

5
CITY OF MILWAUKEE

2002 JAN 28 AM 11:

RONALD D. LEONHA
CITY CLERK

On September 30, 2001 at approximately 8:00pm,
I stepped off of the curb in front of 4158 So 1st Place
Milwaukee, at which time I fell due to the road
being approximately $\frac{3}{4}$ -1" higher than the gutter.
I stepped off with my left foot onto the uneven
road - lost my balance due to my foot giving out
underneath me - tried to catch myself with my right
foot, but fell due to breaking my left ankle +
spraining my right. There are street lights
there, but not very helpful due to the fullness of
the trees and not directly where I was.

I did go to the emergency room at St. Gabriel's South
Shore where I received the above diagnosis. I am
seeking \$100,000 in pain + suffering + lost wages plus
medical. I have enclosed copies of the medical
bills to date, but don't have all of them yet.

Sandra

Sandra A Szymon

10137 So Windsor Drive

Oak Creek, WI 53154

414 704-9332

414 559-4190 - Cell phone

414 704-1949 - Fax

CITY OF MILWAUKEE
CITY CLERK
02 JAN 28 PM 3:55

Take This Medicine With A
Snack Or Small Meal If Stomach
Upset Occurs

6292 SOUTH 27TH ST. MILWAUKEE, WI 53221

SANDRA SEYMOUR

10137 S WINDSOR DR
OAK CREEK, WI 53154

NO 0858714-02911 DATE 09/30/01
HYDROCODONE/APAP 5/500 TABLETS

QTY 12 NO REFILLS - DR. AUTHORIZATION REQUIRED
NEW

PH (414)761-0994
PATIENT PH (414)764-9332

NDC 00603-3881-28
MFG QUALTEST-VINTAGE

\$9.39

RAM/RAM
PLAN WIBC
CLAIM REF# 08587142742125

RECIP# 88882108902

Walgreens Customer Receipt

6292 SOUTH 27TH ST. MILWAUKEE, WI 53221

SANDRA SEYMOUR

10137 S WINDSOR DR
OAK CREEK, WI 53154

NO 0858714-02911 DATE 09/30/01
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\$9.39

RAM/RAM
PLAN WIBC
CLAIM REF# 08587142742125

RECIP# 88882108902

Walgreens Duplicate Receipt

MICHAEL T SEYMOUR
10137 S WINDSOR DR
OAK CREEK, WI
53154-5580



Compcare.
Health Services
Insurance Corporation

Statement Date: 11/19/2001

Page: 2 of 2

Questions-Please Contact Us At:

P.O. BOX 2947
MILWAUKEE, WI 53201-2947
TOLL FREE: 1-800-242 7312
TDD #: _____
HOURS: M-TH 7-7,F 7-5,SAT 8-12

Patient Name: SEYMOUR, SANDRA A

Provider of Service: SPORTS MEDICINE & ORTHOPEDIC C

Member I.D. Number: 888821089

Patient Account Number: 3731011100

Plan Accumulations:

Group Name: ADAMM

Claim Number: 131777776-00-00

Benefit Year 2001	Year to Date	Remaining
Individual Deductible	0.00	0.00
Family Deductible	0.00	0.00
Individual Out-of-Pocket	0.00	0.00
Family Out-of-Pocket	0.00	0.00
Annual Benefit Limit		
Lifetime Maximum	1,126.62	998,873.38

Summary Information:	You may owe:
Amount We Paid: 77.00	Deductible = 0.00
We Paid: PROVIDER OF SERVICE	Coinsurance = 0.00
	Copayment = 10.00
	Other = 0.00
Other Coverage Paid: 0.00	Patient Liability = 10.00

Detail Information Follows:

Provider:	Code/Description:	Date(s) of Service:	Charge:	Allowed:	Not Allowed:	Message:	Deductible:	Coinsurance:	Amount Paid:
DONALD J ZOLTAN MD	99212/MEDICAL SERVICES	11/05/01	75.00	40.00	35.00	01 E8	0.00	10.00	30.00
DONALD J ZOLTAN MD	73610/OFFICE RADIOLOGY	11/05/01	116.00	47.00	69.00	01 E8	0.00	0.00	47.00
TOTALS			191.00	87.00	104.00		0.00	10.00	77.00

(01) PAYMENT IS BASED ON AN AGREEMENT WITH THIS PROVIDER. IF THERE IS A DIFFERENCE BETWEEN THE CHARGE AND THE ALLOWED AMOUNTS, YOU ARE NOT RESPONSIBLE FOR THE BALANCE.
(E8) QUESTIONS ABOUT YOUR CLAIM PAYMENT? VISIT OUR NEW WEBSITE FOR 24-HOUR CUSTOMER SERVICE ACCESS.
WWW.BLUECROSSWISCONSIN.COM

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MICHAEL T SEYMOUR
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OAK CREEK, WI 53154-5580

If you have any questions:

Statement Date: 11/19/2001
Page: 1 of 2

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MICHAEL T SEYMOUR
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TDD #:

HOURS: M-TH 7-7;F 7-5;SAT 8-12

Patient Name: SEYMOUR, SANDRA A

Provider of Service: SPORTS MEDICINE & ORTHOPEDIC C

Member I.D. Number: 888821089

Patient Account Number: 3731 01100

Plan Accumulations:

Group Name: ADAMM

Claim Number: 129843909-00-00

Benefit Year 2001	Year to Date	Remaining
Individual Deductible	0.00	0.00
Family Deductible	0.00	0.00
Individual Out-of-Pocket	0.00	0.00
Family Out-of-Pocket	0.00	0.00
Annual Benefit Limit		
Lifetime Maximum	266.00	999,734.00

