FORM B10 (Official Form 10)

UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

PROOF OF CLAIM
Chapter 11

In Re Kmart Corporation, et. al.

Case Numbers 02-B02474 through 02-B02498

Your claim is scheduled as follows:

Class

Amount

Name of Debtor: (see attached for complete list of debtors)
KMART CORPORATION

Case Number:
02 - B02474

NOTE: This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A "request" for payment of an administrative expense may be filed pursuant to 11 U.S.C § 503.

Name of Creditor (The person or other entity to whom the debtor owes money or property):
REGINA DALTON

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.
☒ Check box if you have never received any notices from the bankruptcy court in this case.
☐ Check box if the address differs from the address on the envelope sent to you by the court.

If address differs from above, please complete the following:
Creditor Name: REGINA DALTON C/O THE STACE WILLIAMS LAW FIRM, P.C. Telephone: # (817) 860 - 9000
Address: 624 SIX FLAGS DRIVE, SUITE 201
City/St/Zip: ARLINGTON, TX 76011

This Space is for Court Use Only

Account or other number by which creditor identifies debtor:

Check here if this claim ☐ replaces ☐ amends a previously filed claim, dated _____

1. Basis for Claim
- ☐ Goods sold
- ☐ Services performed
- ☐ Money loaned
- ☒ Personal injury/wrongful death
- ☐ Taxes
- ☐ Other

☐ Retiree benefits as defined in 11 U.S.C. §1114(a)
☐ Wages, salaries, and compensation (fill out below)
Your SS #: _____
Unpaid compensation for services performed
from _____ (date) to _____ (date)

2. Date debt was incurred: 9-30-01

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $ 9,000
If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below.
☐ Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Secured Claim.
☐ Check this box if your claim is secured by collateral (including a right of setoff).
Brief Description of Collateral:
☐ Real Estate ☐ Motor Vehicle
☐ Other_____
Value of Collateral: $_____
Amount of arrearage and other charges at time case filed included in secured claim, if any: $_____

6. Unsecured Priority Claim.
☐ Check this box if you have an unsecured priority claim.
Amount entitled to priority $ _____
Specify the priority of the claim:
☐ Wages, salaries, or commissions (up to $4,650), earned within 90 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(3).
☐ Contributions to an employee benefit plan – 11 U.S.C. §507(a)(4).
☐ Up to $ 2,100 of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(6).
☐ Alimony, maintenance, or support owed to a spouse, former spouse, or child - 11 U.S.C. § 507(a)(7).
☐ Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8).
☐ Other – Specify applicable paragraph of 11 U.S.C. § 507(a)(__).

7. Credits: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.

8. Supporting Documents: Attach copies of supporting documents, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary.

9. Date-Stamped Copy: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

This Space is for Court Use Only

Date: 4-2-02

Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any):
Paul D. Thorsen ATTORNEY IN FACT

A.B. 4-11-02 3084

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

THE STACE WILLIAMS LAW FIRM, P.C.
ATTORNEY / CLIENT AGREEMENT and POWER OF ATTORNEY

STATE OF TEXAS
COUNTY OF TARRANT **KNOW ALL MEN BY THESE PRESENTS:**

THAT WHEREAS Regina Dalton (hereinafter called Client) desires to retain the services of **THE STACE WILLIAMS LAW FIRM, P.C.** (hereinafter called Attorneys) to represent Client for damages arising out of the injuries which occurred in Tarrant County, Texas on or about the 30th day of September 2001; and Whereas Attorneys agree to represent Client,

IT IS AGREED AS FOLLOWS:

1. **Attorneys agree that unless Client recovers, there will be no Attorneys' fees charged in this case.**

2. Attorneys agree to represent Client in Client's cause of action for personal injuries and/or property damages to settlement or final judgment of Client's claim against any and all parties and/or insurance companies responsible for such damages, seeking all forms of available insurance recovery (liability, personal injury protection, uninsured/underinsured motorist, medical payments, etc.) so that Client's recovery may be maximized.

3. For and in consideration of the legal services to be rendered by Attorneys, Client agrees to pay and hereby assigns to Attorneys a lien on this case in the amount of: **33 ⅓%** if settled prior to filing suit, or **40%** if suit is filed, of total amount recovered on behalf of Client.

4. If the case is settled by means of structured settlement, then the Attorneys' fees will be calculated based upon the present value benefit of the structured settlement to the Client.

5. Any expenses incurred by the Attorneys, including investigation and expert's fees, shall be repaid to the Attorneys from the Client's portion of the recovery. If, however, at the final disposition of the case, Client does not recover, then Client will not be charged for the expenses which have been incurred.

