MONTANA STATEFUND

5 South Last Chance Gulch - P.O. Box 4759 - Helena, MT 59604-4759
Customer Service: 1-800-332-6102 or 406-444-6500
Fraud Hotline: 1-800-682-7463 (800-MT-CRIME)

January 16, 2004

EVAN A. DISNEY
902 SKY
MISSOULA MT 59804

RE: Case No. 032004070196

Dear EVAN A. DISNEY:

Montana State Fund has received a claim for an incident occurring on or about December 23, 2003. Your claim has been assigned to me to investigate and determine liability. If your claim has resulted in any lost time from work and you have not been contacted, please contact me immediately. Please be aware that Montana State Fund must be in receipt of your signed claim form before any wage loss or medical benefits can be paid. I am available to answer questions you have regarding this claim and can be reached at 444-6433. If calling from outside Helena, please call 1-800-332-6102 and enter the last four digits of my telephone number when the voice mail system asks for the extension.

Your claim has been assigned the claim number: 032004070196. Please refer to this number when contacting Montana State Fund. Also, be sure to advise your hospital, doctor, or pharmacy of this claim number when you receive treatment.

If Montana State Fund accepts liability for your claim, we want you to clearly understand your medical benefits. Please read the following very carefully.

TREATING PHYSICIAN

You are allowed to choose your initial treating physician. The treating physician is the doctor who is primarily responsible for the treatment of your workers' compensation injury. The treating physician must also be one of the following according to 39-71-116 (36) MCA:

(A) A physician licensed by the State of Montana, who has admitting privileges in one or more hospitals;

(B) A chiropractor licensed by the State of Montana;

(C) A physician assistant-certified and licensed by the State of Montana; if there is not a physician in the area where the physician assistant is located;

(D) An osteopath licensed by the State of Montana;

(E) A dentist licensed by the State of Montana;

(F) For an Injured Employee residing out of state or upon approval of the insurer, a treating physician defined in (A) through (E) above who is licensed or certified in another state; or

(G) An advanced practice nurse licensed by the State of Montana and recognized by the Board of Nursing as a nurse practitioner or a clinical nurse specialist, and practicing in consultation with a licensed physician, if there is not a treating physician in the area in which the advanced practice registered nurse is located.

Please contact your treating physician's office and verify that your provider meets one of these requirements in order to ensure approval of your treating physician. Once selected, you must have permission from Montana State Fund to change your treating physician.

TRAVEL RE: Case No. 032004070196

For claims arising on or after July 1, 2001, the injured employee is reimbursed for reasonable travel, lodging, meals, and miscellaneous expenses incurred in travel to a medical provider for treatment of an injury pursuant to rules adopted by the department. The claim for reimbursement of travel expenses must be submitted within 90 days of the date the expenses are incurred on a form furnished by the insurer. The injured employee will not be reimbursed for the first 100 miles of automobile travel for each calendar month unless the travel is requested or required by the insurer pursuant to 39-71-605; travel to a medical provider within the community in which the worker resides; travel outside the community in which the worker resides if comparable medical treatment is available within the community in which the worker resides, unless the travel is requested by the insurer; and, travel for unauthorized treatment or disallowed procedures.

DRUGS

Please have your pharmacist bill Montana State Fund directly for your prescriptions. If you pay for your initial prescription, send the receipt with the following information: Prescription number, the date it was filled, quantity, number of days it was for, NDC code and price paid. Your initial prescription reimbursement will be at the amount you paid. Subsequent prescriptions should be billed directly by the pharmacy to MSF. Should you pay for additional prescriptions, they will be reimbursed at the amount we would pay the pharmacy. Payment for drugs is limited to the average wholesale price at the time of purchase, plus a dispensing fee. Additionally, Montana State Fund is responsible only for the purchase of generic drugs if these are the therapeutic equivalent of a brand-name drug, unless the generic drug is unavailable. If you prefer a brand-name to a generic drug, you must pay the difference in the reimbursement rate for the brand-name drug and the generic drug.

MANAGED CARE ORGANIZATIONS AND PREFERRED PROVIDER ORGANIZATIONS

Montana State Fund may refer you to a Managed Care Organization (MCO) for medical treatment related to your claim. Should you qualify for treatment from a managed care organization, I will advise you and work with you on the change.

You may elect to continue treatment with your personal doctor, if your personal doctor agrees to Managed Care Guidelines. You have seven (7) days from the date you were first seen by an MCO provider to notify Montana State Fund or the MCO of your desire to be treated by your personal doctor.

CO-PAYMENTS

Recent revision to Montana Workers' Compensation Law includes a worker co-payment provision for medical benefits related to your claim, Montana State Fund will not implement the co-payment at this time. You will be notified should a co-payment come into effect.

PAYMENTS TO YOU BY OTHERS

If someone other than your employer caused your injury, you may be entitled to payment from them. If so, because we have been paying benefits to you, we are entitled to a reimbursement, subject to the provisions in the Montana Workers' Compensation Act.

IMPORTANT NOTICE

Please be aware that Montana State Fund pays only for medical conditions directly related to your industrial injury or occupational disease claim. If your medical benefits are not used for a period of 60 consecutive months, they will be permanently closed. You may become eligible for temporary total, permanent total or total rehabilitation benefits. If you receive benefits, you must notify Montana State Fund immediately if you return to any gainful employment. Any attempt to obtain or receive medical treatment or benefits you are not entitled to or that are not directly related to your claim may result in legal action or criminal prosecution.

Sincerely,

MARY SIMPSON
CUSTOMER SERVICE SPECIALIST

cc: MOUNTAIN SUPPLY CO INC
2101 MULLAN RD
MISSOULA, MT 59802

SF-MIS- LPCLM293

MONTANA STATE FUND

5 South Last Chance Gulch - P.O. Box 4759 - Helena, MT 59604-4759
Customer Service: 1-800-332-6102 or 406-444-6500
Fraud Hotline: 1-800-682-7463 (800-MT-CRIME)

January 16, 2004

MOUNTAIN SUPPLY CO INC
2101 MULLAN RD
MISSOULA MT 59802

RE: Case No. 032004070196

Dear EMPLOYER:

Montana State Fund has received a claim for an incident occurring on or about December 23, 2003 involving Evan A. Disney. Evan's claim has been assigned to me to investigate and determine liability. If Evan's claim has resulted in any lost time from work and he has not been contacted, he should contact me immediately. Please be aware that Montana State Fund must be in receipt of Evan's signed claim form before any wage loss or medical benefits can be paid. I am available to answer questions you have regarding this claim and can be reached at 444-6433. If calling from outside Helena, please call 1-800-332-6102 and enter the last four digits of my telephone number when the voice mail system asks for the extension.

Evan's claim has been assigned the claim number: 032004070196. Please refer to this number when contacting Montana State Fund. Also, he should advise his hospital, doctor or pharmacy of this claim number when receiving treatment.

If Montana State Fund accepts liability for Evan's claim, we want you to clearly understand the medical benefits available. Please read the following very carefully.

TREATING PHYSICIAN

Evan is allowed to choose the initial treating physician. The treating physician is the doctor who is primarily responsible for the treatment of his workers' compensation injury. The treating physician must also be one of the following according to 39-71-116 (36) MCA:

(A) A physician licensed by the State of Montana, who has admitting privileges in one or more hospitals;

(B) A chiropractor licensed by the State of Montana;

(C) A physician assistant-certified and licensed by the State of Montana; if there is not a physician in the area where the physician assistant is located;

(D) An osteopath licensed by the State of Montana;

(E) A dentist licensed by the State of Montana;

(F) For an Injured Employee residing out of state or upon approval of the insurer, a treating physician defined in (A) through (E) above who is licensed or certified in other state; or

(G) An advanced practice nurse licensed by the State of Montana and recognized by the Board of Nursing as a nurse practitioner or a clinical nurse specialist, and practicing in consultation with a licensed physician, if there is not a treating physician in the area in which the advanced practice registered nurse is located.

