08-5-558

Action

Law Offices, S.C.

Milwaukee Office:
933 North Mayfair Road
Suite 200
Milwaukee, WI 53226
Telephone: (414) 456 • 1111
Facsimile: (414) 456 • 1644

Racine/Kenosha Office:
1020 West Boulevard
Racine, WI 53405
Telephone: (262) 637 • 3000
Facsimile: (262) 632 • 9505

MILWAUKEE OFFICE

December 4, 2008

CITY OF MILWAUKEE
2008 DEC -8 PM 3:21
RONALD D. LEONHARDT
CITY CLERK

City Clerk
City of Milwaukee
200 East Wells Street
Milwaukee, Wisconsin 53202-3551

RE: Claim
My Client: Thomas Tillman
Accident of April 1, 2008

To Whom It May Concern:

Enclosed please find the original and four (4) copies of the Claim forms relative to the above matter.

CITY OF MILWAUKEE
RECEIVED
2008 DEC 8 PM 3:56
OFFICE OF
CITY ATTORNEY

Please indicate the date of receipt and filing on one of the enclosed copies and then return same to my office.

Thank you for your assistance.

Very Truly Yours,

STEVEN C. GABERT

SCG:trm
Enclosure

CLAIM

TO: CITY CLERK
CITY OF MILWAUKEE
200 EAST WELLS STREET
MILWAUKEE, WISCONSIN 53202

PLEASE TAKE NOTICE Pursuant to Wisconsin Statute § 893.80(1)(b) that the undersigned is making a claim for injuries and damages against you by virtue of the reasons set forth hereafter:

NAME OF CLAIMANT:

THOMAS TILLMAN
VETERAN'S ADMINISTRATION

DATE AND TIME OF INJURIES SUSTAINED:

APRIL 1, 2008 at 4:15 pm

PLACE OR LOCATION WHERE INJURY OR DAMAGES OCCURRED:

3334 WEST HIGHLAND
MILWAUKEE, WISCONSIN

MANNER IN WHICH DAMAGES OR INJURIES WERE RECEIVED OR OCCURRED:

Claimant was traveling Eastbound on West Highland Avenue making a left turn into the parking lot at 3334 West Highland Avenue, when the claimant's vehicle drove into a very large pot hole at the driveway entrance (6 feet long and two feet wide and eight inches deep), where there was no barricades, signs, or warnings. Barricades had previously been placed but were removed by the city, leaving the hole unprotected.

GROUNDS ON WHICH CLAIM IS MADE:

Negligence on the part of The City of Milwaukee by its agent, servant, and/or employee in failing to place barricades to protect/warn citizens of a known hazard.

GENERAL DESCRIPTION OF INJURIES AND DAMAGES:

PERSONAL INJURIES:

- Loss of Consciousness
- Bloody Nose with Swelling
- Chronic Sinus Congestion
- Lower lip-cut badly 8 stitches
- Airbag bruised lower forearm
- Right Hand swollen
- Bilateral Hand and Wrist Pain
- Right Thumb Sprained

MEDICAL EXPENSES
PAIN AND SUFFERING

PLEASE TAKE NOTICE that satisfaction for such injuries or damages is claimed, and that pursuant to Section 893.80(1)(b), Wisconsin Statutes, an itemization of Special Damages is attached hereto and this demand is in the sum of Fifty Thousand Dollars and 00 Cents ($50,000.00).

Dated at Milwaukee, Wisconsin, this 4th day of December, 2008.

Claimant: THOMAS TILLMAN
4762 NORTH 53rd STREET
MILWAUKEE, WISCONSIN 53218

ACTION LAW OFFICES

BY: _____

STEVEN C. GABERT
Attorney for the Claimant
933 North Mayfair Road
Suite 200
Milwaukee, Wisconsin 53226
Telephone: (414) 456-1111

Subscribed and sworn to before me
this 4th day of December, 2008.

_____
Notary Public: State of Wisconsin
My Commission Expires: 6/19/11

NOTARY PUBLIC
TINA R. McCOY
STATE OF WISCONSIN

THOMAS TILLMAN -vs- City of Milwaukee
Accident of April 1, 2008

DAMAGES

1. Medical Expenses (see attached itemization)	$ 9,684.70
2. Pain and Suffering	40,315.30
TOTAL DAMAGES	$50,000.00

THOMAS TILLMAN -vs- City of Milwaukee
Accident of April 1, 2008

DAMAGES

1. Medical Expenses (see attached itemization)	$ 9,684.70
2. Pain and Suffering	40,315.30
TOTAL DAMAGES	$50,000.00

Thomas Tillman
1-Apr-08

****

Itemization Of Medical Information & Special Damages

****

a	**Property Damage**		EST.	1,255.00
1	**V.A. Hospital**			
	REC	4/1/08		IN
	STMT	4/1/08		$5,553.58
	REC	5/2/08		IN
	STMT	5/2/08		$391.85
	REC	5/16/08		IN
	STMT	5/16/08		$2,484.27
2	**Photographs**			IN
3	**Mileage**			21.21
			Total	**$9,705.91**

Thomas Tillman
1-Apr-08

****

Itemization Of Medical Information & Special Damages

****

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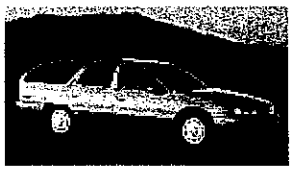
	REC	5/16/08		IN
	STMT	5/16/08		$2,484.27
2	**Photographs**			IN
3	**Mileage**			21.21
			Total	**$9,705.91**

Kelley Blue Book
THE TRUSTED RESOURCE
kbb.com

Send to Printer

1993 Ford Taurus GL Wagon 4D

BLUE BOOK® PRIVATE PARTY VALUE



	Condition	Value
	Excellent	$1,915
✓	Good	$1,610
	(Selected)	
	Fair	$1,255

Average Consumer Rating (78 Reviews) Read Reviews

☆☆☆☆☆ 4 out of 5 Review This Vehicle

Vehicle Highlights

Mileage: 169,000
Engine: V6 3.8 Liter
Transmission: Automatic
Drivetrain: FWD

Selected Equipment

Standard

Air Conditioning	Power Steering	AM/FM Stereo

Optional

Power Windows	Tilt Wheel	Cassette
Power Door Locks	Cruise Control	Dual Front Air Bags

Blue Book Private Party Value

Private Party Value is what a buyer can expect to pay when buying a used car from a private party. The Private Party Value assumes the vehicle is sold "As Is" and carries no warranty (other than the continuing factory warranty). The final sale price may vary depending on the vehicle's actual condition and local market conditions. This value may also be used to derive Fair Market Value for insurance and vehicle donation purposes.

Vehicle Condition Ratings

Excellent
$1,915

- Looks new, is in excellent mechanical condition and needs no reconditioning.
- Never had any paint or body work and is free of rust.
- Clean title history and will pass a smog and safety inspection.
- Engine compartment is clean, with no fluid leaks and is free of any wear or visible defects.
- Complete and verifiable service records.

Less than 5% of all used vehicles fall into this category.

✓ Good (Selected)
$1,610

- Free of any major defects.
- Clean title history, the paints, body, and interior have only minor (if any) blemishes, and there are no major mechanical problems.
- Little or no rust on this vehicle.
- Tires match and have substantial tread wear left.
- A "good" vehicle will need some reconditioning to be sold at retail.

Most consumer owned vehicles fall into this category.

Fair
$1,255

- Some mechanical or cosmetic defects and needs servicing but is still in reasonable running condition.
- Clean title history, the paint, body and/or interior need work performed by a professional.
- Tires may need to be replaced.
- There may be some repairable rust damage.

Poor
N/A

- Severe mechanical and/or cosmetic defects and is in poor running condition.
- May have problems that cannot be readily fixed such as a damaged frame or a rusted-through body.
- Branded title (salvage, flood, etc.) or unsubstantiated mileage.

Kelley Blue Book does not attempt to report a value on a "poor" vehicle because the value of these vehicles varies greatly. A vehicle in poor condition may require an independent appraisal to determine its value.

* Wisconsin 4/7/2008

NOTE DATED: 04/01/2008 17:57
LOCAL TITLE: INJECTIONS / IMMUNIZATION OUTPT NOTE [DT]
STANDARD TITLE: NURSING OUTPATIENT IMMUNIZATION NOTE
VISIT: 04/01/2008 17:13 ER/TRIAGE/ACC(PM)
Reason for visit:
Immunizations

CPT: 90471
Tetanus/Diptheria/Acellular Pertussis Immunization Administered:

Vaccine Information Statement given to patient.