6. It shall be the exclusive privilege of Attorneys to determine when and where suits shall be filed and whether or not appeal should be perfected from any judgment rendered. No compromise or settlement of Client's claim will be made without the consent of both Client and Attorneys.

7. Attorneys are hereby granted full authority and **Power of Attorney** to sign and/or endorse all legal and negotiable instruments, pleadings, drafts, checks, authorizations and papers as shall be reasonably necessary to conclude this particular claim on Client's behalf. Attorneys are authorized to hold in trust for Client's protection any sums received until final disbursement, so that possible medical/lien reductions may be procured on behalf of Client, thereby further maximizing Client's recovery.

8. At the time of settlement, Attorneys are hereby authorized by Client to pay on Client's behalf from Client's portion of the settlement any remaining unpaid medical bills incurred by the Client in connection with this case.

9. It shall be the privilege of Attorneys to associate with other attorneys, but in such event, the fees of such associate attorneys shall be paid by the Attorneys herein employed.

IT IS FURTHER UNDERSTOOD AND AGREED by said Client that said Attorneys, after investigation of the facts and research of Law, may at any time return the file and copies of all documents related to the aforesaid claim back to the Client; in such event, said Attorneys shall be released from further action on said claim and discharged from further obligation under this contract, and shall have no further liability or responsibility to said Client with respect to this matter.

WITNESS OUR HANDS on this 16TH day of October, 2001.

By: _____
THE STACE WILLIAMS LAW FIRM, P.C.

X Regina Dalton
CLIENT (S)

SPECIALS SHEET

RE: Ms. Regina Dalton's Personal Injury of September 30, 2001.

MEDICAL TOTALS

Pearson Chiropractic..... Dr. John E. Pearson, D.C.	$ 2,602.00
Community Diagnostics.....	$ 225.00
Westside Orthopedic Clinic..... Dr. Myron L. Glickfeld, D.O.	$ 220.00

Total Accrued Medical----------> $3,047.00

Pearson Chiropractic

John Pearson, D.C.

1808-D South Bowen
Arlington, Texas 76013
(817) 274-0222

Final Report
Regina Dalton

Date of injury:October 16,2001
Date of Exam: December 3,2001

Diagnosis: Thoracic Strain\Sprain

Status:The patient is currently beening treated for recurrent symptoms. The patient still has occasional pain with right lateral flexion of the thoracic spine.

Prognosis:Ms.Dalton is now only having occasional thoracic pain that is ameliorated with a TENS unit.

Conclusion:Patient will continue to be observed for further neurological developments. The patient had a resection of the 5th rib which makes her more vulnerable to spinal injuries. The resection of the 5th rib was done during an operation 1999. The patient's spine does not have the inherit strength of a normal spine. The patient has made a good recovery due to cooperation on the patient's part.

Prior to this accident Ms.Dalton did not have pain in her upper thoracic spine. This is not case now as the patient still has occasional pain in the thoracic spine. The patient needs to be seen once a month for the next year at an approximate cost of 1000 dollars.

Signature: December 3,2001

Dr.John E.Pearson

Pearson Chiropractic

John Pearson, D.C.

1808-D South Bowen
Arlington, Texas 76013
(817) 274-0222

Narrative Report
Regina Dalton

The above named patient presented herself to our office on October 16,2001. The patient was complaining upper thoracic pain. The patient did not have these symptoms prior to her injury.

HISTORY: Ms.Dalton was a customer at K-mart when she had slipped in urine left by a previous customer. The patient had lost her footing when she had stepped into the urine while waiting in line. Ms. Dalton was wearing an open toed shoe at the time of the accident.

Ms.Dalton presented to my office complaining of upper thoracic pain. The patient related that the pain was stabbing and constant.

Diagnosis: Thoracic Strain\Sprain

Treatment: Treatment will consist of conservative care which will include E-stimulation,heat,ice,and exercise for the thoracic spine.

Exam: (1) Decreased R.O.M. in the thoracic spine
(2) Palpable spasms in the thoracic spine

Prognosis At this present time it is not possible to give a proper prognosis without more treatment.