Evan should contact his treating physician's office and verify that his provider meets one of these requirements in order to ensure approval of his treating physician. Once selected, he must have permission from Montana State Fund to change his treating physician.

TRAVEL RE: Case No. 032004070196

For claims arising on or after July 1, 2001, the injured employee will be reimbursed for reasonable travel, lodging, meals, and miscellaneous expenses incurred in travel to a medical provider for treatment of an injury pursuant to rules adopted by the department. The claim for reimbursement of travel expenses must be submitted within 90 days of the date the expenses are incurred on a form furnished by the insurer. The injured employee will not be reimbursed for the first 100 miles of automobile travel for each calendar month unless the travel is requested or required by the insurer pursuant to 39-71-605; travel to a medical provider within the community in which the worker resides; travel outside the community in which the worker resides if comparable medical treatment is available within the community in which the worker resides, unless the travel is requested by the insurer; and, travel for unauthorized treatment or disallowed procedures.

DRUGS

Evan should have his pharmacist bill Montana State Fund directly for the prescriptions. If he pays for the initial prescription, he should send the receipt with the following information: Prescription number, the date it was filled, quantity, number of days it was for, NDC code and price paid. His initial prescription reimbursement will be at the amount he paid. Subsequent prescriptions should be billed directly by the pharmacy to MSF. Should she pay for additional prescriptions, they will be reimbursed at the amount we would pay the pharmacy. Payment for drugs is limited to the average wholesale price at the time of purchase, plus a dispensing fee. Additionally, Montana State Fund is responsible only for the purchase of generic drugs if these are the therapeutic equivalent of a brand-name drug, unless the generic drug is unavailable. If Evan prefers a brand-name to a generic drug, he must pay the difference in the reimbursement rate for the brand-name drug and the generic drug.

MANAGED CARE ORGANIZATIONS AND PREFERRED PROVIDER ORGANIZATIONS

Montana State Fund may refer Evan to a Managed Care Organization (MCO) for medical treatment related to his claim. Should he qualify for treatment from a managed care organization, I will advise him and work with him on the change.

He may elect to continue treatment with his personal doctor, if his personal doctor agrees to Managed Care Guidelines. He has seven (7) days from the date he was first seen by an MCO provider to notify Montana State Fund or the MCO of his desire to be treated by his personal doctor. Once the co-payment provision is put into effect, he will be responsible for a co-payment for services from his personal doctor.

CO-PAYMENTS

Montana State Fund will not implement the co-payment at this time. He will be notified should a co-payment come into effect.

PAYMENTS TO YOU BY OTHERS

If someone other than Evan caused the injury, he may be entitled to payment from them. If so, because we have been paying benefits to him, we are entitled to a reimbursement, subject to the provisions in the Montana Workers' Compensation Act.

IMPORTANT NOTICE

Please be aware that Montana State Fund pays only for medical conditions directly related to the claimant's industrial injury or occupational disease claim. If those medical benefits are not used for a period of 60 consecutive months, they will be permanently closed. He may become eligible for temporary total, permanent total or total rehabilitation benefits. If he receives benefits, he must notify Montana State Fund immediately if he returns to any gainful employment. Any attempt to obtain or receive medical treatment or benefits he is not entitled to or that are not directly related to the claim may result in legal action or criminal prosecution.

Sincerely,

MARY SIMPSON
CUSTOMER SERVICE SPECIALIST

SF-MIS- LPCLM293

PLEASE DO NOT STAPLE IN THIS AREA 121 STFU

STATE FUND OF MONTANA
PO BOX 4759
HELENA MT 59604

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
[ ] (Medicare #) [ ] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [X] (ID)	032004070196
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DISNEY EVAN A	3. PATIENT'S BIRTH DATE: 04 17 78 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): DISNEY EVAN A	
5. PATIENT'S ADDRESS (No., Street): 4809 CHESAPEAKE WAY	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 4809 CHESAPEAKE WAY	
CITY: MISSOULA STATE: MT	8. PATIENT STATUS: Single [ ] Married [X] Other [ ]
CITY: MISSOULA STATE: MT	
ZIP CODE: 59808 TELEPHONE (Include Area Code): (406) 240 2196	Employed [X] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE: 59808 TELEPHONE (INCLUDE AREA CODE): (406) 240 2196	
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: 517137948	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) [X] YES [ ] NO
a. INSURED'S DATE OF BIRTH: 04 17 78 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: MOUNTAIN SUPPLY	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FUND OF MONTANA	
d. INSURANCE PLAN NAME OR PROGRAM NAME: NO OTHER COVERAGE	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 01 12 04

SIGNED _____ DATE _____

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

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
12 23 03	01 05 04	FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE		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. 726 90 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 01 05 04	01 05 04	11	01	99213		1	80 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
810226415	[ ]	[X]	2964107	[X] YES [ ] NO	$ 80 00	$ 0 00	$ 80 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
TERENCE CALDERWOOD	WESTERN MONTANA CLINIC	WESTERN MONTANA CLINIC
SIGNED 01 12 04 DATE	500 W BROADWAY	PO BOX 7609
	MISSOULA, MT 59802	MISSOULA MT 59807 (406)721-5600
		PIN# GRP#

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

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

DISNEY, Evan MR#: 293767

01-05-2004

S: Evan had a fall 10 days ago on the ice at work. He landed on a partially outstretched right hand. He came in complaining of major shoulder pain to the emergency room. He was x-rayed; there was no fracture, no dislocation. He is still quite sore. He has been working at Sails at the office. Normally his work is fairly physical. Again, his pain is still fairly substantial and it is mostly in the medial shoulder near the area of the coracoid.

O: On exam today, his external rotation is limited due to pain. Internal rotation is markedly limited also because of pain. The deltoid structures seem fine. Biceps tendon seems fine.

A: Rotator cuff strain.

P: There is just no way he can do heavy work for at least three more weeks. I am going to limit his amount of pushing, pulling, lifting to 25 pounds over the next three weeks and then I will re-evaluate him to see if he is able to return to work at full capacity. I gave him some samples of **VIOXX** 50 mg today for about 12 days, then drop it down to 25 mg. He has some written exercises that were given to him at Community Hospital. He should do those gently a couple times per day.

T. CALDERWOOD, M.D./ljk R: 01-07-04 T: 01-07-04

DIVISION OF WORKERS' COMPENSATION

Montana Division of Workers' Compensation
5 South Last Chance Gulch
Helena, Montana 59601

ATTENDING PHYSICIAN'S FIRST REPORT AND INITIAL TREATMENT BILL

MAIL ROOM DATE: 293767

COMPLETE FORM IN FULL. All questions must be answered. Form must be mailed to the employer's worker's compensation insurer or the Division of Workers' Compensation at the address shown above within 48 hours after the first examination. IMPORTANT: Please be sure to give the correct spelling of the name and address of patient and employer.

CLAIMANT'S NAME (Last Name, First Name, Middle Initial)	EMPLOYER'S NAME
Disney, Evan A	Mountain Supply
CLAIMANT'S ADDRESS (Street, City, State, Zip Code)	EMPLOYER'S ADDRESS (Street, City, State, Zip Code)
4809 Chesapeake MSLA, MT 59808	210 Mullan Rd. MSLA, MT 59808
CLAIMANT'S TELEPHONE	EMPLOYER'S POLICY NO. (If known)

CLAIMANT'S SSN	ACCIDENT DATE (mm/dd/yy)	CLAIMANT'S SEX	EMPLOYER'S INSURER (If known)
571379448	12/23/03	☒ M ☐ F	State Fund

DWC ACCID /CLAIMANT (If known)

MORE INSTRUCTIONS ON BACK.