Patient agrees to Tetanus/Diptheria/Acellular Pertussis Vaccine

Dose: 0.5ml
Route: IM
Lot#: U2299CA Expiration Date: JUN/07/09
Site: Left Deltoid
Injections

Signed by: /es/ CHERYL ROHLOFF BSN, RN
REGISTERED NURSE
04/01/2008 17:59

NOTE DATED: 04/01/2008 17:38
LOCAL TITLE: 1010M - (TRIAGE/ER/ACC) NOTE
STANDARD TITLE: EMERGENCY DEPT NOTE
VISIT: 04/01/2008 17:13 ER/TRIAGE/ACC(PM)

FORM - 1010M

PRESENTING COMPLAINT: S/P MVC . STATES DROVE AROUND A CORNER AND HOT A BIG POTHOLE . STATES FACE HIT THE STEERING WHEEL AIRBAG DEPLOYED STATES PT . STATES WAS GOING 10 MPH. DENIES LOC BUT WIFE STATES HE WAS OUT FOR A MINUTE . LACERATION TO LOWER LIP AREA 1.5 INCHES BLEEDING CONTROLLED . BLOODY NOSE WITH SWELLING CURRENTLY NON BLEEDING . C/O PAIN TO RIGHT HAND ESP THENAR AREA SWELLING NOTED. DENIES CHEST PAIN SOB . STATES REPORTED TO POLICE AND EMS ON SCENE . DENIES NECLK PAIN C COLLAR APPLIED

TRIAGE - TIME OF ARRIVAL: 17:39
ON ARRIVAL: Ambulatory
AGE: 50
SEX: Male
DO TO INJURY?: No
HOMELESS?: No
Unintentional weight gain/loss (10 lbs or >) in the last month?: No
Any change in the use of your arms or legs in the last 3 months?: No
Have you FALLEN in the last six months?: No

========== PAST MEDICAL HISTORY ==========
ACTIVE PROBLEM LIST:

UPDATED	ICD9	PROBLEM
06/26/03	455.0	Internal hemorrhoids without mention of complication (ICD-9-CM 455.0)
06/26/03	562.10	Diverticulosis, Colonic (ICD-9-CM 562.10)
07/22/03	401.9	Hypertension (ICD-9-CM 401.9)
02/18/04	780.57	Sleep Apnea (ICD-9-CM 780.57/786.09)
03/05/04	272.1	Hypertriglyceridemia (ICD-9-CM 272.1)
03/05/04	278.00	Obesity (ICD-9-CM 278.00)
03/05/04	305.1	Tobacco Use (ICD-9-CM 305.1)
11/08/05	362.89	Retinal Disorder
09/26/06	366.9	Cataract NOS
06/13/07	724.2	Low Back Pain (ICD-9-CM 724.2)

========== NEUROSENSORY ==========
Oriented to: place,

========== CURRENT MEDICATONS ==========

Exp Date	Medication
03/01/09	LISINOPRIL 20MG TAB TAKE ONE-HALF TABLET BY MOUTH EVERY DAY FOR BLOOD PRESSURE
02/01/09	AMITRIPTYLINE HCL 50MG TAB TAKE ONE TABLET BY MOUTH AT BEDTIME
02/01/09	GABAPENTIN 400MG CAP TAKE THREE CAPSULES BY MOUTH THREE TIMES A DAY
01/17/09	SIMVASTATIN 40MG TAB TAKE ONE-HALF TABLET BY MOUTH EVERY EVENING - TO LOWER CHOLESTEROL. , AVOID GRAPEFRUIT AND ITS JUICE WITH THIS MED.
01/16/09	HYDROCHLOROTHIAZIDE 25MG TAB TAKE ONE TABLET BY MOUTH EVERY MORNING FOR BLOOD PRESSURE
06/13/08	DOCUSATE NA 100MG CAP TAKE ONE CAPSULE BY MOUTH EVERY DAY AS NEEDED TO SOFTEN STOOLS

** THIS NOTE CONTINUED ON NEXT PAGE **

04/01/2008 17:38 ** CONTINUED FROM PREVIOUS PAGE **

06/13/08 NAPROXEN 500MG TAB TAKE ONE TABLET BY MOUTH TWICE A DAY FOR PAIN - TAKE WITH FOOD

========== ALLERGIES ==========
Known Allergies Reviewed, No Allergy to LATEX (rubber),
ALLERGIES:
LOVASTATIN 40MG TAB - HEADACHE
FLUNISOLIDE NASAL SOLUTION 25ML - BURNING;DISCOMFORT

========== MEDS ==========
Patient's medications are listed in the computer.
========== VITAL SIGNS ==========

Time	Temp	Pulse	Resp	B/P	FS	POx	Pain
17:39	98.7	77	16	151/109		97	6
BP: Lying/Left arm							
17:45				156/100			6
BP: Sitting/Left arm							

NURSING DIAGNOSIS:
Acute pain
========== DISPOSITION ==========
DISPOSITIONED TO: Emergency Room
CONDITION: Satisfactory

Signed by: /es/ MARGIT A ERKKILA
REGISTERED NURSE
04/01/2008 17:45

04/01/2008 18:02 ADDENDUM STATUS: COMPLETED
CC: MVA

HPI:
50 yo M w/ h/o HTN, LBP came to ED following MVA. Pt was driving, hit "very large pothole" - car bounced in and then out of it, airbag deployed but not before pt's face hit steering wheel. Seatbelt was on. Brief LOC, able to get out of car on own. 911 called, police came but pt preferred to be brought to VA ED. C/o pain in lip - lac; nosebleed on scene but resolved; bilat hand & wrist pain, R worse. Denies CP, SOB, abd pain, LE pain.

PMH:

Computerized Problem List is the source for the following:

1. Internal hemorrhoids without mention of complication (ICD-9-CM 455.0)
2. Diverticulosis, Colonic * (ICD-9-CM 562.10)
3. Hypertension * (ICD-9-CM 401.9)
4. Sleep Apnea (ICD-9-CM 780.57/786.09)
5. Hypertriglyceridemia * (ICD-9-CM 272.1)
6. Obesity * (ICD-9-CM 278.00)

** THIS NOTE CONTINUED ON NEXT PAGE **

04/01/2008 17:38 ** CONTINUED FROM PREVIOUS PAGE **

7. Tobacco Use * (ICD-9-CM 305.1)
8. Retinal Disorder
9. Cataract NOS
10. Low Back Pain * (ICD-9-CM 724.2)

Physical:

Vitals:
Temperature: 98.7 F [37.1 C] (04/01/2008 17:39)
Respirations: 16 (04/01/2008 17:39)
Pulse: 77 (04/01/2008 17:39)
Blood Pressure: 156/100 (04/01/2008 17:45)
Height: 70.5 in [179.1 cm] (02/29/2008 14:01)
Weight: 219 lb [99.5 kg] (02/29/2008 14:01)
Pain: 6 (04/01/2008 17:45)

Alert, uncomfortable but no reps distress
Nose swollen, early bruising, blood crusted in bilat nares. No tenderness on palpation of orbits or facial bones. 2.5 cm laceration entirely within lower lip, ~5mm deep/flap, oozing blood. No teeth tenderness, no bleeding within mouth.
C collar in place (placed on arrival)
R hand/wrist: Tenderness ventral aspect mid forearm with some swelling, no wrist tenderness. Tender & swollen thenar eminence, base of thumb, 2nd & 3rd carpals and MCP joints. ROM mildly limited. Sensation intact.
L hand/wrist: Localized swelling ventral aspect ~3 cm prox to wrist with bruising; tender & swollen 2nd & 3rd MCP joints. ROM mildly limited, sensation intact.
Abd soft NT/ND
LE nontender, full ROM

A/P:
MVA - lip laceration, possible fractures of nose, wrists/hands.
- C-spine films
- CT orbits
- XR Facial bones
- XR bilat wrists & hands
- CBC, BMP, coags
- Tetanus shot
- OMFS consult for lip lac

Pt signed out to Dr. Benjakul for further eval & tx
Signed by: /es/ JULIA M. WREN, MD
RESIDENT
04/01/2008 18:18

Cosigned by: /es/ PHILIP BENJAKUL MD
STAFF PHYSICIAN,PRIMARY CARE
04/01/2008 20:37

4

04/01/2008 20:37 ADDENDUM STATUS: COMPLETED** THIS NOTE CONTINUED O

Affidavit

Being first duly sworn, I do hereby state:

That my name is Everett Cherry. For approximately 11 years, I have been a resident at College Court, 3334 W. Highland, a City of Milwaukee Housing Authority residential facility. I stay in Unit #620. My telephone number is 414-934-0317.