Signature: Dr. John E.Pearson

Date: 12-05-01 WEST SIDE ORTHOPAEDIC CLINIC Page: 1
Time: 11:34:50 Patient History

Chart #13670 SSN# 451374230 WEST SIDE ORTHOPAEDIC CLINIC
DALTON,REGINA DOB 06-24-64 1002 MONTGOMERY ST
2008 OAKWOOD CT SUITE 107
From
ARLINGTON, TX 76012 To 12/05/01 FT. WORTH, TX 76107
Home-(817)299-8565 Office-817 (817) 738-6668

T	Date	Code	Diagnosis	Prov	Amount	R	IB	Paid	Balance/ Susp. Amt	Carr
C	10-26-01	99204	354.0	CW	145.00	N	YY	0.00	145.00	3
C	11-26-01	99213	847.0	CW	75.00	N	YY	0.00	75.00	3

	Charges	Receipts	Debits	Credits	Balance
Patient:	0.00	0.00	0.00	0.00	0.00
Insurance:	220.00	0.00	0.00	0.00	220.00
TOTALS:	220.00	0.00	0.00	0.00	220.00

HEALTH INSURANCE CLAIM FORM

FORM APPROVED
OMB No. 0938-0008

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ BLUE SHIELD OF TEXAS

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name) Deiter, Regina	2. PATIENT'S DATE OF BIRTH 05/24/64	3. INSURED'S NAME (First name, middle initial, last name) UNKNOWN INSURED INFO.
4. PATIENT'S ADDRESS (Street, city, state, ZIP code AND Telephone Number) 2008 Oakwood Ct (817) 299-8565 Arlington, TX 76012	5. PATIENT'S SEX MALE ☐ FEMALE X	6. INSURED'S I.D. No. or MEDICARE No. (include any letters)
	7. PATIENT'S RELATIONSHIP TO INSURED SELF X SPOUSE CHILD OTHER	8. INSURED'S GROUP NO. (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number 	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES ☐ NO X B. AN AUTO ACCIDENT YES ☐ NO X	11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing) I authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below SIGNED DATE		13. I authorize direct pymnt to undersigned physician

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO	16a. IF AN EMERGENCY CHECK HERE ☐
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH	
19. NAME OF REFERRING PHYSICIAN		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO CHARGES	

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1 2 3 ETC. OR DX CODE

1.
2.
3.
4.

24. A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F
10/16/01	0	99204	New Patient Visit	ALL	$ 125.00	
10/16/01	0	97014	Electrotherapy	ALL	20.00	
10/16/01	0	97010	Ice/Heat	ALL	15.00	
10/16/01	0	99080	Narrative Report	ALL	100.00	
10/17/01	0	99213	Office Visit MP	ALL	86.00	
10/17/01	0	97014	Electrotherapy	ALL	20.00	
10/17/01	0	97010	Ice/Heat	ALL	15.00	
10/18/01	0	99213	Office Visit MP	ALL	86.00	
10/18/01	0	97014	Electrotherapy	ALL	20.00	
10/18/01	0	97010	Ice/Heat	ALL	15.00	
10/19/01	0	99213	Office Visit MP	ALL	86.00	
10/19/01	0	97014	Electrotherapy	ALL	20.00	
10/19/01	0	97010	Ice/Heat	ALL	15.00	
10/20/01	0	99213	Office Visit MP	ALL	86.00	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing) SIGNED DATE	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ NO X 30. YOUR SOCIAL SECURITY NO	27. TOTAL CHARGE $ 509.00	28. AMOUNT PAID	29. BALANCE DUE
32. YOUR PATIENT'S ACCOUNT NO 1070	33. YOUR EMPLOYER I.D. NO 75-2343776	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO Peat Soll, John E. 1808 S. Bowen Rd., Ste. D 817-274-0222 Arlington, TX 76013 License # 5285, I.D. NO		

*PLACE OF SERVICE CODES (Codes For Medicare And Medicaid Are Shown In Parenthesis)

1-INPATIENT HOSPITAL-IH-(3)
2-OUTPATIENT HOSPITAL-OH-(5)
3-DOCTOR'S OFFICE-O-(1)
4-PATIENT'S HOME-H-(2)
5-DAY CARE FACILITY
6-NIGHT CARE FACILITY
7-NURSING HOME-NH-(8)
8-SKILLED NURSING FACILITY-SNF-(4)
9-AMBULANCE (7 Medicare Only)
0-OTHER LOCATIONS-OL-(7 Medicare 9 Medicaid)
A-INDEPENDENT LABORATORY-IL-(6)
B-OTHER MEDICAL/SURGICAL FACILITY
C-RESIDENTIAL TREATMENT CENTER-RTC-(CHAMPUS Only)
D-SPECIALIZED TREATMENT FACILITY-STF-(CHAMPUS Only)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

3707.010-DD383

HEALTH INSURANCE CLAIM FORM

FORM APPROVED
OMB No. 0938-0008

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ BLUE SHIELD OF TEXAS

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1 PATIENT S NAME (First name middle initial last name)
Dalton, Regina