ACCIDENT

State in the patient's own words how the accident occurred:
Fell on ice

TREATMENT INFORMATION

Date first treatment rendered: 1/5/04 Hour 10:02 (AM) PM Place, Office

Name of hospital N/A Was private room ordered by you? ☐ Yes ☐ No N/A

Diagnosis and description of injury Rotata Cuff strain, Contusion (R) shoulder

X-Ray findings (-) at Comm. Med Center.

Describe treatment Rest, Exercise, Anti inflammatories.

SECTION BELOW MUST BE COMPLETED BEFORE CHARGES CAN BE PAID

DISABILITY

Will patient be off work more than 6 days because of this injury? ☐ Yes ☒ No

What date did the patient cease work? N/A

Estimate how long the patient will be off work due to this injury. ____ days/weeks

Will injury result in permanent disability? ☐ Yes ☐ No Hopefully not

Is the patient suffering from a condition which pre-existed this accident? ☐ Yes ☒ No

If yes, describe the condition.

Is present condition due to work related accident? ☒ Yes ☐ No

PHYSICIAN OR SUPPLIER INFORMATION

DWC ONLY TRANS	LN NO	SERVICE DATE (mm/dd/yy)	PROCEDURE CODE	MOD	DESCRIPTION	DIAGNOSTIC CODE	SIDE OF BODY	AMOUNT CHARGED	UNITS	DWC ONLY BYP
	01									
	02									
	03									
	04									
	05								1	
	06									

FINAL BILLING? ☐ Yes ☐ No Date of next appointment. TOTAL CHARGED ▶

SIGNATURE OF PHYSICIAN OR SUPPLIER: I certify statements on this bill are true and correct and the amounts billed are those I customarily charge.
T. Caldwell MD
DATE: 1/5/04

INCOMPLETE FORMS WILL BE RETURNED.

Your Montana License No. 6468

Your Social Security No. N/A

Physician's, Supplier's and/or Group Name, Address, Zip Code and Telephone No.

Your Patient Account No.

Your Tax I.D. No. 81-0226415

Your State Fund Payee No.

All items should be billed at amounts customarily charged. However, the DWC relative value fee schedule establishes a limitation on the amount payable for most procedures. After acceptance of liability by the insurer, the provider is prohibited from seeking payment from the patient.

INSURER'S USE ONLY

DOCUMENT ____ Batch ____ Document No. ____ Date

EXAM ____ Date ____ Initials ____ Code

RELS ____ Date ____ Initials ____ Code

LF 462 (Rev. 1/88)

DS 269/270

COMMUNITY MEDICAL CENTER 2827 FORT MISSOULA RD MISSOULA, MT 59804 406-728-4100	2	3 PATIENT CONTROL NO. 52902277	4 TYPE OF BILL 131

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
810247705	122303	122303					

12 PATIENT NAME	13 PATIENT ADDRESS
DISNEY , EVAN A	4809 CHESAPEAKE WAY MISSOULA MT59808

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
04171978	M	M	122303	13	9	7		01	0197756								

	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a	04	122303										A
b												B
												C

38	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT	
EVAN A DISNEY 4809 CHESAPEAKE WAY MISSOULA MT 59808	a 45	1100					a
	b						b
	c						c
	d						d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	270	MED-SUR SUPPLIES		122303	1	1275			1
2	320	SHOULDER COMP 73030	73030	122303	1	7975			2
3	320	HAND-COMP 73130	73130	122303	1	8475			3
4	450	EMERG ROOM	9928325	122303	1	11480			4
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23	001	TOTAL CHARGES							23

NOTICE:
2 CLAIMS ATTACHED

SEE ATTACHMENT
29205

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	
YO1 SCIF	02-0678-9	Y	Y				A
							B
							C

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	
DISNEY, EVAN A	18	517137948		032004070196	A
					B
					C

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	
	9	MOUNTAIN SUPPLY		A
				B
				C

67 PRIN. DIAG. CD.	68 CODE	69 CODE	OTHER DIAG. CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
8409	84210								9592	E8859	

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID	
9							G57689 GREER SCOTT Q	a
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID	b
								a
							OTHER PHYS. ID	b
								a
								b

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE	
a THIS COPY IS FOR YOUR RECORDS. LATER			
b REQUESTS FOR COPIES ARE SUBJECT TO CHARGE.			
c			
d FC = I PT TYPE = E	X PATIENT ACCOUNTS	012104	

UB-92 HCFA-1450 APPROVED OMB NO. 0938-0279 OCR/ORIGINAL

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

PLEASE DO NOT STAPLE IN THIS AREA I

Y01 SCIF

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 517137948

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

3. PATIENT'S BIRTH DATE: 04 17 78 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 4809 CHESAPEAKE WAY

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

7. INSURED'S ADDRESS (No., Street): 4809 CHESAPEAKE WAY

CITY: MISSOULA STATE: MT

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

CITY: MISSOULA STATE: MT

ZIP CODE: 59808 TELEPHONE (Include Area Code): (406) 240 2196

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

ZIP CODE: 59808 TELEPHONE (INCLUDE AREA CODE): (406) 240 2196

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: 032004070196

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH: 04 17 78 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: MOUNTAIN SUPPLY

c. EMPLOYER'S NAME OR SCHOOL NAME:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Y01 SCIF

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 12/23/03

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: 12 23 03

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: CALDERWOOD TERENCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E28046

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

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. 840.9
2. 842.10
3. 959.2
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 23 03	12 23 03	23	0	99282		1	62 05	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 810247705 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 52902277

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

28. TOTAL CHARGE: $ 62 05

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 62 05

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.)

GREER SCOTT Q 01/21/04

SIGNED DATE

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

COMMUNITY MEDICAL CT
2827 FORT MISSOULA R
MISSOULA MT 59804

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

COMMUNITY MEDICAL CENTER
2827 FORT MISSOULA R
MISSOULA, MT 59804

PIN# GRP#

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

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

COMMUNITY MEDICAL CENTER
MISSOULA MT 59804

ACCT# 52902277 MR# 019-7756
PATIENT INFORMATION: PT STATUS ET
NAME: DISNEY ,EVAN A SSN: 517-13-7948 RLG:
ADDR: 4809 CHESAPEAKE WAY DOB: 04/17/1978 25 Y
SEX: M M STS: M RACE: W
CTY/ST: MISSOULA MT 59808 AKA:
PHONE: 406 240-2196 (H) EMPL: MOUNTAIN SUPPLY

GUARANTOR INFORMATION:
NAME: DISNEY ,EVAN A REL: S SSN: 517137948
ADDR: 4809 CHESAPEAKE WAY EMPL: MOUNTAIN SUPPLY
CTY/ST:
CTY/ST: MISSOULA MT 59808 PHONE: 406 240-2196

EMERGENCY CONTACT: REL: P ACCIDENT INFORMATION:
NAME: DISNEY ,NICOLE
ADDR: SAME ACC IND: D LOC: O PLACE: O
DATE/TIME: 12/23/03 11:15
CTY/ST: SLIPPED ON ICE
PHONE: (H), (W)

INSURANCE INFORMATION: PT TYPE: E FIN CL: R
PLAN 1: Y99 WCOMP INFO NEEDED POL# 517137948 CB: 1
ADDR: 4809 CHESAPEAKE WAY GRP# REL: 01
SUBSCR: A
MISSOULA MT 59808- INS PHONE:
PLAN 2: POL# CB:
ADDR: GRP# REL:
SUBSCR:
INS PHONE:
PLAN 3: POL# CB:
ADDR: GRP# REL:
SUBSCR:
INS PHONE:
PLAN 4: POL# CB:
ADDR: GRP# REL:
SUBSCR:
INS PHONE:
PASSPORT PROV:

CASE INFORMATION:
ADM DT/TM: 12/23/03 13:27 HOSP SVC: EMD ADM SRC: EO
ADM PROV: CALDERWOOD TERENCE M 002204 ORGAN DONOR: ARR MODE: AU
ATN PROV: GREER SCOTT Q MD 004283 N STN/BED:
CARE PROF: LIV WILL: DPOA:
COMPLAINT: RT SHOULDER PAIN VALUABLES: ENV#:
EMAN MINOR: HEARING:

ALLERGIES: PCN
BY: DNS
DSCH DT/TM: __/__/____ __:__ LOS: ____

DA 959.2

DX 840.9
842.10
E885.9
E849.3

P 99282/13120050

E 99283(25)/13302179

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By Missoula Community
Medical Center

4992/69/20 HSE

HSH 02/23/2004

Community Medical Center
Emergency Department Patient Record
Adult (Nursing) - Page 1
Triage History & Assessment

ARRIVED BY: ☑ Ambulatory ☐ Carried ☐ Gurney ☐ Wheelchair ☐ Ambulance

☐ Emergent - Red ☑ Urgent - Yellow ☐ Non Urg - Green

Private MD: Calderwood

TRIAGE INTERVENTIONS: Time / Initials
☒ Ice Pack 1320 [initials]
☐ Splint
☐ C Collar
☐ Dressing
☐ Other

Time: 1319 **Allergies:** ☐ Latex NKDA

RESP: ☑ Normal Effort SKIN: ☑ Natural Color, W & D LOC: ☑ Alert/Age appropriate	ONSET OF SYMPTOMS: Date: 12/23/03 Time: 1115 ☐ Answers questions appropriately	TEMP.	PULSE REG ☑ / IRREG ☐	RESP.	PULSE OX ☑ RA	B/P
		96.7	86	20	O_2 96%	134/77

Chief Complaint: While @ work slipped on ice landing on Ⓡ
Assessment: arm - c/o severe Ⓡ shoulder pain/c numbness down arm to fingers - No obvious deformity - Ⓡ elbow & wrist also sore - strong Ⓡ radial pulse

UNIT ASSIGNMENT: ☒ E.D. ☐ FIRST CARE **RN Init.** CS

Past Medical History: Fx Ⓡ 5th finger 5 wks ago

Medications: (Rx, Herbal, OTC) ☐ None ☐ List attached
Excedrin tabs ii @ 1135

PAIN RATING NOW 6-7

Where is your pain located? Ⓡ shoulder, elbow, wrist Where did it start? same
What makes it better? nothing Worse? movement Pain Goal 3

Gross Physical and/or Developmental anomalies: ☐ Yes ☑ No If indicated, head circumference ______ Ht. ______

Height: ______ **Weight:** 79.5 kg. ☒ Std ☐ Act **LMP** NA

Smoking History: ☒ Never smoked ☐ Smoked ____ ppd x ____ years ☐ Quit

Immunizations: FLU ☐ Yes Yr ____ ☑ No Hepatitis A: ☒ Yes Yr 1996 ☐ No Tetanus date: 1996
Pneumonia: ☐ Yes Yr ____ ☑ No Hepatitis B: ☒ Yes Yr 1996 ☐ No Childhood current: ☐ Yes ☐ No

RN Init. CS

DISPOSITION

Admit Room #: ______ Report Called To ______ @ ______
Transported by: ☐ RN ☐ Tech ☐ Transporter ☐ ST ☐ WC ☐ O_2 ☐ Monitor
D/C Time: 1455 D/C With: RN D/C Pain Rating: 7-8 IV D/C Intact@ NA by ______
Mode: ☒ Walk ☐ Carried ☐ W/C
Status: ☐ Improved ☒ Stable
MD d/c instructions: ☒ Verbal ☒ Computer ☒ Dictated 65277

D/C Diagnosis
R Shoulder & Hand Sprain

Triage RN/Init. [signature] CS
RN Signature/Init. [signature] Bradley RN [initials]
RN Signature/Init.
RN Signature/Init.
Tech II Signature/Init.
Tech I Signature/Init.

RED stamp ... original copy. Any rep... by ... community

DISNEY, CAEVAN R
25 M DOB 04/17/1978
DATE 12/23/03 TIME 13:27 ET
GREER, SCOTT
ACCT#: 52902277 MR# 0197756

MD Signature / Initial [signature]

Emergency Department
Continuation Form - Page 2

ROOM (R) 15-A(?) TIME 1345

Primary RN Assessment: See triage note.

INITIAL SAFETY

☑ Name Band in Place ☐ Call Light in Reach ☑ Family/S.O. at Bedside ☐ Other ______

SKIN

Temperature: ☑ Warm ☐ Hot ☐ Cool ☐ Cold ☐ Dry ☐ Moist

Color: ☑ Pink ☐ Pale ☐ Ashen ☐ Jaundiced ☐ Cyanotic ☐ Flushed ☐ Mottled

Turgor: ☑ Normal ☐ Decreased

Mucous Membranes: ☑ Moist ☐ Dry ☑ Pink ☐ Pale

Fontanel: ☐ Sunken ☐ Bulging ☐ Flat — DNA

___ # of wet diapers in last 6 hours.

Tears ☐ Yes ☐ No

CARDIOVASCULAR

Pulse: ☐ Full ☐ Delayed ☐ Thready ☐ JVD ☐ Normal ☐ Edema

Capillary Refill:

EKG Rhythm: ☐ see strips

B/P Rt. | Lt.

RESPIRATORY

☑ Normal ☐ No Distress ☐ Cough ☐ Tripoding ☐ Aud. Wheeze ☐ Stridor ☐ Grunting ☐ Nasal Flare ☐ Retractions ☐ Sputum (color)

Lung Sounds: Rt. Lt. ☐ ☐ Clear ☐ ☐ Crackles ☐ ☐ Rhonchi ☐ ☐ Diminished ☐ ☐ Absent ☐ ☐ Wheeze

EYE ACUITY ☑ N/A

Left Eye /
Right Eye /
Corrected to
Left Eye /
Right Eye /

NEUROLOGICAL

LOC: GCS 15

☐ PERLA ☐ Alert ☐ Constricted ☐ Verbal ☐ Dilated ☐ Painful ☐ Unequal ☐ Unresponsive ☐ Nonreact

R ____ mm L ____ mm

Cry: ☐ Shril ☐ Lusty ☐ Weak ☐ N/A

Hand Grasp: ☐ Equal ☐ Unequal

Oriented: ☐ Person ☐ Place ☐ Time

GASTROINTESTINAL DNA

Abdomen: ☐ Soft ☐ Rigid ☐ Distended ☐ Tender ☐ Guarding

Bowel Sounds: ☐ RUQ ☐ RLQ ☐ LUQ ☐ LLQ

MUSCULOSKELETAL ☐ N/A

Area of Injury: (R) Shoulder

Pulse Present: ☑ All Ext. — Tingling 4th + 5th (R) fingers

Swelling: ☑ Yes

Sensory: ☐ All Ext.