In March 2008, a very large pothole appeared at the driveway entrance to the parking lot. The City placed a large orange and white barricade over the pothole that we had to go around to get in or out of the lot. The barricade was up for at least a week, but I am unsure how long. I then noticed that the barricade had been removed, but the hole was still there.

On April 1, 2008, I was waiting in the rear of the building to be picked up by Thomas Tillman. I understand that while I was waiting, Thomas was injured when his car hit the unprotected pothole in the driveway. I found out about it minutes after he got hurt.

If the City of Milwaukee had made a proper repair of the hole or if it left the barricade in place, this accident would not have happened.

I swear that the statement above is true and accurate.

Everett Cherry

Everett Cherry

Subscribed and sworn to before me
This 27th day of October 2008

Joanne Franken, Notary Public
My commission expires: 12-27-09

Affidavit

Being first duly sworn, I do hereby state:

That my name is Lena Cherry. For approximately 5 years, I have been a resident at College Court, 3334 W. Highland, a City of Milwaukee Housing Authority residential facility. I stay in Unit #812. My telephone number is 414-933-7285.

In March 2008, a very large pothole appeared at the driveway entrance to the parking lot. The City placed a large orange and white barricade over the pothole that we had to go around to get in or out of the lot. The barricade was up for at least a week, but I am unsure how long. I then noticed that the barricade had been removed, but the hole was still there.

On April 1, 2008, I left the parking lot in my car and had to avoid the hole in the driveway. The barricade had been removed a day or so earlier and as I left the lot I remarked to my companion words to the effect of, "I guess they are not going to fix that hole until somebody gets hurt!" When I returned to the lot I again avoided the hole, but as I got out of my car and was still in the lot, I saw a car go into the pothole.

It turned out that the person in the car was Thomas Tillman. When he drove into the hole, the barricade was no longer present. I believe the barricade was placed by the City of Milwaukee because it owns and manages both the building and the street in front of it. If the City of Milwaukee had made a proper repair of the hole or if it left the barricade in place, this accident would not have happened.

I swear that the statement above is true and accurate.

Lena Cherry

Lena Cherry

Subscribed and sworn to before me
This 27th day of October 2008

Joanne Franken, Notary Public
My commission expires: 12-27-09

04/01/2008 17:38 ** CONTINUED FROM PREVIOUS PAGE **

addendum:
pt seen and sutured by oral max surgery. pt to fu in clinic on monday tx with keflex x 5 days. awaiting radiology for imaging. further evaluation of neck and face and hand neg. pt without any gross deformities or pinpt boney tenderness.

Signed by: /es/ PHILIP BENJAKUL MD
STAFF PHYSICIAN,PRIMARY CARE
04/01/2008 21:25

04/01/2008 21:02 ADDENDUM STATUS: COMPLETED
PT GIVEN 2 TYLENOL # 3 PER VO DR BENJAKUL
Signed by: /es/ SHEILA R ADAMEAK
REGISTERED NURSE
04/01/2008 21:02

HAND (ROUTINE) MIN 3 VIEW.

Exm Date: APR 01, 2008@18:30
Req Phys: WREN,JULIA

Pat Loc: ER/TRIAGE/ACC(PM) (Req'g Loc)
Img Loc: RADIOLOGY/MAIN DEPARTMENT
Service: Unknown

(Case 1187 COMPLETE) HAND (ROUTINE) MIN 3 VIEWS (RAD Detailed) CPT:73130
Proc Modifiers : BILATERAL EXAM
Reason for Study: See Clinical History:

Clinical History:
MVA; bilat hand & wrist pain with decreased mobility

Report Status: Verified

Date Reported: APR 01, 2008
Date Verified: APR 01, 2008

Verifier E-Sig:/ES/MITCHELL S SANDLER

Report:
Three views of each hand and each wrist were obtained. An intravenous catheter is present in the soft tissue on the dorsum of the left hand, and a portion of the intravenous tubing is noted on the dorsal aspect of the left wrist and distal forearm. No fracture, dislocation, or additional abnormality is seen.

Impression:

Normal bilateral hands and wrists, with intravenous catheter in soft tissue on dorsum of left hand.

Primary Interpreting Staff:
MITCHELL S SANDLER, STAFF PHYSICIAN,RADIOLOGY (Verifier)
/MSS

****

CERVICAL SPINE (ROUTINE) MIN 4 VIEWS

Exm Date: APR 01, 2008@18:30
Req Phys: WREN,JULIA

Pat Loc: ER/TRIAGE/ACC(PM) (Req'g Loc)
Img Loc: RADIOLOGY/MAIN DEPARTMENT
Service: Unknown

(Case 1189 COMPLETE) CERVICAL SPINE (ROUTINE) MIN 4 VI(RAD Detailed) CPT:72050
Reason for Study: See Clinical History:

Clinical History:
MVA, airbag

Report Status: Verified

Date Reported: APR 01, 2008
Date Verified: APR 01, 2008

Verifier E-Sig:/ES/MITCHELL S SANDLER

Report:
AP, lateral, oblique, odontoid, and swimmers views of the cervical spine reveal disc space narrowing which is marked at the level of C5-6 and mild at C3-4. Hypertrophic degenerative disease is present, with osteophytes on the anterior and posterior vertebral body margins at C5-6 and on the facet joints at several levels. The oblique views demonstrate encroachment upon intervertebral foramina which is moderate to marked at C3-4 on the left and mild at C5-6 and C6-7 on both sides.

There is loss of the normal lordosis. No fracture, dislocation, or additional abnormality is seen in the visualized bones. Incidentally noted are small calcified lymph nodes in the right paratracheal region of the mediastinum and the hilum of the right lung due to old inactive inflammatory disease.

Impression:

1. Intervertebral disc space narrowing which is marked at C5-6 and mild at C3-4.

2. Hypertrophic degenerative disease with encroachment of osteophytes upon intervertebral foramina which is moderate to marked at C3-4 and left and mild at C5-6 and C6-7 bilaterally.

3. Loss of normal lordosis which may be a result of muscle spasm or patient position.

4. Otherwise normal cervical spine.

Primary Interpreting Staff:
MITCHELL S SANDLER, STAFF PHYSICIAN,RADIOLOGY (Verifier)
/MSS

****

FACIAL BONES (ROUTINE) MIN. 3 VIEWS

Exm Date: APR 01, 2008@18:30
Req Phys: WREN,JULIA

Pat Loc: ER/TRIAGE/ACC(PM) (Req'g Loc)
Img Loc: RADIOLOGY/MAIN DEPARTMENT
Service: Unknown

(Case 1191 COMPLETE) FACIAL BONES (ROUTINE) MIN. 3 VIE(RAD Detailed) CPT:70150
Reason for Study: See Clinical History:

Clinical History:
MVA, airbag deployed, nose swollen

Report Status: Verified

Date Reported: APR 01, 2008
Date Verified: APR 01, 2008

Verifier E-Sig:/ES/MITCHELL S SANDLER

Report:
PA, Townes, and left lateral views of the facial bones reveal no definite fractures or additional abnormalities. For unknown reasons, a Waters view is not submitted, and should be obtained to complete the examination of the facial bones. Also the clinical history states that the patient's nose is swollen. The nasal bones are poorly visualized on radiographs of the facial bones, and if the patient hurts in the region of the nose, radiographs of the nasal bones should be obtained.

Impression:

Normal PA, Townes, and left lateral views of facial bones. A Waters view of the facial bones should be obtained as well, along with radiographs of the nasal bones if the patient has pain or swelling in this area.

Primary Interpreting Staff:
MITCHELL S SANDLER, STAFF PHYSICIAN,RADIOLOGY (Verifier)
/MSS

****

WRIST (ROUTINE) MIN 3 VIEWS

Exm Date: APR 01, 2008@18:30
Req Phys: WREN,JULIA

Pat Loc: ER/TRIAGE/ACC(PM) (Req'g Loc)
Img Loc: RADIOLOGY/MAIN DEPARTMENT
Service: Unknown

(Case 1192 COMPLETE) WRIST (ROUTINE) MIN 3 VIEWS (RAD Detailed) CPT:73110
Proc Modifiers : BILATERAL EXAM
Reason for Study: See Clinical History:

Clinical History:
Bilat wrist pain post MVA

Report Status: Verified

Date Reported: APR 01, 2008
Date Verified: APR 01, 2008

Verifier E-Sig:/ES/MITCHELL S SANDLER

Report:
Three views of each hand and each wrist were obtained. An intravenous catheter is present in the soft tissue on the dorsum of the left hand, and a portion of the intravenous tubing is noted on the dorsal aspect of the left wrist and distal forearm. No fracture, dislocation, or additional abnormality is seen.