Summary Information:

Amount We Paid:	167.00	Deductible =	0.00
We Paid: PROVIDER OF SERVICE		Coinsurance =	0.00
		Copayment =	10.00
		Other =	0.00
Other Coverage Paid:	0.00	Patient Liability =	10.00

You may owe:

Detail Information Follows:

Provider:	Code/Description:	Date(s) of Service:	Charge:	Allowed:	Not Allowed:	Message:	Deductible:	Coinsurance:	Amount Paid:
DONALD J ZOLTAN MD	29405/OFFICE SURGERY	10/02/01	476.00	90.00	386.00	01 E8	0.00	0.00	90.00
DONALD J ZOLTAN MD	Q4038/EQUIPMENT PURCHASE	10/02/01	146.00	0.00	146.00	E8 097	0.00	0.00	0.00
DONALD J ZOLTAN MD	99214/MEDICAL SERVICES	10/02/01	160.00	0.00	160.00	E8 097	0.00	0.00	0.00
DONALD J ZOLTAN MD	99212/MEDICAL SERVICES	10/08/01	75.00	40.00	35.00	01 E8	0.00	10.00	30.00
DONALD J ZOLTAN MD	73610/OFFICE RADIOLOGY	10/08/01	116.00	47.00	69.00	01 E8	0.00	0.00	47.00

TOTALS	973.00	177.00	796.00	0.00	10.00				167.00
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(097) PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PRO
CEDURE.



United Wisconsin Group

MICHAEL T SEYMOUR
10137 S WINDSOR DR
OAK CREEK, WI
53154-5580



Compcare.
Health Services
Insurance Corporation

Statement Date: 11/05/2001

Page: 3 of 3

Patient Name: SEYMOUR, SANDRA A
Member I.D. Number: 888821089
Group Name: ADAMM

Provider of Service: SPORTS MEDICINE & ORTHOPEDIC C
Patient Account Number: 3731 01100
Claim Number: 129843909-00-00

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Detail Information Follows:

Provider:	Code/Description:	Date(s) of Service:	Charge:	Allowed:	Not Allowed:	Message:	Deductible:	Coinsurance:	Amount Paid:
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Page: 1 of 3

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Statement Date: 12/26/2001

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MICHAEL T SEYMOUR
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OAK CREEK, WI
53154-5580

Questions-Please Contact Us At:

P.O. BOX 2947
MILWAUKEE, WI 53201-2947
TOLL FREE: 1-800-242 7312
TDD #:
HOURS: M-F 7-5; SAT 8-12

Patient Name: SEYMOUR, SANDRA A Provider of Service: SPORTS MEDICINE & ORTHOPEDIC C

Member I.D. Number: 888821089 Patient Account Number: 3731011200

Group Name: ADAMM Claim Number: 134778511-00-00

Plan Accumulations:

Benefit Year	2001	Year to Date	Remaining
Individual Deductible	0.00	0.00	0.00
Family Deductible	0.00	0.00	0.00
Individual Out-of-Pocket	0.00	0.00	0.00
Family Out-of-Pocket	0.00	0.00	0.00
Annual Benefit Limit			
Lifetime Maximum		1,355.62	998,644.38

You may owe:

Amount We Paid:	77.00	Deductible =	0.00
We Paid: PROVIDER OF SERVICE		Coinsurance =	0.00
		Copayment =	10.00
		Other =	0.00
Other Coverage Paid:	0.00	Patient Liability =	10.00

Detail Information Follows:

Provider:	Code/Description:	Date(s) of Service:	Charge:	Allowed:	Not Allowed:	Message:	Deductible:	Coinsurance:	Copayment:	Amount Paid:
DONALD J ZOLTAN MD 99212/MEDICAL SERVICES		12/06/01	75.00	40.00	35.00	01 E8	0.00	0.00	10.00	30.00
DONALD J ZOLTAN MD 73610/OFFICE RADIOLOGY		12/06/01	116.00	47.00	69.00	01 E8	0.00	0.00	0.00	47.00

TOTALS			191.00	87.00	104.00		0.00		10.00	77.00
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Statement Date: 12/26/2001

Page: 3 of 3

MICHAEL T SEYMOUR
10137 S WINDSOR DR
OAK CREEK, WI
53154-5580

Patient Name: SEYMOUR, NICOLE R

Member I.D. Number: 888821089

Group Name: ADAMM

Provider of Service: LAKESHORE MEDICAL CLINIC LTD

Patient Account Number: 049453680

Claim Number: 185306620-00-00

Questions-Please Contact Us At:

P.O. BOX 2947

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TDD #: _____
HOURS: M-F 7-5; SAT 8-12

Plan Accumulations:

Benefit Year 2001	Year to Date	Remaining
Individual Deductible	0.00	0.00
Family Deductible	0.00	0.00
Individual Out-of-Pocket	0.00	0.00
Family Out-of-Pocket	0.00	0.00
Annual Benefit Limit		
Lifetime Maximum	181.00	999,819.00

You may owe:

Amount We Paid:	99.00	Deductible =	0.00
We Paid: PROVIDER OF SERVICE		Coinsurance =	0.00
		Copayment =	10.00
		Other =	0.00
Other Coverage Paid:	0.00	Patient Liability =	10.00

Detail Information Follows:

Provider:	Code/Description:	Date(s) of Service:	Charge:	Allowed:	Not Allowed:	Message:	Deductible:	Coinsurance: Copayment:	Amount Paid:
DAVID MUNOZ MD	99214/MEDICAL SERVICES	12/05/01	122.00	109.00	13.00	01 E8	6.00	0.00 10.00	99.00

TOTALS			122.00	109.00	13.00		0.00	10.00	99.00
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