
090602	1		KNEE 4+ VIEWS R	31800617	251.28	0.00	0.00	0.00
090602	1		EMERGENCY RM LE	34010145	282.33	0.00	0.00	0.00
101502	-1		PRIMECARE PAYME	10117895	0.00	-222.24	0.00	0.00
101502	-1		PRIMECARE DISC	16030090	0.00	-290.25	0.00	0.00
101502	1		PRIMECARE DISC	16030090	0.00	290.25	0.00	0.00
112502	-1		PATIENT PAYMENT	10117097	0.00	0.00	0.00	-25.00
030503	-1		COMMERCIAL/OTH	10117992	-497.18	0.00	0.00	0.00
030503	-1		FIRST HEALTH PR	16030597	-40.31	0.00	0.00	0.00

St. Mary's Ozaukee + Milwaukee

12:48 04/08/03 FROM IBIX,EDPABLFX

IPMX2603

ST.MARY'S HOSPITAL MILWAUKEE RECORD OF SERVICE PG# 1
DRAWER 78408 DATE: 04/08/03
MILWAUKEE, WI 53278-0408 414 961-3770 ACCT TYPE: O

PATIENT NAME: REICHARD ,SCOTT A PATIENT NUMBER: 505330307 FC: S
ADMIT DATE: 09/06/02 DISCHARGE DATE: BIRTH DT: 09/16/1959 PT: E

GUARANTOR: SCOTT A REICHARD | ACCOUNT BAL: -247.24
NAME AND : 1041 W MONTCLAIRE | PATIENT BAL: -25.00
ADDRESS :
GLENDALE WI 53217

TOTAL CHARGES: 537.49 INS1: R58 .00 INS2: G31 -222.24
INS3: INS4:

1	PAYMENTS	-744.42	-719.42	-25.00
2	ADJUSTMENTS	-40.31	-40.31	0.00
3	X-RAY DIAGNOSTI	251.28	251.28	0.00
4	EMERG. CENTER	282.33	282.33	0.00
5	SELF ADMIN DRUG	3.88	3.88	0.00