Impression:

Normal bilateral hands and wrists, with intravenous catheter in soft tissue on dorsum of left hand.

8

Primary Interpreting Staff:
MITCHELL S SANDLER, STAFF PHYSICIAN,RADIOLOGY (Verifier)
/MSS

>>> Warning: Some list items lines may have been truncated.
>>> This list requires 81 characters/line.
>>> This device supports 80 characters/line.

ACTION LAW OFFICI
933 N MAYFAIR RD STE 200
MILWAUKEE, WI 53226

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 478789425
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TILLMAN, THOMAS LEE	3. PATIENT'S BIRTH DATE MM DD YY: 11 04 1957 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): TILLMAN, THOMAS LEE
5. PATIENT'S ADDRESS (No., Street): 4762 N 53RD STREET	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street): 4762 N 53RD STREET
CITY: MILWAUKEE STATE: WI	8. PATIENT STATUS: Single [ ] Married [ ] Other [X]	CITY: MILWAUKEE STATE: WI
ZIP CODE: 53218 TELEPHONE (Include Area Code): (414) 535-0212	Employed [X] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE: 53218 TELEPHONE (Include Area Code): (414) 535-0212
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: NONE
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: 11 04 1957 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: LAKEWOOD CARE CENTER
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: LEGAL
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 THOMAS L TILLMAN DATE 4/1/2008

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 THOMAS L TILLMAN

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 04 01 2008	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: 04 01 2008	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: BENJAKUL, PHILIP	17a. G3VA000 / 17b. NPI 1487687810	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04 01 2008 TO 04 01 2008
18. 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. 782.3 2. 719.43 3. 722.4 4. 729.5		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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 04 01 08 04 01 08	23		70150	26	1	6767	1		0B	27316
									NPI	1659473957
2 04 01 08 04 01 08	23		72050	26	2	8359	1		0B	27316
									NPI	1659473957
3 04 01 08 04 01 08	23		73110	50 26	3	7050	1		0B	27316
									NPI	1659473957
4 04 01 08 04 01 08	23		73130	50 26	4	7050	1		0B	27316
									NPI	1659473957
5									NPI	
6									NPI	

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
39-1326366 [ ] [X]	695-K8095QE	[X] YES [ ] NO	$ 29226	$ 000	$ 29226

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. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #
MITCHELL S SANDLER MD 8/5/2008 SIGNED DATE	MILWAUKEE VAMC 5000 W NATIONAL AVE MILWAUKEE, WI 53295 a. 1073563417 b.	VAMC MILWAUKEE BOX 55119 MADISON, WI 53705 (414) 384-2000 a. 1073563417 b. G2391326366

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APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

FIRST FOLD WHOF-10-ENV / WHOF-10-ENV-SS

SECOND FOLD

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

ACTION LAW OFFICE
933 N MAYFAIR RD STE 200
MILWAUKEE, WI 53226

2

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☒ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 478789425
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TILLMAN, THOMAS LEE	3. PATIENT'S BIRTH DATE: 11 04 1957 SEX: M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial): TILLMAN, THOMAS LEE
5. PATIENT'S ADDRESS (No., Street): 4762 N 53RD STREET	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street): 4762 N 53RD STREET
CITY: MILWAUKEE STATE: WI	8. PATIENT STATUS: Single ☐ Married ☐ Other ☒	CITY: MILWAUKEE STATE: WI
ZIP CODE: 53218 TELEPHONE (Include Area Code): (414) 535-0212	Employed ☒ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE: 53218 TELEPHONE (Include Area Code): (414) 535-0212
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: NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒	a. INSURED'S DATE OF BIRTH: 11 04 1957 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: LAKEWOOD CARE CENTER
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? YES ☐ NO ☒	c. INSURANCE PLAN NAME OR PROGRAM NAME: LEGAL
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.
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04 01 2008 TO 04 01 2008
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. 873.43 2. 719.43 3. 729.5 4. 782.3		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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 01 08 04 01 08	23		99284	GR	1234	43481	1		NPI	1487687810
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

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
39-1326366 ☒	695-K8095R2	YES ☒ NO ☐	$ 43481	$ 000	$ 43481

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. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (414) 384-2000
PHILIP BENUAKUE MD 8/5/2008 SIGNED DATE	MILWAUKEE VAMC 5000 W NATIONAL AVE MILWAUKEE, WI 53295 a. 1073563417 b.	VAMC MILWAUKEE BOX 55119 VAMC MILWAUKEE MADISON, WI 53705 a. 1073563417 b. G2391326366

ACTION LAW OFFICE
933 N MAYFAIR RD STE 200
MILWAUKEE, WI 53226

3

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 478789425
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CITY: MILWAUKEE STATE: WI	8. PATIENT STATUS: Single [ ] Married [ ] Other [X] Employed [X] Full-Time Student [ ] Part-Time Student [ ]	CITY: MILWAUKEE STATE: WI
ZIP CODE: 53218 TELEPHONE (Include Area Code): (414) 535-0212		ZIP CODE: 53218 TELEPHONE (Include Area Code): (414) 535-0212
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a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH: 11 04 1957 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: LAKEWOOD CARE CENTER
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: LEGAL
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.

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SIGNED THOMAS L TILLMAN DATE 4/1/2008

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SIGNED THOMAS L TILLMAN

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: BENJAKUL, PHILIP	17a. 1GEVAD0004 17b. NPI 1487687810	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04 01 2008 TO 04 01 2008
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. 782.3 2. E819.0 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 04 01 08 04 01 08	23		70480	26	12	34431	1		0B	47313
									NPI	1548297500
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

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
39-1326366 [ ] [X]	695-K8095NG	YES [X] NO [ ]	$ 34431	$ 000	$ 34431

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. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (414) 384-2000
HOSSAM K HAMDA MD 8/5/2008 SIGNED DATE	MILWAUKEE VAMC 5000 W NATIONAL AVE MILWAUKEE, WI 53295 a. 1073563417 b.	VAMC MILWAUKEE BOX 55119 VAMC MILWAUKEE MADISON, WI 53705 a. 1073563417 b. G2391326366

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

SECOND FOLD — FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

1 MILWAUKEE VAMC 5000 W NATIONAL AVE MILWAUKEE WI 53295 4143842000	2 VAMC MILWAUKEE F 55119 VAMC MILWA MADISON WI 53705	3a PAT. CNTL # 695-K8095RC b. MED. REC. # 789425 5 FED. TAX NO. 39-1326366 6 STATEMENT COVERS PERIOD FROM 040108 THROUGH 040108	4 TYPE OF BILL 0131 7

8 PATIENT NAME	9 PATIENT ADDRESS
a b TILLMAN, THOMAS LEE	a 4762 N 53RD STREET b MILWAUKEE c WI d 53218 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18-28 CONDITION CODES	29 ACDT STATE	30
11041957	M	040108	9	1			01			

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38
ACTION LAW OFFICES
933 N MAYFAIR RD STE 200
MILWAUKEE, WI 53226

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

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0320	DX X-RAY	70150	040108	1	33220	000	
0320	DX X-RAY	72050	040108	1	60755	000	
0320	DX X-RAY	7311050	040108	1	33220	000	
0320	DX X-RAY	7313050	040108	1	33220	000	
0351	CT SCAN/HEAD	70480	040108	1	189980	000	
0450	EMERG ROOM	9928425	040108	1	91712	000	
0771	VACCINE ADMIN	90471	040108	1	6113	000	

PAGE 1 OF 2 CREATION DATE 080508 TOTALS

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1073563417
ACTION LAW OFFICES		Y	Y	000	448220	57 OTHER PRV ID	39-1326366

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
TILLMAN, THOMAS LEE	18	478789425	LEGAL	NONE

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
		LAKEWOOD CARE CENTER

66										
873.43	719.43	729.5	782.3	722.4	715.98	723.1	V06.1			

67 ADMIT. DX	70 PATIENT REASON DX			71 PPS CODE	72 ECI			73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
90471	040108	90715	040108	99284	040108	

OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE
70150	040108	72050	040108	73110	040108

76 ATTENDING	NPI 1487687810	QUAL 1GVAD000
LAST BENJAKUL	FIRST PHILIP	
77 OPERATING	NPI 1548297500	QUAL 1GVAD000
LAST HAMDA	FIRST HOSSAM K	
78 OTHER	NPI 1659473957	QUAL 1GVAD000
LAST SANDLER	FIRST MITCHELL S	
79 OTHER	NPI	QUAL
LAST	FIRST	