Deformity: ☐ Yes

Movement: ☐ All Ext. ↓ (R) arm

PSYCHOSOCIAL CHARACTERISTICS

☑ No ~~abnormalities~~ known of mood or affect ☐ Suicidal Ideation ☐ Combative ☐ Agitation ☐ HOH (hard of hearing) ☐ Does not maintain eye contact ☐ Communication Barrier ☐ Language Barrier ☐ Cries when approached by health care worker ☐ Easily comforted by caregiver

RN INIT. JB

VITAL SIGNS / **NURSES NOTES**

TIME	BP	P	R	T	SaO2/FiO2	AVPU	PAIN 0-10	CARDIAC RHYTHM:	INIT.
1345								Pillow under (R) arm for support	JB
								and Head of Bed up.	
1355								Dr Greer in & examined pt. JB	
1410								To XR via wheelchair. JB	
1435								Ret'd to ED JB	
								Dr Greer in & talked c̄ pt & wife	
								regarding x-ray results and	
								discharge plan. ——— JB	
1443	127/66	86	20		98/RA	A	7-8	In to give instructions. Rev'd	
								c̄ pt & wife who express understanding	
								Pt requests Rx for stronger pain med -	
								Dr. notified & Rx written. Sling	
								applied & pt instructed. Good	
								(Cont'd on back)	

Intake - IV or PO	Amount	Output - Type	Amount
TOTAL INTAKE		TOTAL OUTPUT	

PATIENT LABEL:

DISNEY, EVAN A
25 M DOB 04/17/1978
DATE 12/23/03 TIME 13:27 ET
GREER SCOTT D MD
ACCT# 152902277 MR# 0197756

Emergency Department
Patient Record
Addendum - Page 3

TIME	BP	P	R	T	SaO2 FiO2	AVPU	PAIN 0-10		INIT.
								cap refill + CSM of (R) fingers - has tingling numbness of 4th & 5th fingers still.	JB

PATIENT

DISNEY ,EVAN A
25 M DOB 04/17/1978
DATE 12/23/03 TIME 13:27 ET
GREER SCOTT Q MD
ACCT# 52902277 MR# 0197756

MSE 02/03/2004

Emergency Department
Physician's Orders - Pg 4

LAB

	Time/ORD	Initials	Time Sent/Drawn	Initials
☐ Amylase				
☐ ABG				
☐ BMP				
☐ Cardiac enz				
☐ CBC				
☐ CMP				
☐ Liver panel				
☐ Preg-Ur/Se				
☐ PT/PTT				
☐ Quant HCG				
☐ Rapid Strep				
☐ U/A				
☐ R/O MI				
☐ Trauma Panel				
☐ Wet Prep				
☐ GC Screen				
☐ Chlamydia				
☐ Urine C & S				
☐ Blood CX ____ SITE X				
☐				
☐				
☐				
☐				
☐				

DIAG. IMAG

	Time/ORD	Initials
☐ Port CXR		
☐ X tbl C Spine		
☐ PA & Lat CXR		
☐ Flat & up abd		
☐ KUB		
☐ C Spine Complete ☐ LTD		
☐ T Spine		
☐ L Spine		
☒ R Shoulder & R Hand	1405	[illegible]

		Initials
☐ Cat Scan ____ r/o ____		
☐ Cat Scan ____ r/o ____		
☐ US ____ r/o ____		
☐ MRI ____ r/o ____		

RT

	Time/ORD	Initials
☐ EKG		
☐ HHN		
☐ ABG		
☐ Peak Flows		

Time Ordered	Procedure/Med/Fluid/DOSE/ROUTE/RATE	Time Started	Initials	Outcome	Stop Time	Initials
	DT Lot # **Exp Date:**					
	Heplock			**Ga**____ **Site**____ **Flush**____	**Attempts**____	
	Sling	1445	[illegible]	support of Ⓡ arm	[illegible]	

ALLERGIES: ☐ Latex NKDA

MDs Signature [signature]

PATIENT LABEL:

DISNEY ,EVAN A
25 [illegible] DOB 04/12/1978
DATE 12/23/03P TIME 13:27
GREER/SCOTT [illegible] MD
ACCT# 52902277 MR# 0197756

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Community Medical Center

04/08/2019

MD NOTES

MD Signature/Initials

PAT
DISNEY ,EVAN A
25 M DOB 04/17/1978
DATE 12/23/03 TIME 13:27 ET
GREER SCOTT Q MD
ACCT# 52902277 MR# 0197756

REVIEW OF SYSTEMS: Please review this list and circle all present complaints

Psychiatric
- Depression
- Anxiety
- Hallucinations
- Sleeplessness
- Schizophrenia

Endocrine
- Weight gain/loss
- Excessive thirst
- Always hot/cold
- Hunger
- Change in shoe size
- Excessive hair growth

Eyes
- Glasses / Contacts
- Blurred vision
- Eye itching
- Pain
- Redness
- Drainage
- Light irritation
- Double vision

Respiratory
- Persistent cough
- Pain with breathing
- Shortness of breath
- Coughing blood
- Wheezing / Asthma
- Breathing chemical exposure

Constitutional Symptoms
- Fever / Chills
- Weakness
- Sweats
- Fatigue
- Loss of appetite

Allergic / Immunologic
- Rash
- Itching
- Frequent infections
- Difficulty healing

Musculoskeletal
- Stiff / Painful
- Swollen / Red joint
- Back pain
- Arm / Leg Weakness (r / l)

Integumentary
- Rashes
- Itches / Burning
- Sores
- Growths / Moles
- Skin color changes

Neurological
- Dizziness
- Weakness
- Headaches
- Problems walking
- Shakes / Seizures
- Speech Problem
- Fainting

Gastrointestinal
- Heartburn
- Excess Gas
- Vomiting
- Vomiting Blood
- Nausea
- Diarrhea
- Constipation
- Blood in bowel movement
- Black/Tarry bowels
- Difficulty swallowing
- Rectal pain
- Abdominal Pain
- Ulcer
- Yellow Skin / Eyes

Cardiovascular
- Chest pain (tight)
- Palpitations
- High blood pressure
- Dizzy spells
- Swollen feet / ankles
- Blood Clots
- Night time shortness of breath
- Difficulty lying flat in bed
- Pain (L) arm
- Cold sweats
- Heart murmur
- Heart attacks
- Angioplasty / Bypass surgery

Hematologic
- Bruising / Bleeding
- Swollen glands

Genitourinary
- General - Pain with urination
  - Blood in urine
  - Pus in urine
  - Back pain
  - Inability to hold urine
  - Kidney stones
  - Venereal disease
- Male - Discharge/Sores on genitals
  - Testicle pain / swelling
- Female - Problems with period
  - Abdominal bleeding
  - Pelvic Pain
  - Vaginal Discharge

Ears, Nose, Mouth, Throat
- Ears - Bleeding Drainage
  - Drainage
  - Pain
  - Decreased hearing
  - Ringing
  - Swelling / Redness
- Nose - Bleeding
  - Congestion
  - Discharge
- Mouth - Bleeding
  - Congestion
  - Swelling
- Throat - Swallowing difficulty
  - Pain
  - Change in voice
  - Swelling

Explanations:

PAST AND FAMILY HISTORY:

Have you or any members of your immediate family have or had any of the following conditions: (please explain any checked problems on the lines below).

Condition	You	Family	Condition	You	Family
Bleeding problems	( )	( )	Seizures	( )	( )
HIV (AIDS)	( )	( )	Diabetes	( )	( )
Heart Problems	( )	( )	Kidney problems	( )	( )
Lung Problems	( )	( )	Abdominal problems	( )	( )
Mental Problems	( )	(X)	Cancer	( )	( )
High Blood Pressure	( )	( )	Strokes	( )	(X)
Weakness or uncoordination	( )	( )	High Cholesterol	( )	(X)
Venereal Disease (Syphilis, Gonorrhea)	( )	( )	Headaches	(X)	(X)
Sickle Cell	( )	( )			

Explanations:

SOCIAL HISTORY:

Occupation: Warehouse worker

Do you use tobacco? Amount and type per day: NO

Do you use alcohol? Amount and type per day: rarely

Have you used drugs? Amount and type: NO

PHYSICIAN SIGNATURE:

I have reviewed this history with patient / family: [signature]

6231-11B 10/99

6231-11B

COMMUNITY MEDICAL CENTER **Emergency Services Department**

PATIENT HISTORY REVIEW

DISNEY, EVAN A
25 M DOB 04/17/1978
DATE 12/23/03 TIME 13:27 ET
GREER, SCOTT Q MD
ACCT# 52302277 MR# 0197756

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COMMUNITY MEDICAL CENTER

2827 FORT MISSOULA ROAD
MISSOULA, MONTANA 59804
(406)728-4100

PATIENT:	DISNEY, EVAN	
MR:	0197756	
PROVIDER:	SCOTT Q. GREER, MD	EMERGENCY ROOM REPORT
SVC/ROOM:	EMD	

DATE OF SERVICE: December 23, 2003

CHIEF COMPLAINT: Right arm injury.