2 PATIENT S DATE OF BIRTH
06/24/64

3 INSURED S NAME (First name middle initial last name)
UNKNOWN INSURED INFO.

4 PATIENT S ADDRESS (Street city state ZIP code AND Telephone Number)
2008 Oakwood Ct (817) 299-8565
Arlington, TX 76012

5 PATIENT S SEX
MALE ☐ FEMALE X

6 INSURED S I D No or MEDICARE No (include any letters)

7 PATIENT S RELATIONSHIP TO INSURED
SELF X SPOUSE CHILD OTHER

8 INSURED S GROUP NO (Or Group Name)

9 OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10 WAS CONDITION RELATED TO
A PATIENT S EMPLOYMENT
YES ☐ NO X
B AN AUTO ACCIDENT
YES ☐ NO X

11 INSURED S ADDRESS (Street city state ZIP code)

12 PATIENT S OR AUTHORIZED PERSON S SIGNATURE (Read back before signing)
I authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below
SIGNED DATE

13
I authorize direct pymnt to undersigned physician

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐

16a IF AN EMERGENCY CHECK HERE ☐

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19 NAME OF REFERRING PHYSICIAN

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES

23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1 2 3 ETC OR DX CODE
1
2
3
4

24 A DATE OF SERVICE	B * PLACE OF SERV-ICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F
10/20/01	0	97014	Electrotherapy	AL	$ 20.00	
10/20/01	0	97010	Ice/Heat	AL	15.00	
10/22/01	0	99213	Office Visit MP	AL	36.00	
10/22/01	0	97014	Electrotherapy	AL	20.00	
10/22/01	0	97010	Ice/Heat	AL	15.00	
10/23/01	0	99213	Office Visit MP	AL	36.00	
10/23/01	0	97014	Electrotherapy	AL	20.00	
10/23/01	0	97010	Ice/Heat	AL	15.00	
10/24/01	0	99213	Office Visit MP	AL	36.00	
10/24/01	0	97014	Electrotherapy	AL	20.00	
10/24/01	0	97010	Ice/Heat	AL	15.00	
10/25/01	0	99213	Office Visit MP	AL	36.00	
10/25/01	0	97014	Electrotherapy	AL	20.00	
10/25/01	0	97010	Ice/Heat	AL	15.00	

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing)
SIGNED DATE

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES ☐ NO X

27 TOTAL CHARGE $ 315.00

28 AMOUNT PAID

29 BALANCE DUE

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN S OR SUPPLIER S NAME ADDRESS ZIP CODE & TELEPHONE NO
Peterson, John E.
1808 S. Bowen Rd., Ste. D 817-274-0222
Arlington, TX 76013
License # 5285,
I D NO

32 YOUR PATIENT S ACCOUNT NO
1070

33 YOUR EMPLOYER I D NO
75-2349776

* PLACE OF SERVICE CODES (Codes For Medicare And Medicaid Are Shown In Parenthesis)
1-INPATIENT HOSPITAL-IH-(3)
2 OUTPATIENT HOSPITAL-OH-(5)
3-DOCTOR S OFFICE O-(1)
4 PATIENT S HOME-H-(2)
5-DAY CARE FACILITY
6-NIGHT CARE FACILITY
7-NURSING HOME-NH-(8)
8-SKILLED NURSING FACILITY-SNF-(4)
9-AMBULANCE (7 Medicare Only)
0-OTHER LOCATIONS-OL-(7 Medicare 9 Medicaid)
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B-OTHER MEDICAL/SURGICAL FACILITY
C-RESIDENTIAL TREATMENT CENTER-RTC-(CHAMPUS Only)
D-SPECIALIZED TREATMENT FACILITY-STF-(CHAMPUS Only)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

3707.010-DD383

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OMB No. 0938-0008

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Dalton, Regina

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2008 Oakwood Ct (817) 299-8565
Arlington, TX 76012

5 PATIENT'S SEX
MALE ☐ FEMALE ☒

6 INSURED'S I.D. No. or MEDICARE No. (include any letters)

7 PATIENT'S RELATIONSHIP TO INSURED
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8 INSURED'S GROUP NO. (Or Group Name)

9 OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10 WAS CONDITION RELATED TO
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YES ☐ NO ☒
B AN AUTO ACCIDENT
YES ☐ NO ☒

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16a IF AN EMERGENCY CHECK HERE ☐

17 DATE PATIENT ABLE TO RETURN TO WORK

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FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