80 REMARKS

81CC	
a	
b	
c	
d	

1 MILWAUKEE VAMC
5000 W NATIONAL AVE
MILWAUKEE WI 53295
4143842000

2 VAMC MILWAUKEE
B 55119 VAMC MILWA
MADISON WI 53705

Field	Value
3a PAT. CNTL #	695-K8095RC
b. MED. REC. #	4 789425
4 TYPE OF BILL	0131
5 FED. TAX NO.	39-1326366
6 STATEMENT COVERS PERIOD FROM	040108
THROUGH	040108
7	

8 PATIENT NAME	9 PATIENT ADDRESS
TILLMAN, THOMAS LEE	4762 N 53RD STREET
	MILWAUKEE WI 53218

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
11041957	M	040108		9	1		01			

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38
ACTION LAW OFFICES
933 N MAYFAIR RD STE 200
MILWAUKEE, WI 53226

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

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0001	PAGE 2 OF 2	CREATION DATE	080508	TOTALS	448220	000	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
ACTION LAW OFFICES		Y	Y	000	448220	1073563417

57 OTHER PRV ID: 39-1326366

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
TILLMAN, THOMAS LEE	18	478789425	LEGAL	NONE

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME
LAKEWOOD CARE CENTER

66 DX | 67 | 68
69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
73130	040108	70480	040108			

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

Provider	NPI	QUAL	LAST	FIRST
76 ATTENDING	1487687810	1G VAD000	BENJAKUL	PHILIP
77 OPERATING	1548297500	1G VAD000	HAMDA	HOSSAM K
78 OTHER	1659473957	1G VAD000	SANDLER	MITCHELL S
79 OTHER				

80 REMARKS
81CC a b c d

NOTE DATED: 05/02/2008 13:54
LOCAL TITLE: PC OUTPT NP F/U NOTE [T]
STANDARD TITLE: PRIMARY CARE NURSE PRACTITIONER OUTPATIENT NOTE
VISIT: 05/02/2008 11:30 PC GOLD MANCUSO NP
DEMOGRAPHICS: TILLMAN,THOMAS LEE 478-78-9425
50 year old BLACK OR AFRICAN AMERICAN MALE

SUBJECTIVE: Here for follow up appointment. He arrives at 1:30 p.m. for his 11:30 a.m. appointment. Last seen by me February 1, 2008.
1. History of low back pain with radiation to both hip areas and down both legs. Left worse than right at this time. Followed by pain clinic and had injection on 1/29/08 without results. Second injection on March 18th worked. He is no longer with cane. Has still has trouble bending low and lifting. He is taking it easy. He is off of the Gabapentin since the injection and is not taking the Amitriptyline. Uses Darvocet N 100 only for severe pain. Reports he is still using the Naproxen. He is working as a CNA and still on restriction. Taking it easy and trying not to do to much bending, lifting, stooping, and twisting. He will need a note to further extend his work restriction. Will follow up with pain clinic in July.
2. History of hypertension and hyperlipidemia. Reports taking medications regularly. Denies substernal chest pain, dyspnea, edema, palpitations, headache, dizziness, coughing or wheezing.
3. History of sleep apnea. Using CPAP with no issues
4. On April 1 he hit a pothole and his airbag went off and hit him in the face. Seen at VA ER and needed stitches to his lip. Lip has healed but has a bit of an elevated area. He also now has chronic sinus congestion since this incident and feels miserable. Further he notes right thumb pain and is not sure if he hit the thumb somewhere, but it is quite painful.
5. Last sigmoidoscopy in 2003. Due for colonoscopy this year.
6. History of macular degeneration. Reports that he no longer sees well enough to drive and will no longer drive or renew his license. Followed by eye clinic.
7. Requests temporary disability card for parking when he has exacerbations of his back pain.

ALLERGIES: LOVASTATIN 40MG TAB, FLUNISOLIDE NASAL SOLUTION 25ML

MEDICATIONS: Active and Recently Expired Outpatient Medications T-90+3 (excluding Supplies):

	Outpatient Medications	Status	Expiration
1)	AMITRIPTYLINE HCL 50MG TAB Qty: 30 for 30 days Sig: TAKE ONE TABLET BY MOUTH AT BEDTIME - not taking this	ACTIVE	02-01-09
2)	DOCUSATE NA 100MG CAP Qty: 90 for 90 days Sig: TAKE ONE CAPSULE BY MOUTH EVERY DAY AS NEEDED TO SOFTEN STOOLS	ACTIVE	06-13-08
3)	GABAPENTIN 400MG CAP Qty: 270 for 30 days Sig: TAKE THREE CAPSULES BY MOUTH THREE TIMES A DAY - not taking this	ACTIVE	02-01-09
4)	HYDROCHLOROTHIAZIDE 25MG TAB Qty: 90 for 90 days Sig: TAKE ONE TABLET BY MOUTH EVERY MORNING FOR BLOOD PRESSURE	ACTIVE	01-16-09
5)	LISINOPRIL 20MG TAB Qty: 45 for 90 days Sig: TAKE ONE-HALF TABLET BY MOUTH EVERY DAY FOR BLOOD PRESSURE	ACTIVE	03-01-09

** THIS NOTE CONTINUED ON NEXT PAGE **

10

05/02/2008 13:54 ** CONTINUED FROM PREVIOUS PAGE **

6)	NAPROXEN 500MG TAB Qty: 180 for 90 days Sig: TAKE ONE TABLET BY MOUTH TWICE A DAY FOR PAIN - TAKE WITH FOOD	ACTIVE	06-13-08
7)	PROPOXYPHENE-N-100 & APAP-650 OT Qty: 60 for 30 days Sig: TAKE 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR SEVERE PAIN ONLY	ACTIVE	03-30-08
8)	SIMVASTATIN 40MG TAB Qty: 45 for 90 days Sig: TAKE ONE-HALF TABLET BY MOUTH EVERY EVENING - TO LOWER CHOLESTEROL. AVOID GRAPEFRUIT AND ITS JUICE WITH THIS MED.	ACTIVE	01-17-09

MEDICATION REVIEWED [X]

OBJECTIVE:
PHYSICAL EXAM:
Wt: 213 lb [96.8 kg] (05/02/2008 13:43)
BMI: BODY MASS INDEX - 05/02/2008 13:43 29.8
Blood Pressure:

DATE	BP
MAY 02, 2008@13:45	152/96 Repeat BP 122/82
MAY 02, 2008@13:44	143/79
MAY 02, 2008	147.5/87.5AVERAGE BP

Pulse: 73 (05/02/2008 13:45)
Temp: 98.2 F [36.8 C] (05/02/2008 13:44)
Pain: 4 (05/02/2008 13:43)
Pleasant, alert, oriented x 3 male in no acute distress.

ASSESSMENT:
1. Low Back Pain secondary to Central Disc Herniation
2. Hypertension
3. Chronic Sinus Congestion
4. Right Thumb Pain

PLANS:
1. Will keep him off of Gabapentin.
2. He is to resume the Amitriptyline at 50 mg at hs.
3. Will continue with Darvocet for severe pain.
4. Continue other medications.
5. X-ray of right thumb.
6. CT of sinuses
7. Prescription for Loratadine 10 mg daily.
8. Filled out the form for a temporary parking ID card until November 2008.
9. Yearly labs fasting on 5/08/08: CBC, TSH, PSA, lipid panel, liver numbers, urinalysis, UDS.
10. Referral for colonoscopy.
11. He is dismayed regarding the waxing and waning of his back pain. Desires an opinion for possible surgical intervention. Referral to neurosurgery for evaluation.
12. Given a note for work on VA letterhead re his restriction. See below.
13. Follow up with me in July. Needs a 2 p.m. appointment.

PREVENTATIVE CARE:

** THIS NOTE CONTINUED ON NEXT PAGE **

05/02/2008 13:54 ** CONTINUED FROM PREVIOUS PAGE **

Clinical Reminder Activity
POSITIVE-Pain Screen:
Pain Assessment completed and documented in today's progress note.
Comment: Back Pain
Resting (5 Minutes) Vital Signs:
B/P: 122/82
Blood Pressure > 139/89:
Blood Pressure taken at this visit.
B/P: 122/82
The patient's current medication regimen is appropriate based on the patient's concomitant cardiovascular risk factors and/or other comorbidities.
Comment: Same

May 2, 2008

RE: Thomas Tillman
DOB 11/04/57

To Whom It May Concern:

Mr. Thomas Tillman is a patient at the Zablocki VA Medical Center. He was seen in the primary care clinic on May 2, 2008.

He may return to work with restrictions on May 2, 2008. His restrictions will continue and are no bending, stooping, twisting or lifting.

These restrictions are in effect until seen by pain clinic and this provider in July.