HISTORY OF PRESENT ILLNESS: The patient is a 25-year-old male who presented ambulatory to the emergency room with the above complaint. He was at work today trying to kick a frozen pipe loose off the ground when his other foot slipped out and he fell on his back. He first had his right arm stretched out behind him to break the fall and he landed on the arm and then he states it gave way. Since then, he has had a pain in his anterior shoulder and a burning discomfort. He also feels some tingling in his fifth finger and ring finger. The patient denies other injuries. He states he broke his right fifth finger approximately two months ago and has had some soreness and swelling since then.

PAST MEDICAL HISTORY: Negative for chronic illnesses.

CURRENT MEDICATIONS: None regular.

ALLERGIES: None.

SOCIAL HISTORY: The patient works at Mountain Supply, which is a plumbing company. He is a warehouse worker.

REVIEW OF SYSTEMS: The patient filled out the intake form, which is reviewed. Please refer to the medical record.

PHYSICAL EXAMINATION:
GENERAL: This is an alert 25-year-old male who is holding the right upper arm close against his chest and has an ice pack on his shoulder. He is in no distress.
VITAL SIGNS: Unremarkable.
EXTREMITIES: Examination of the right upper extremity reveals tenderness over the head of the biceps and pain with forced flexion. He did not have pain over the acromioclavicular joints, lateral shoulder or posterior shoulder. He had painful passive range of motion but the shoulder did not have any deformity or signs of dislocation. The elbow was nontender with full range of motion. His forearm also was nontender to palpation. He does have tenderness over the mid dorsal wrist but no swelling is noted and there is no pain over the anatomic snuffbox. No tenderness over the metacarpals. The patient has some mild swelling of the proximal fifth digit. There is no deformity noted. He had normal range of motion of his wrist and fingers. The patient had intact two-point discrimination of the little finger and ring finger. He had 2+ radial pulse.

DIAGNOSTIC DATA: X-rays were obtained of the right shoulder and right hand. No acute fractures or dislocations were identified. There is some callus noted of the right fifth finger.

IMPRESSION:
1. Right shoulder sprain, I think this is primarily over the head of the biceps.
2. Right hand strain.

PLAN: The patient is given a shoulder sling to wear for the next two to five days. He is told after two days to do gentle range of motion exercises three to four times daily. These were demonstrated to him. He is to take an anti-inflammatory on a regular basis and is also given a prescription for ten Lortab tablets. He is referred to Dr. Christopher Price who is on town orthopedic call if he is not improving. He was discharged in stable condition.

FINAL DIAGNOSIS: Right shoulder and right hand sprain.

Scott Q. Greer, MD

SQG: 12/23/2003
shy: 12/24/2003
J: 65277

12/23/2003 1:51 #65277

CMC MEDICAL CENTER
EMERGENCY DEPARTMENT
SCREENING AND REFERRAL FORM
Patient Questions

INITIAL LATEX SCREENING TOOL

Check All That Apply

	Yes	No
Do you have a KNOWN allergy/sensitivity/reaction to latex? (if "YES" disregard remaining questions.)	☐	☒
1. Do you have a history of allergic reactions after eating fruit? (such as avocado, banana, chestnut, pears, nectarine, potatoes, plums, tomatoes, kiwi, hazelnut, fig, melon, celery, peach, papaya, cherry?	☐	☒
2. Have you ever had an unexplained allergic reaction during a dental or medical procedure?	☐	☒
3. Do you have continued or prolonged exposure to latex through work or medical treatment?	☐	☒
4. Have you ever noticed that you had a runny nose, watery eyes or wheezing during or immediately after contact with latex products or in an environment where latex is used (e.g. hospital or clinic)?	☐	☒
Psycho-social assessment:		
a. Are there spiritual or cultural issues that will impact patient's health care?	☐	☒
Functional assessment:		
b. Has there been a decline in your level of physical function in the last month?	☒	☐
c. Do new health problems interfere with your daily activities?	☒	☐
d. Pediatrics: sensory, gross motor, fine motor, or muscle weakness concerns.	☐	☒
Barriers to learning assessment:		
e. Primary language if other than English (Employees please reference translator policy in Administrative Policy/Procedure Manual (4.1.10).	☐	☐
f. Reading ability.	☒	☐
g. Sensory problem.	☐	☒
h. Diminished comprehension.	☐	☒
i. Disinterest.	☐	☒
Nutritional assessment:		
j. Unintentional weight loss in the past 1 to 3 months?	☐	☒
k. Swallowing or chewing difficulties?	☐	☒
l. Poor appetite for last 1 to 3 months?	☐	☒
m. "How does your child eat?		
i. Can feed self	☐	☒
ii. Needs help	☐	☐
iii. Uses cup or bottle	☐	☐
iv. Uses fingers	☐	☐

If Yes, is answered in any of the above boxes are checked, notify provider for possible physical therapy consult.

DISNEY ,EVAN A
25 M DOB 04/17/1978
DATE:12/23/03 TIME 13:27 ET
GREER SCOTT Q MD
ACCT#F529022771 MRH 0197756

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6231-5A

COMMUNITY MEDICAL CENTER

CMC MEDICAL CENTER
EMERGENCY DEPARTMENT
SCREENING AND REFERRAL FORM, continued
Nursing Questions

ABUSE/NEGLECT SCREEN

Sample Script:

- "Over the past several years, domestic violence has come to be recognized as an important, often overlooked, health issue in our society. Because violence is common in domestic life, we now ask all our patients about domestic violence".

	Yes	No
"Are you currently in a relationship where you feel threatened or not safe?"	☐	☒
"Are you experiencing any physical or emotional abuse?"	☐	☒

(Refer to Patient Care Services policy on abuse, Abu 1-5 and Domestic Violence Dv 1.)
Positive findings in this assessment will be reported to the provider for possible Social Services referral.

If 'yes' is checked, see end of page for referral guidelines.

SOCIAL SERVICE SCREENING FORM **Check all that apply**

1. Concerns about home situation, ability to care for self or caregiver's ability/coping..	☐
2. Potential discharge to nursing home, rehab or other facility.	☐
3. Home health or homemaker needs.	☐
4. Patients who are currently receiving services from community agencies.	☐
5. Financial concerns.	☐
6. Diagnosis involves major lifestyle or emotional adjustment.	☐
7. Terminal illness or death.	☐
8. Potential abuse: physical, sexual, emotional, neglect.	☐
9. Emotional problems: depression, ineffective coping, anxiety.	☐
10. Psychiatric or substance abuse problems.	☐
11. Case Management - issues of utilization, continuity and coordination of care.	☐
12. Are there signs of non-compliance or did the patient leave AMA?	☐
13. Does the patient have frequent Visits to the E.D.?	☐
14. Other potential or actual problems:	☐

If any of the responses are "YES" or checked off and/or there are any other concerns, please refer patient for Social Service

If the provider deems the above checked issue to be of an emergent nature, please page the on-call social worker at **329-6863**.
If no issues are emergent, but referral is indicated – fax this referral form to Social Services at **4714**

☐ Form Faxed — NA

JBrady RN
RN Signature

6231-BA

Patier
DISNEY ,EVAN A
25 M DOB 04/17/1978
DATE 12/23/03 TIME 13:27 ET
GREER SCOIT Q MD
ACCT# 52902277 MR# 0197756

ASE 92/23/2004

COMMUNITY MEDICAL CENTER
2827 Fort Missoula Road
Missoula, MT 59804
(406) 728-4100

NAME: DISNEY, EVAN	**DATE OF EXAM:** 12/23/2003
SEX: M	**MR#:** 0197756
AGE: 25Y	**ORDER#:** 90001
DATE OF BIRTH: 04/17/1978	**ORDERING PHYSICIAN:** SCOTT Q GREER

*****Final Report*****

Procedure: RAD 3130 - HAND COMP 73130 - RIGHT
Procedure Date: Dec 23 2003

RIGHT HAND, THREE VIEWS

FINDINGS: On the oblique view only, there is a questionable bony density separated from the volar plate of the fifth middle phalanx. There is some soft-tissue swelling in this region. Subacute volar plate injury would be difficult to exclude. A dedicated lateral view of the right fifth digit would be helpful for further evaluation.