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10/26/01	0	97014	Electrotherapy	ALL	20.00	
10/26/01	0	97010	Ice/Heat	ALL	15.00	
10/29/01	0	99213	Office Visit MP	ALL	36.00	
10/29/01	0	97014	Electrotherapy	ALL	20.00	
10/29/01	0	97010	Ice/Heat	ALL	15.00	
10/30/01	0	99213	Office Visit MP	ALL	36.00	
10/30/01	0	97014	Electrotherapy	ALL	20.00	
10/30/01	0	97010	Ice/Heat	ALL	15.00	
10/31/01	0	99213	Office Visit MP	ALL	36.00	
10/31/01	0	97014	Electrotherapy	ALL	20.00	
10/31/01	0	97010	Ice/Heat	ALL	15.00	

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing)
SIGNED DATE

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES ☐ NO ☐

27 TOTAL CHARGE
$ 284.00

28 AMOUNT PAID

29 BALANCE DUE

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO
Pearson, John E.
1808 S. Bowen Rd., Ste. D 817-274-0221
Arlington, TX 76013
License # 5265,
I.D. NO

32 YOUR PATIENT'S ACCOUNT NO
1074

33 YOUR EMPLOYER I.D. NO
75-2349776

* PLACE OF SERVICE CODES (Codes For Medicare And Medicaid Are Shown In Parenthesis)
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READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ BLUE SHIELD OF TEXAS

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1 PATIENT S NAME (First name, middle initial, last name)
Dalton, Regina

2 PATIENT S DATE OF BIRTH
06/24/64 | |

3 INSURED S NAME (First name, middle initial, last name)
UNKNOWN INSURED INFO.

4 PATIENT S ADDRESS (Street, city, state, ZIP code AND Telephone Number)
2008 Oakwood Ct (817) 299-8565
Arlington, TX 76012

5 PATIENT S SEX
MALE | | FEMALE X

6 INSURED S I D No or MEDICARE No (include any letters)

7 PATIENT S RELATIONSHIP TO INSURED
SELF X | SPOUSE | CHILD | OTHER

8 INSURED S GROUP NO (Or Group Name)

9 OTHER HEALTH INSURANCE COVERAGE (Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number)

10 WAS CONDITION RELATED TO
A PATIENT S EMPLOYMENT
YES | | NO X
B AN AUTO ACCIDENT
YES | | NO X

11 INSURED S ADDRESS (Street, city, state, ZIP code)

12 PATIENT S OR AUTHORIZED PERSON S SIGNATURE (Read back before signing)
I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below
SIGNED DATE

13
I authorize direct pymnt to undersigned physician

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
YES | | NO

16a IF AN EMERGENCY CHECK HERE ☐

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19 NAME OF REFERRING PHYSICIAN

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES | | NO CHARGES

23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1 2 3 ETC OR DX CODE
1.
2.
3.
4.

24 A DATE OF SERVICE	B * PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F
11/01/01	0	99213	Office Visit MP	ALL	$ 36.00	
11/01/01	0	97014	Electrotherapy	ALL	20.00	
11/01/01	0	97010	Ice/Heat	ALL	15.00	
11/02/01	0	99213	Office Visit MP	ALL	36.00	
11/02/01	0	97014	Electrotherapy	ALL	20.00	
11/02/01	0	97010	Ice/Heat	ALL	15.00	
11/05/01	0	99213	Office Visit MP	ALL	36.00	
11/05/01	0	97014	Electrotherapy	ALL	20.00	
11/05/01	0	97010	Ice/Heat	ALL	15.00	
11/06/01	0	99213	Office Visit MP	ALL	35.00	
11/06/01	0	97014	Electrotherapy	ALL	20.00	
11/05/01	0	97010	Ice/Heat	ALL	15.00	
11/07/01	0	99213	Office Visit MP	ALL	36.00	
11/07/01	0	97014	Electrotherapy	ALL	20.00	

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing)
SIGNED DATE

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES | | NO

27 TOTAL CHARGE
$ 340.00

28 AMOUNT PAID

29 BALANCE DUE

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN S OR SUPPLIER S NAME ADDRESS ZIP CODE & TELEPHONE NO
Pearson, John E.
1808 E. Bower Rd., Ste. D 817-274-0222
Arlington, TX 76013
License # 5285,
I D NO

32 YOUR PATIENT S ACCOUNT NO
1070

33 YOUR EMPLOYER I D NO
75-2349776

* PLACE OF SERVICE CODES (Codes For Medicare And Medicaid Are Shown In Parenthesis)
1 (INPATIENT HOSPITAL-IH-(3)
2 OUTPATIENT HOSPITAL-OH-(5)
3 DOCTOR S OFFICE -0-(1)
4 PATIENT S HOME-H-(2)
5-DAY CARE FACILITY
6-NIGHT CARE FACILITY
7-NURSING HOME-NH-(8)
8-SKILLED NURSING FACILITY-SNF-(4)
9-AMBULANCE (7 Medicare Only)
0-OTHER LOCATIONS-OL-(7 Medicare 9 Medicaid)
A-INDEPENDENT LABORATORY-IL-(6)
B-OTHER MEDICAL/SURGICAL FACILITY
C-RESIDENTIAL TREATMENT CENTER-RTC-(CHAMPUS Only)
D-SPECIALIZED TREATMENT FACILITY-STF-(CHAMPUS Only)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