Sincerely,

Josephine M. Mancuso, MS, ANP-BC
Adult Nurse Practitioner
Primary Care Clinic - Gold Team

Signed by: /es/ JOSEPHINE M MANCUSO MS, ANP-BC
ADULT NURSE PRACTITIONER
05/02/2008 18:01

12

ACTION LAW OFFICE
933 N MAYFAIR RD STE 200
MILWAUKEE, WI 53226

8

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 478789425
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TILLMAN, THOMAS LEE	3. PATIENT'S BIRTH DATE: 11 04 1957 SEX: M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): TILLMAN, THOMAS LEE
5. PATIENT'S ADDRESS (No., Street): 4762 N 53RD STREET	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street): 4762 N 53RD STREET
CITY: MILWAUKEE STATE: WI	8. PATIENT STATUS: Single [ ] Married [ ] Other [X]	CITY: MILWAUKEE STATE: WI
ZIP CODE: 53218 TELEPHONE (Include Area Code): (414) 535-0212	Employed [X] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE: 53218 TELEPHONE (Include Area Code): (414) 535-0212
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: NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH: 11 04 1957 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: LAKEWOOD CARE CENTER
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: LEGAL
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 THOMAS L TILLMAN DATE 5/2/2008

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 THOMAS L TILLMAN

14. DATE OF CURRENT: MM DD YY 05 02 2008 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 PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 05 02 2008 TO 05 02 2008
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. 724.2 3. 473.9 2. 401.9 4. 729.5		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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 02 08 05 02 08	22		99214		1234	15010	1		NPI	1912909664
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

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
39-1326366 [ ] [X]	695-K8095MH	[X] YES [ ] NO	$ 15010	$ 000	$ 15010

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. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #
JOSEPHINE MANCUSO NP 8/5/2008 SIGNED DATE	MILWAUKEE VAMC 5000 W NATIONAL AVE MILWAUKEE, WI 53295 a. 1073563417 b.	(414) 384-2000 VAMC MILWAUKEE BOX 55119 VAMC MILWAUKEE MADISON, WI 53705 a. 1073563417 b. G2391326366

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

SECOND FOLD — FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

MILWAUKEE VAMC
000 W NATIONAL AVE
ILWAUKEE WI 53295
143842000

2 VAMC MILWAUKEE
E 55119 VAMC MILWA
MADISON WI 53705

- 3a PAT. CNTL #: 695-K8095MK
- b. MED. REC. #: 4 789425
- 4 TYPE OF BILL: 0131
- 5 FED. TAX NO.: 39-1326366
- 6 STATEMENT COVERS PERIOD FROM: 050208 THROUGH: 050208
- 7

- 8 PATIENT NAME: a
- b: TILLMAN,THOMAS LEE
- 9 PATIENT ADDRESS: a 4762 N 53RD STREET
- b MILWAUKEE c WI d 53218

BIRTHDATE	11 SEX	12 DATE (ADMISSION)	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18–28	29 ACDT STATE	30
1041957	M	050208		9	1		01			

31 OCCURRENCE CODE DATE · 32 OCCURRENCE CODE DATE · 33 OCCURRENCE CODE DATE · 34 OCCURRENCE CODE DATE · 35 OCCURRENCE SPAN CODE FROM THROUGH · 36 OCCURRENCE SPAN CODE FROM THROUGH · 37

CTION LAW OFFICES
33 N MAYFAIR RD STE 200
ILWAUKEE, WI 53226

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 / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
510	CLINIC	99214	050208	1	241 85	0 00	
0001	***PAGE*** 1 ***OF*** 1	***CREATION DATE***	080508	***TOTALS***	241 85	0 00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
ACTION LAW OFFICES		Y	Y	0 00	241 85	1073563417

57 OTHER PRV ID: 39-1326366

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
TILLMAN,THOMAS LEE	18	478789425	LEGAL	NONE

- 63 TREATMENT AUTHORIZATION CODES
- 64 DOCUMENT CONTROL NUMBER
- 65 EMPLOYER NAME: LAKEWOOD CARE CENTER

- 66 DX: 9 · 67: 724.2 · 401.9 · 473.9 · 729.5
- 68
- 69 ADMIT DX · 70 PATIENT REASON DX · 71 PPS CODE · 72 ECI · 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE
99214	050208				

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

75

- 76 ATTENDING NPI 1912909664 QUAL 1G VAD000
- LAST MANCUSO FIRST JOSEPHINE
- 77 OPERATING NPI QUAL
- LAST FIRST
- 78 OTHER NPI QUAL
- LAST FIRST
- 79 OTHER NPI QUAL
- LAST FIRST

80 REMARKS

81CC a b c d

CT SINUSES W/O

Exm Date: MAY 16, 2008@12:30
Req Phys: MANCUSO,JOSEPHINE

Pat Loc: PC GOLD MANCUSO NP (Req'g Loc)
Img Loc: CT/RADIOLOGY
Service: Unknown

(Case 1625 COMPLETE) CT SINUSES W/O (CT Detailed) CPT:70486
Reason for Study: See Clinical History:

Clinical History:
Ordering Provider's Pager #: 9996561

Last weight: 213 lb [96.8 kg] (05/02/2008 13:43)

Allergies: LOVASTATIN 40MG TAB, FLUNISOLIDE NASAL SOLUTION 25ML

Creatinine: SL2 - CREATININE
No data available for CREATININE----------O

GFR - ESTIMATED (1 occurrence in the past year) Collection DT
Spec EGFR
04/01/2008 17:30 PLASM 131.6

*If Creatinine and GFR above is not within the last 30 days please order. Indication for the scan: has chronic sinus congestion since being hit in face with an airbag.

Contrast allergy: No Is the patient on metformin? No Is there an aspiration risk? No Pertinent past history: as above

Clinical history: as above

Body piercings: No CT needed by (The date that the examination is desired) : May 30,2008

Report Status: Verified

Date Reported: MAY 16, 2008
Date Verified: MAY 16, 2008

Verifier E-Sig:/ES/HOSSAM K HAMDA

Report:
Contiguous axial non-enhanced CT sections of the paranasal sinuses were obtained and reviewed in bone algorithm and coronal formats. Comparison: Reference is made to a CT of the orbit dated 4/1/08.

Unchanged minimal bilateral ethmoid and frontal mucosa thickening is noted. The parannasal sinuses are well-aerated. The osteomeatal units are narrowed bilaterally, secondary to focal mucosa thickening. There is 4 mm leftwards nasoseptal deviation, including 2 mm bony spur. There is bilateral concha bullosa with a small mucus retention cyst within the left one.

The scans through the intracranial structures are significant for cavum septum pellucidum and cavum vergae (anatomical variants). The scans through both orbits appear unremarkable.

ACTION LAW OFFICE
933 N MAYFAIR RD STE 200
MILWAUKEE, WI 53226

6

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) [X] / FECA BLK LUNG (SSN) / OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 478789425
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TILLMAN, THOMAS LEE	3. PATIENT'S BIRTH DATE MM DD YY: 11 04 1957 SEX: M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): TILLMAN, THOMAS LEE
5. PATIENT'S ADDRESS (No., Street): 4762 N 53RD STREET	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street): 4762 N 53RD STREET
CITY: MILWAUKEE STATE: WI	8. PATIENT STATUS: Single [ ] Married [ ] Other [X]	CITY: MILWAUKEE STATE: WI
ZIP CODE: 53218 TELEPHONE (Include Area Code): (414) 535-0212	Employed [X] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE: 53218 TELEPHONE (Include Area Code): (414) 535-0212
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: NONE
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: 11 04 1957 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: LAKEWOOD CARE CENTER
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: LEGAL
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 THOMAS L TILLMAN DATE 5/16/2008

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 THOMAS L TILLMAN

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 05 16 2008	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: 05 16 2008	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: MANCUSO, JOSEPHINE	17a. G VAD000 / 17b. NPI 1912909664	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 05 16 2008 TO 05 16 2008
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. 782.3 2. 473.9 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 16 08 05 16 08	22		70486	26	12	30649	1		0B	47313
									NPI	1548297500
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

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
39-1326366 [ ] [X]	695-K8095M2	[X] YES [ ] NO	$ 30649	$ 000	$ 30649

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. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (414) 384-2000
HOSSAM K HAMDA MD 8/5/2008 SIGNED DATE	MILWAUKEE VAMC 5000 W NATIONAL AVE MILWAUKEE, WI 53295 a. 1073563417 b.	VAMC MILWAUKEE BOX 55119 VAMC MILWAUKEE MADISON, WI 53705 a. 1073563417 b. G2391326366

ACTION LAW OFFICE
933 N MAYFAIR RD STE 200
MILWAUKEE, WI 53226

5

(1500)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA — PICA — CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 478789425