IMPRESSION: Please see findings above.

MT: 12-23-2003
klg: 12-24-2003

4992/68/26 3:54

Interpreting Physician: TRYHUS M.D., MICHAEL R
Transcribed by / Date: KLG on Dec 24 2003 4:27P
Approved Electronically by / Date: BIRCK M.D., WILLIAM J Dec 24 2003 4:52P
Distribution: SCOTT Q GREER
TERENCE M CALDERWOOD

COMMUNITY MEDICAL CENTER
Missoula, Montana

DIAGNOSTIC IMAGING

DISNEY, EVAN
MR#: 0197756 Location:
Hospital Service: EMDP
Attending Dr: GREER, SCOTT Q

COMMUNITY MEDICAL CENTER
2827 Fort Missoula Road
Missoula, MT 59804
(406) 728-4100

NAME: DISNEY, EVAN
SEX: M
AGE: 25Y
DATE OF BIRTH: 04/17/1978

DATE OF EXAM: 12/23/2003
MR#: 0197756
ORDER#: 90001
ORDERING PHYSICIAN: SCOTT Q GREER

*****Final Report*****

Procedure: RAD 3030 - SHOULDER COMP 73030 - RIGHT
Procedure Date: Dec 23 2003

RIGHT SHOULDER, THREE VIEWS

INDICATION: Pain - fell on arm.

FINDINGS: Normal. No evidence of acute fracture or dislocation.

IMPRESSION: Please see findings above.

MT/klg: 12-23-2003

12/23/2003 15:24

Interpreting Physician: TRYHUS M.D., MICHAEL R
Transcribed by / Date: KLG on Dec 24 2003 4:24P
Approved Electronically by / Date: BIRCK M.D., WILLIAM J Dec 24 2003 4:52P
Distribution: SCOTT Q GREER
TERENCE M CALDERWOOD

COMMUNITY MEDICAL CENTER
Missoula, Montana

DIAGNOSTIC IMAGING

DISNEY, EVAN
MR#: 0197756 Location:
Hospital Service: EMD
Attending DR. GREER, SCOTT Q

COMMUNITY MEDICAL CENTER
2827 Fort Missoula Rd, Missoula MT 59804
(406) 728-4100

SCOTT GREER MD

EVAN DISNEY

Work Release Form

This notice verifies that your employee, **EVAN DISNEY**, was seen in this facility on **12/23/2003**.

He/she may return to work on **12/23/2003** with the following restrictions:

None:	X
No heavy lifting:	(over **0** pounds)
No prolonged standing:	
Desk Work Only:	
Other:	X

KEEP RIGHT ARM IN A SLING FOR THE NEXT WEEK. FOLLOW UP WITH PRIVATE PHYSICIAN/ORTHOPEDIST IF UNABLE TO RETURN TO FULL WORK DUTIES IN 1 WEEK.

These restrictions apply through **12/30/2003**. After this date, your employee should be able to participate fully in all work duties.

NOTE: If symptoms continue and the employee is unable to perform the full duties of their job by this date, please advise the employee to return to this facility or make an appointment with the referral physician for further evaluation.

SCOTT GREER MD

DISNEY ,EVAN A
25 M DOB 04/17/1978
DATE 12/23/03 TIME 13:27 ET
GREER SCOTT Q MD
ACCT# 52902277 MRH 0197756

12/23/2003 (14:52)

EMERGENCY DEPARTMENT

COMMUNITY MEDICAL CENTER
2827 Fort Missoula Rd, Missoula MT 59804
(406) 728-4100

COMMUNITY MEDICAL CENTER
2827 Fort Missoula Rd
(406) 728-4100

Patient: EVAN DISNEY Age:____

Address: 12/23/2003

Rx

LORTAB 5 mg hydrocodone
Sig: 1-2 tab Q6h prn pain

Disp: #10
Refills: None Ok to Substitute

FILE COPY: Do Not Fill

Signature: ______________________ State Lic:
SCOTT GREER MD DEA #:

MSF 02/03/2004

THIS IS YOUR PRESCRIPTION.

DO NOT LOSE IT.

Take it to a pharmacy as soon as possible so that you may begin taking your medicine.

DISNEY ,EVAN A
25 M DOB 04/17/1978
DATE 12/23/03 TIME 13:27 ET
GREER SCOTT Q MD
ACCT# 52902277 MR# 0197756

COMMUNITY MEDICAL CENTER
2827 Fort Missoula Rd, Missoula MT 59804
(406) 728-4100
Discharge Instructions

SCOTT GREER MD

EVAN DISNEY

I HAVE RECEIVED AND UNDERSTAND THE INSTRUCTIONS ABOVE.

x Jordan Albert (girlfriend)
Patient or Representative

x J Brady RN
Staff

4882/68/2884 ISI

DISNEY ,EVAN A
25 M DOB 04/17/1978
DATE 12/23/03 TIME 13:27 ED
GREER SCOTT Q MD
ACCT# 52902277 MR# 0197756

The exam and treatment that you received today has been provided on an emergency basis only. If your problem worsens or new symptoms appear, contact your doctor or return to this facility for further care.

12/23/2003 (14:52)

EMERGENCY DEPARTMENT

COMMUNITY MEDICAL CENTER
2827 Fort Missoula Rd, Missoula MT 59804
(406) 728-4100
Discharge Instructions

SCOTT GREER MD

EVAN DISNEY

SPRAIN: SHOULDER

A SPRAIN is a tearing of the ligaments that hold a joint together. This may take up to six weeks to fully heal, depending on how severe it is. Moderate to severe shoulder sprains are treated with a sling or "shoulder immobilizer". Minor sprains can be treated without any special support.

HOME CARE:

1) If a sling was provided, leave it in place for the time advised by your doctor. If you are unsure how long to wear it, ask for advice. If the sling becomes loose, adjust it so that your forearm is level with the ground and the shoulder feels well supported.

2) Apply an ice pack over the injured area for 20 minutes every 2 hours for the first day. Continue this 3-4 times a day for the next few days.

3) You may take Tylenol (acetaminophen) or ibuprofen (Advil, Motrin) for pain, unless another pain medicine was prescribed.

4) Shoulder joints become stiff if left in a sling for too long. Range of motion exercises should usually be started within the first ten days after injury. Consult your doctor on what type of exercises to do and how soon to start.

FOLLOW UP with your doctor as directed if the pain does not start to improve within the next five days.

[NOTE: If X-rays were taken, they will be reviewed by a radiologist. You will be notified of any new findings that may affect your care.]

RETURN PROMPTLY if you develop any of the following:
- -- Increasing shoulder pain or arm swelling
- -- Fingers become cold, blue, numb or tingly
- -- Large amount of bruising of the shoulder or upper arm

DISNEY ,EVAN A
25 M DOB 04/17/1978
DATE 12/23/03 TIME 13:27 ET
GREER SCOTT Q MD
ACCT# 52902277 MR# 0197756

SPECIAL INSTRUCTIONS

Call CHRISTOPHER PRICE MD to make an appointment to be seen within the next 7 days if not improving. When you call, explain that you were referred from this facility. When you visit the doctor, bring these instructions and any medicines that you are taking.
WEAR THE SLING FOR 2-7 DAYS, BUT NO LONGER. AFTER 2 DAYS, DO GENTLE RANGE OF MOTION EXERCISES AS SHOWN IN THE ER. TAKE ANTI-INFLAMMATORIES (IBUPROFEN OR ALEVE) DAILY FOR THE NEXT 1-2 WEEKS.
IF THE TINGLING IN THE HAND PERSISTS BEYOND THIS WEEK, DEFINITLEY FOLLOW UP WITH THE ORTHOPEDIC SURGEON.