3707.010-DD383

HEALTH INSURANCE CLAIM FORM

FORM APPROVED
OMB No. 0938-0008

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ BLUE SHIELD OF TEXAS

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (First name, middle initial, last name)
Dalton, Regina	06/24/64	UNKNOWN INSURED INFO.
4. PATIENT'S ADDRESS (Street, city, state, ZIP code AND Telephone Number)	**5. PATIENT'S SEX**	**6. INSURED'S I.D. No. or MEDICARE No.** (include any letters)
2008 Oakwood Ct (817) 299-8565 Arlington, TX 76012	MALE ☐ FEMALE X	
	7. PATIENT'S RELATIONSHIP TO INSURED SELF X SPOUSE CHILD OTHER	**8. INSURED'S GROUP NO.** (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	**10. WAS CONDITION RELATED TO** A. PATIENT'S EMPLOYMENT YES ☐ NO X; B. AN AUTO ACCIDENT YES ☐ NO X	**11. INSURED'S ADDRESS** (Street, city, state, ZIP code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing) I authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below SIGNED DATE		**13.** I authorize direct pymnt to undersigned physician

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO	16a. IF AN EMERGENCY CHECK HERE ☐
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM ___ THROUGH ___	DATES OF PARTIAL DISABILITY FROM ___ THROUGH ___	
19. NAME OF REFERRING PHYSICIAN		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED ___ DISCHARGED ___	
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO CHARGES	

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1 2 3 ETC. OR DX CODE

1.
2.
3
4

24. A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F
11/07/01	0	97010	Ice/Heat	AL	$ 15.00	
11/08/01	0	99213	Office Visit MP	AL	36.00	
11/08/01	0	97014	Electrotherapy	AL	20.00	
11/08/01	0	97010	Ice/Heat	AL	15.00	
11/09/01	0	99213	Office Visit MP	AL	36.00	
11/09/01	0	97014	Electrotherapy	AL	20.00	
11/09/01	0	97010	Ice/Heat	AL	15.00	
11/12/01	0	99213	Office Visit MP	AL	36.00	
11/12/01	0	97014	Electrotherapy	AL	20.00	
11/12/01	0	97010	Ice/Heat	AL	15.00	
11/13/01	0	99213	Office Visit MP	AL	36.00	
11/13/01	0	97014	Electrotherapy	AL	20.00	
11/13/01	0	97010	Ice/Heat	AL	15.00	
11/14/01	0	99213	Office Visit MP	AL	36.00	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing)	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
SIGNED DATE	YES ☐ NO X	$ 335.00		
	30. YOUR SOCIAL SECURITY NO	31. PHYSICIAN'S OR SUPPLIER'S NAME ADDRESS ZIP CODE & TELEPHONE NO		
32. YOUR PATIENT'S ACCOUNT NO	33. YOUR EMPLOYER I.D. NO	Pearson, John E. 1808 S. Bowen Rd., Ste. D 817-274-0221 Arlington, TX 76013 License # 5285,		
1070	75-2349776	I.D. NO		

*PLACE OF SERVICE CODES (Codes For Medicare And Medicaid Are Shown In Parenthesis)

1-INPATIENT HOSPITAL-IH-(3)
2-OUTPATIENT HOSPITAL-OH-(5)
3-DOCTOR'S OFFICE-O-(1)
4-PATIENT'S HOME-H-(2)
5-DAY CARE FACILITY
6-NIGHT CARE FACILITY
7-NURSING HOME-NH-(8)
8-SKILLED NURSING FACILITY-SNF-(4)
9-AMBULANCE-(7 Medicare Only)
0-OTHER LOCATIONS-OL-(7 Medicare 9 Medicaid)
A-INDEPENDENT LABORATORY-IL-(6)
B-OTHER MEDICAL/SURGICAL FACILITY
C-RESIDENTIAL TREATMENT CENTER-RTC-(CHAMPUS Only)
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APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