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TILLMAN,THOMAS LEE

3. PATIENT'S BIRTH DATE MM DD YY: 11 04 1957 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): TILLMAN,THOMAS LEE

5. PATIENT'S ADDRESS (No., Street): 4762 N 53RD STREET

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

7. INSURED'S ADDRESS (No., Street): 4762 N 53RD STREET

CITY: MILWAUKEE STATE: WI

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

CITY: MILWAUKEE STATE: WI

ZIP CODE: 53218 TELEPHONE (Include Area Code): (414) 535-0212

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

ZIP CODE: 53218 TELEPHONE (Include Area Code): (414) 535-0212

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: NONE

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: 11 04 1957 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: LAKEWOOD CARE CENTER

c. EMPLOYER'S NAME OR SCHOOL NAME:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: LEGAL

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 THOMAS L TILLMAN DATE 5/16/2008

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 THOMAS L TILLMAN

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 05 16 2008

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 PROVIDER OR OTHER SOURCE: MANCUSO,JOSEPHINE

17a. 1G VAD000

17b. NPI 1912909664

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 05 16 2008 TO 05 16 2008

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. 715.94
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 16 08	05 16 08	22		73130	RT 26	1	45 78	1		NPI	1457461436
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 39-1326366 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 695-K8095LM

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

28. TOTAL CHARGE $ 45 78

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 45 78

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.)

RONALD D HARRIS MD 8/5/2008

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

MILWAUKEE VAMC
5000 W NATIONAL AVE
MILWAUKEE, WI 53295

a. 1073563417 b.

33. BILLING PROVIDER INFO & PH. # (414) 384-2000

VAMC MILWAUKEE
BOX 55119 VAMC MILWAUKEE
MADISON, WI 53705

a. 1073563417 b. G2391326366

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

SECOND FOLD — FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-6S

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1	2	3a PAT. CNTL #	4 TYPE OF BILL
MILWAUKEE VAMC 5000 W NATIONAL AVE MILWAUKEE WI 53295 4143842000	VAMC MILWAUKEE B 55119 VAMC MILWA MADISON WI 53705	695-K8095M7 b. MED. REC. # 789425	0131

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
39-1326366	051608	051608	

8 PATIENT NAME	9 PATIENT ADDRESS			
a TILLMAN,THOMAS LEE	b MILWAUKEE	c WI	d 53218	e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
11041957	M	051608		9	1		01													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38

ACTION LAW OFFICES
933 N MAYFAIR RD STE 200
MILWAUKEE, WI 53226

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

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0320	DX X-RAY	73130RT	051608	1	33220	000	
0351	CT SCAN/HEAD	70486	051608	1	189980	000	
0001	PAGE 1 OF 1	CREATION DATE	080508	TOTALS	223200	000	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1073563417
ACTION LAW OFFICES		Y	Y	000	223200	57 OTHER PRV ID	39-1326366

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
TILLMAN,THOMAS LEE	18	478789425	LEGAL	NONE

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
		LAKEWOOD CARE CENTER

66 DX												67	68
9	715.94	782.3	473.9										

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI				73

74 a. PRINCIPAL PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	75
73130	051608	70486	051608							

76 ATTENDING	NPI 1912909664	QUAL 1GVAD000
LAST MANCUSO		FIRST JOSEPHINE
77 OPERATING	NPI 1457461436	QUAL 1GVAD000
LAST HARRIS		FIRST RONALD D
78 OTHER	NPI 1548297500	QUAL 1GVAD000
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80 REMARKS

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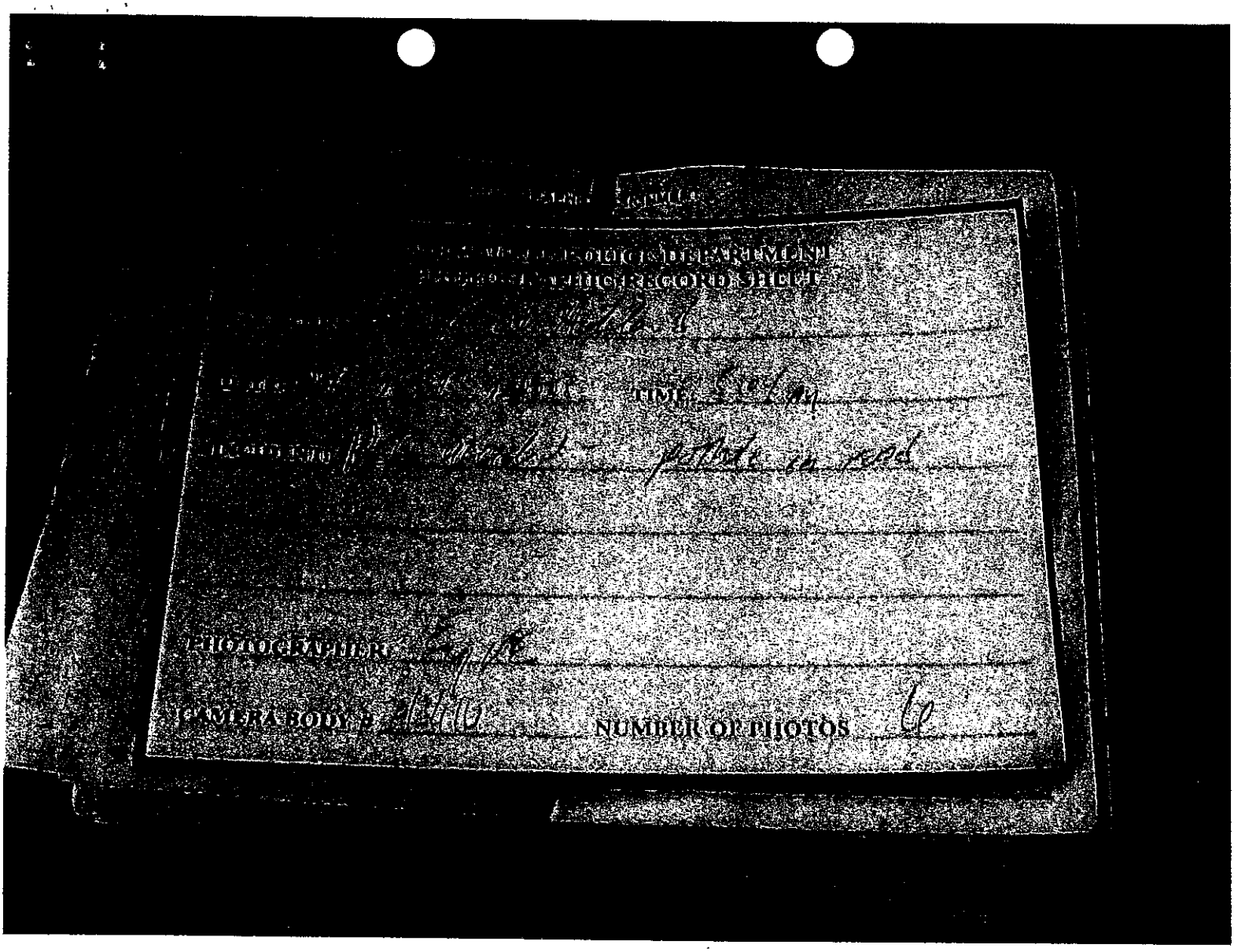
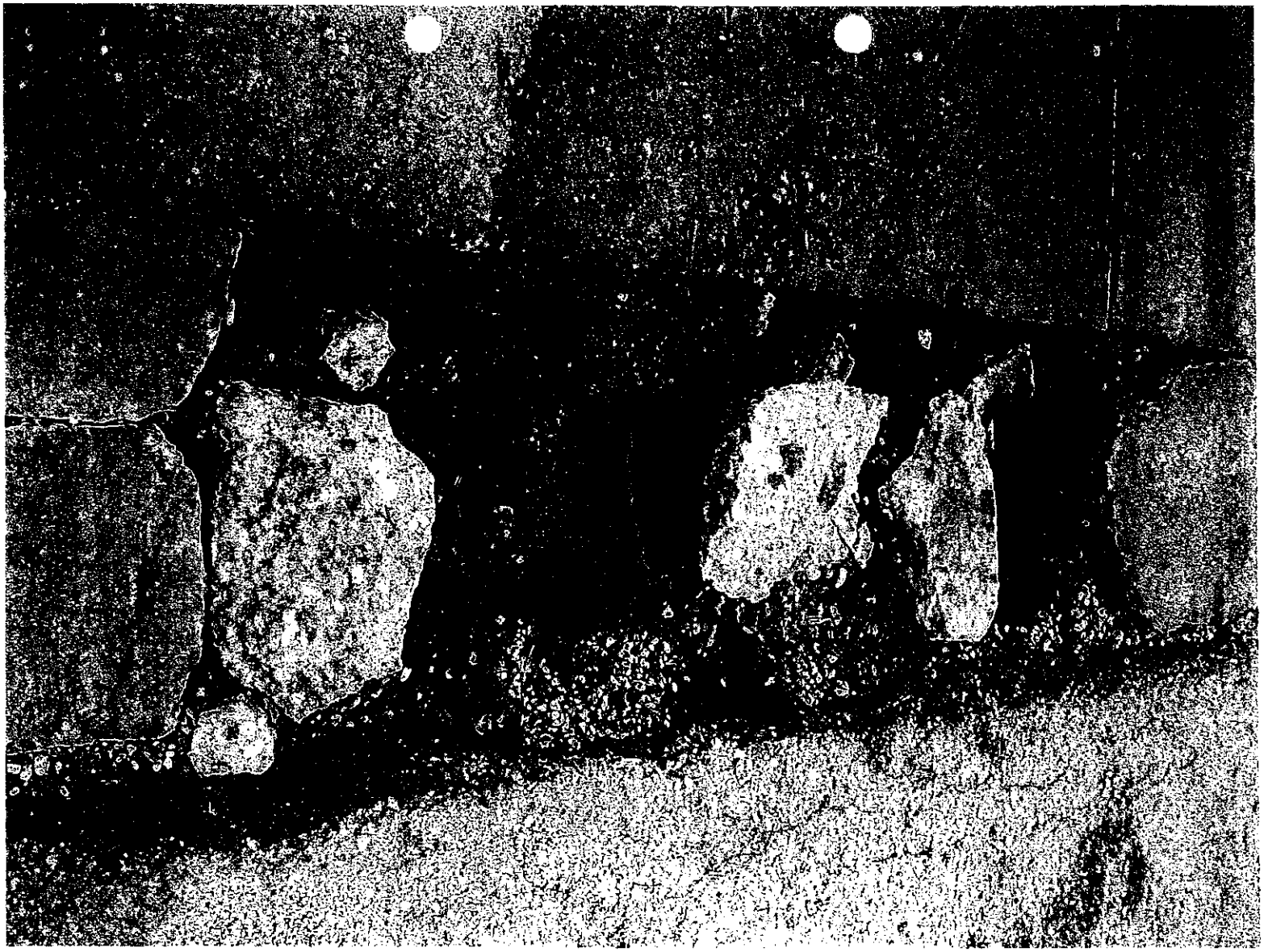