REFERRALS: CHRISTOPHER PRICE MD [ORTHOPEDIC]
2360 MULLAN RD., SUITE C, MISSOULA 406-721-4436

I HAVE RECEIVED AND UNDERSTAND THE INSTRUCTIONS ABOVE:

x Amber Albert (girlfriend) x J Brady RN

Patient or Representative Staff

The exam and treatment that you received today has been provided on an emergency basis only. If your problem worsens or new symptoms appear, contact your doctor or return to this facility for further care.

12/23/2003 (14:44) EMERGENCY DEPARTMENT

COMMUNITY MEDICAL CENTER

2827 Fort Missoula Road ■ Missoula, MT 59804
406/728-4100 ■ TDD 406/728-6724

CONDITIONS FOR ADMISSION

1. **General Admission Consent:** The patient is under the control of his attending physicians and the hospital is not liable for any act or omission in following the instructions of said physicians. The undersigned consents to and authorizes the administration and performance of diagnostic or therapeutic procedures that are necessary or helpful in carrying out treatment which in the judgement of the attending physicians may be considered necessary and advisable. This paragraph does not preclude the taking of special consents that may be required.

2. **Students:** I recognize that Community Medical Center participates in various medical and paramedical training programs involving students and that students from such programs may participate with qualified personnel in my care.

3. Release of Information: RADIOLOGISTS, PATHOLOGISTS, AND ANESTHESIOLOGISTS ARE INDEPENDENT PHYSICIANS. They are not employees of the hospital and will bill separately. Authorization is hereby granted to Community Medical Center, Missoula Radiology, Pathologists and my Anesthesiologists to make any inquiries to determine my eligibility for third party coverage and to release such medical record information, including but not limited to diagnosis and emergency room information as may be necessary for the completion of my hospital insurance claim(s). **THIS RELEASE ALSO INCLUDES THE RELEASE OF INFORMATION PERTAINING TO ANY PSYCHIATRIC CARE, PSYCHOLOGICAL CARE, OR TREATMENT FOR DRUG OR ALCOHOL ABUSE.**

4. **Personal Valuables:** It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables and the hospital shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents, furs, fur coats and fur garments, or other articles of unusual value and small articles of value, unless placed in safe, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. It is strongly recommended that personal valuables be left at home or sent home.

5. **Assignment of Insurance:** I hereby assign my rights and authorize and direct my insurance company, or any other liable insurance company, or any other concerned party, including but not limited to Medicare, to make payment directly to Community Medical Center, Missoula Radiology, Pathologists and my Anesthesiologists.

   CMC makes no representation as to whether or not the physicians participate in or accept assignment for the patient's specific insurance or payor plan.

   This assignment and direct payment authorization shall include any payments for physicians services billed by Community Medical Center in connection with its services. This agreement shall specifically include emergency room physician treatment.

6. Financial Agreement: I UNDERSTAND, WHETHER SIGNING AS PATIENT OR AGENT, THAT THE TERMS OF PAYMENT FOR SERVICES RENDERED ARE PAYMENT IN FULL WITHIN 30 DAYS OF SERVICE OR BALANCES REMAINING AFTER INSURANCE PAYMENTS ARE DUE WITHIN 30 DAYS OF THE INSURANCE PAYMENT UNLESS OTHER FINANCIAL ARRANGEMENTS ARE MADE. I also understand that I am responsible for all charges incurred regardless of insurance or third party liability, unless verified as eligible for Medicare or Medicaid (excluding applicable co-insurance, deductibles and non-covered charges). I will pay the account in accordance with the regular rates and terms of the hospital. For and in consideration of services rendered, I agree that I may be responsible for 100% payment of the account.

   All accounts not paid in full within 60 days from discharge bear interest on the unpaid balance as of the last day of each month and at the rate of 0.8% per month (annual percentage rate 9.6%).

   Should I not pay this account as due, I will be liable for any court, attorney or collection fees incurred by Community Medical Center in collection of any balance due on the account for services rendered.

   I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

7. **Medicare (TRICARE/Champus) Beneficiaries:** I have received "An Important Message from Medicare". ("An Important Message from TRICARE/Champus"). The answers I have given to the Medicare secondary payor questions are accurate to the best of my knowledge.

8. **Patient Rights/Patient Self Determination Act: INPATIENTS ONLY** I have received a copy of the PATIENT RIGHTS and Advance Directive information.

9. **Notice of Information/Privacy Practices:** I acknowledge that the Notice of Information/Privacy Practices was provided to me during my first visit to Community Medical Center on or after April 14, 2003. Another copy will be provided to me at any time upon my request.

The undersigned certifies that he/she has read the foregoing, has received a copy thereof, and is the patient, or is duly authorized by the patient to execute the above and accepts its terms.

SIGNATURE(S): [signature] **DATE OF SIGNING** 12/23/03 **TIME** ______

______________________ **DATE OF SIGNING** ______ **TIME** ______

PRINT PATIENT'S NAME [signature]

WITNESS ______

DISNEY ,EVAN A
25 M DOB 04/17/1978
DATE 12/23/03 TIME 13:27 ET
GREER, SCOTT Q MD
ACCT# 52902277260 MR# 0197756

8261-401 / 1866 (3/03)

PLEASE
DO NOT73
STAPLE
IN THIS
AREA STFU

STATE FUND OF MONTANA
PO BOX 4759
HELENA MT 59604

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA ☐☐ PICA ☐☐

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (VA File #)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 032004070196

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

3. PATIENT'S BIRTH DATE: MM 04 DD 17 YY 78 — SEX: M ☒ F ☐

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

5. PATIENT'S ADDRESS (No., Street): 902 SKY LN

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

7. INSURED'S ADDRESS (No., Street): 902 SKY LN

CITY: MISSOULA **STATE:** MT

8. PATIENT STATUS: Single ☐ Married ☒ Other ☐

CITY: MISSOULA **STATE:** MT

ZIP CODE: 59804 **TELEPHONE (Include Area Code):** (406) 240 2196

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

ZIP CODE: 59804 **TELEPHONE (INCLUDE AREA CODE):** (406) 240 2196

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: 517137948

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH: MM 04 DD 17 YY 78 — 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: MOUNTAIN SUPPLY

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FUND OF MONTANA

d. INSURANCE PLAN NAME OR PROGRAM NAME: NO OTHER COVERAGE

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 02 05 04

SIGNED _____ DATE _____

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

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM 12 DD 23 YY 03 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM 01 DD 05 YY 04

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: TERENCE CALDERWOOD, MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E28046

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO — **$ CHARGES**

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

1. 726 90
2.
3.
4.

22. MEDICAID RESUBMISSION CODE — **ORIGINAL REF. NO.**

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 26 04	01 26 04	11	01	99213		1	80 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 810226415 — SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 3006833

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

28. TOTAL CHARGE: $ 80 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 80 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.)

TERENCE CALDERWOOD

SIGNED 02 05 04 DATE

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

WESTERN MONTANA CLINIC
500 W BROADWAY
MISSOULA, MT 59802

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

WESTERN MONTANA CLINIC
PO BOX 7609
MISSOULA MT 59807
4067215600

PIN# GRP#

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

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

DISNEY, Evan　　　　　　　　　　　　MR#: 293767

01-26-2004

S: Follow up of his shoulder pain. It is improving but not quite better. When he elevates his arms above his head he feels a sharp pain in the coracoid region.

A: I think he will continue to heal.

P: I gave him some samples of **BEXTRA** 20 mg daily for the next 10 days. We will see him back in about 10 days and hopefully he will be able to go back to his routine work at that point in time. I gave him a note to him for his boss.

T. CALDERWOOD, M.D./ljk　　R: 01-29-04　　T: 01-29-04