3707.010-DD383

HEALTH INSURANCE CLAIM FORM

FORM APPROVED
OMB No. 0938-0008

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ BLUE SHIELD OF TEXAS

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (First name, middle initial, last name) Dalton, Regina	2 PATIENT'S DATE OF BIRTH 06/24/64	3 INSURED'S NAME (First name, middle initial, last name) UNKNOWN INSURED INFO.
4 PATIENT'S ADDRESS (Street, city, state, ZIP code AND Telephone Number) 2008 Oakwood Ct (817) 299-8565 Arlington, TX 76012	5 PATIENT'S SEX MALE ☐ FEMALE X 7 PATIENT'S RELATIONSHIP TO INSURED SELF X SPOUSE CHILD OTHER	6 INSURED'S I.D. No. (or MEDICARE No. (include any letters) 8 INSURED'S GROUP NO. (Or Group Name)
9 OTHER HEALTH INSURANCE COVERAGE (Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number)	10 WAS CONDITION RELATED TO A PATIENT'S EMPLOYMENT YES ☐ NO X B AN AUTO ACCIDENT YES ☐ NO X	11 INSURED'S ADDRESS (Street, city, state, ZIP code)
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing) I authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below SIGNED DATE		13 I authorize direct pymnt to undersigned physician

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15 DATE FIRST CONSULTED YOU FOR THIS CONDITION	16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO	16a IF AN EMERGENCY CHECK HERE ☐
17 DATE PATIENT ABLE TO RETURN TO WORK	18 DATES OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH	
19 NAME OF REFERRING PHYSICIAN		20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)		22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO CHARGES	

23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1 2 3 ETC. OR DX CODE

1
2
3
4

24 A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F
11/14/01	0	97014	Electrotherapy	ALL	$ 20.00	
11/14/01	0	97010	Ice/Heat	ALL	15.00	
11/15/01	0	99213	Office Visit MP	ALL	36.00	
11/15/01	0	97014	Electrotherapy	ALL	20.00	
11/15/01	0	97010	Ice/Heat	ALL	15.00	
11/16/01	0	99213	Office Visit MP	ALL	36.00	
11/16/01	0	97014	Electrotherapy	ALL	20.00	
11/16/01	0	97010	Ice/Heat	ALL	15.00	
11/19/01	0	99213	Office Visit MP	ALL	36.00	
11/19/01	0	97014	Electrotherapy	ALL	20.00	
11/19/01	0	97010	Ice/Heat	ALL	15.00	
11/21/01	0	99213	Office Visit MP	ALL	36.00	
11/21/01	0	97014	Electrotherapy	ALL	20.00	
11/21/01	0	97010	Ice/Heat	ALL	15.00	

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing) SIGNED DATE	26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ NO X 30 YOUR SOCIAL SECURITY NO	27 TOTAL CHARGE $ 319.00	28 AMOUNT PAID	29 BALANCE DUE
32 YOUR PATIENT'S ACCOUNT NO 1070	33 YOUR EMPLOYER I.D. NO 75-2349776	31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO Pearson, John E. 1808 S. Bowen Rd., Ste. D 817-274-0221 Arlington, TX 76013 License # 5285, I.D. NO		

*PLACE OF SERVICE CODES (Codes For Medicare And Medicaid Are Shown In Parenthesis)

1-INPATIENT HOSPITAL-IH-(3)
2-OUTPATIENT HOSPITAL-OH-(5)
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4-PATIENT'S HOME-H-(2)
5-DAY CARE FACILITY
6-NIGHT CARE FACILITY
7-NURSING HOME-NH-(8)
8-SKILLED NURSING FACILITY-SNF-(4)
9-AMBULANCE (7 Medicare Only)
0-OTHER LOCATIONS-OL-(7 Medicare 9 Medicaid)
A-INDEPENDENT LABORATORY-IL-(6)
B-OTHER MEDICAL/SURGICAL FACILITY
C-RESIDENTIAL TREATMENT CENTER-RTC-(CHAMPUS Only)
D-SPECIALIZED TREATMENT FACILITY-STF-(CHAMPUS Only)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

3707.010-00383

HEALTH INSURANCE CLAIM FORM

FORM APPROVED
OMB No. 0938-0008

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ BLUE SHIELD OF TEXAS

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (First name, middle initial, last name)
Dalton, Regina

2 PATIENT'S DATE OF BIRTH
06/24/64

3 INSURED'S NAME (First name, middle initial, last name)
UNKNOWN INSURED INFO.

4 PATIENT'S ADDRESS (Street, city, state, ZIP code AND Telephone Number)
2008 Oakwood Ct (817) 299-8565
Arlington, TX 76012