TIME:
NUMBER OF PHOTOS



Client: Thomas Tillman

DOI: 4/1/2008

****

MILEAGE

****

1 HOME VA Hospital

4762 N. 53rd St., Milwaukee, WI TO 5000 W. National Ave., Milwaukee, WI

7 miles X 0.505 = $ 3.54 X 3 times = 10.605 X 2 times (there & back) = $ 21.21

****

TOTAL MILEAGE COSTS: = $ 21.21

****

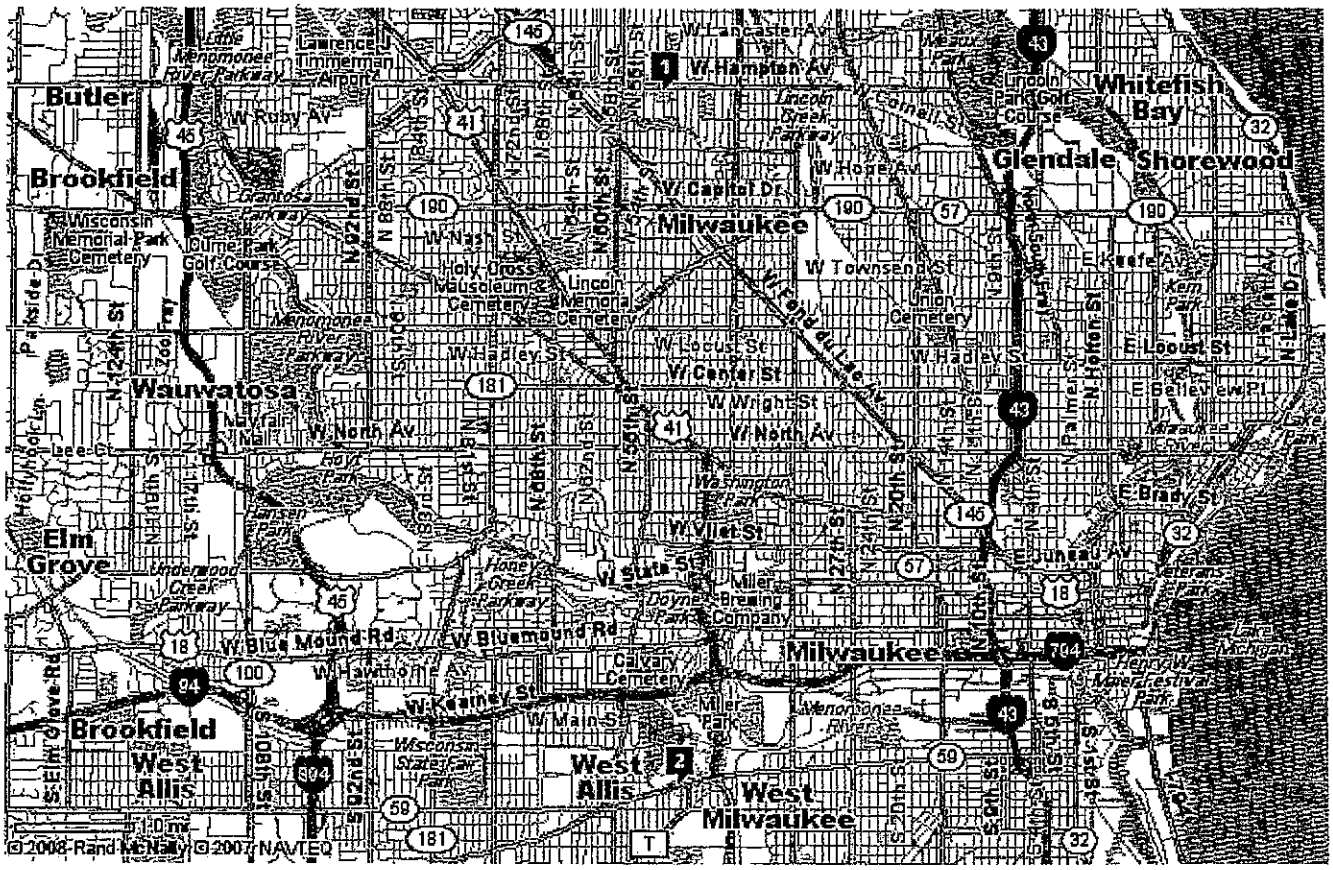
RAND McNALLY

Driving Directions

ROUTE SUMMARY

1. **4762 N 53rd St, Milwaukee, WI 53218-5013**
2. **5000 W National Ave, Milwaukee, WI 53295-0001**

STEPS: 9 **EST DRIVE TIME:** 21 minutes **EST. DISTANCE:** 7 miles



Advertisement

RAND McNALLY

Driving Directions

From : 4762 N 53rd St
Milwaukee , WI 53218-5013

To : 5000 W National Ave
Milwaukee , WI 53295-0001

1.	You are at 4762 N 53rd St, Milwaukee, WI 53218-5013	
2.	Go North on N 53rd St	< 0.1 miles
3.	Turn left onto W Hampton Av	0.4 miles
4.	Turn left onto N 60th St	2.3 miles
5.	Bear left onto US-41 (W Appleton Av)	1.1 miles
6.	Bear right onto US-41 S	1.7 miles
7.	Continue onto Miller Park Wy	1.0 miles
8.	Turn right onto WI-59 W (W National Av)	0.4 miles
9.	You are at 5000 W National Ave, Milwaukee, WI 53295-0001	

EST. DRIVE TIME: 21 minutes **EST. DISTANCE:** 7 miles

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true copy of the attached:

CLAIM

was served upon the hereinafter named:

CITY CLERK
CITY OF MILWAUKEE
200 EAST WELLS STREET
MILWAUKEE, WISCONSIN 53202

by enclosing same in an adequately postpaid envelope, bearing the sender's name and address which was duly deposited in a U.S. Mailbox on the 4th day of December, 2008, pursuant to Section 801.14(2), Milwaukee, Wisconsin.

TINA R. MCCOY, Paralegal
933 North Mayfair Road
Suite 200
Milwaukee, Wisconsin 53226
Telephone: (414) 456-1111