5 PATIENT'S SEX
MALE ☐ FEMALE ☒

6 INSURED'S I.D. No. or MEDICARE No. (Include any letters)

7 PATIENT'S RELATIONSHIP TO INSURED
SELF ☒ SPOUSE ☐ CHILD ☐ OTHER ☐

8 INSURED'S GROUP NO. (Or Group Name)

9 OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10 WAS CONDITION RELATED TO
A PATIENT'S EMPLOYMENT
YES ☐ NO ☒
B AN AUTO ACCIDENT
YES ☐ NO ☒

11 INSURED'S ADDRESS (Street, city, state, ZIP code)

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing)
I authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below
SIGNED DATE

13
I authorize direct pymnt to undersigned physician

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐
16a IF AN EMERGENCY CHECK HERE ☐

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19 NAME OF REFERRING PHYSICIAN

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES

23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1 2 3 ETC. OR DX CODE
1
2
3
4

24 A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F
11/26/01	0	99213	Office Visit MP	ALL	$ 56.00	
11/26/01	0	97014	Electrotherapy	ALL	20.00	
11/26/01	0	97010	Ice/Heat	ALL	15.00	
12/03/01	0	99214	Est. Patient Exten	ALL	75.00	
12/03/01	0	TENS	Therapy unit	ALL	250.00	
12/03/01	0	99080	Narrative Report	ALL	100.00	

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing)
SIGNED DATE

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES ☐ NO ☒

27 TOTAL CHARGE $ 496.00

28 AMOUNT PAID

29 BALANCE DUE

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO
Pearson, John E.
1808 S. Bowen Rd., Ste. D 817-274-0222
Arlington, TX 76013
License # 5285,
I.D. NO

32 YOUR PATIENT'S ACCOUNT NO
1070

33 YOUR EMPLOYER I.D. NO
75-2349776

* PLACE OF SERVICE CODES (Codes For Medicare And Medicaid Are Shown In Parentheses)
1 INPATIENT HOSPITAL-IH-(3)
2 OUTPATIENT HOSPITAL-OH-(5)
3 DOCTOR'S OFFICE-O-(1)
4 PATIENT'S HOME-H-(2)
5 DAY CARE FACILITY
6 NIGHT CARE FACILITY
7 NURSING HOME-NH-(8)
8 SKILLED NURSING FACILITY-SNF-(4)
9 AMBULANCE (7 Medicare Only)
0 OTHER LOCATIONS-OL-(7 Medicare 9 Medicaid)
A INDEPENDENT LABORATORY-IL-(6)
B OTHER MEDICAL/SURGICAL FACILITY
C RESIDENTIAL TREATMENT CENTER-RTC-(CHAMPUS Only)
D SPECIALIZED TREATMENT FACILITY-STF-(CHAMPUS Only)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

3707.010-DO383

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

THI ACE WILLIAMS LAW FIRM
624 SIX FLAGS DRIVE, STE 201
ARLINGTON, TX 76011

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 [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 451374230

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DALTON, REGINA

3. PATIENT'S BIRTH DATE MM DD YY: 06 24 1964 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DALTON, REGINA

5. PATIENT'S ADDRESS (No., Street): 2008 OAK WOOD CT

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

7. INSURED'S ADDRESS (No., Street): 2008 OAK WOOD CT

CITY: ARLINGTON STATE: TX

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

CITY: ARLINGTON STATE: TX

ZIP CODE: 76014 TELEPHONE (Include Area Code): (817) 299-8565

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

ZIP CODE: 76014 TELEPHONE (INCLUDE AREA CODE): (817) 299-8565

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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: 06 24 1964 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 06 24 1964 SEX M [ ] F [X]

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: THE STACE WILLIAMS LAW FIRM

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.

SIGNED Signature on file DATE 11 28 2001

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR J.E. PEARSON D.C.

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. 847.0
2. 723.1
3. 847.1
4. 724

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER: LOP, DR. PEARSON

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
10 17 2001	10 17 2001	11	4	72040	WP	12	115 00	1				
10 17 2001	10 17 2001	11	4	72070	WP	34	110 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 75-2807208 X

26. PATIENT'S ACCOUNT NO: 188

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

28. TOTAL CHARGE: $ 225 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 225 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.)
COMMUNITY DIAGNOSTICS
SIGNED [signature] DATE 11 28 2001

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)
COMMUNITY DIAGNOSTICS
2349 W. PIONEER PKWY
Arlington, Tx 76013

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Community Diagnostics
122 W. Colorado Blvd.
Dallas, TX 75208
PIN# GRP# (214) 941-2711

PATIENT AND INSURED INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8 98)

PLEASE PRINT OR TYPE

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THE STACE WILLIAMS LAW FIRM

A PROFESSIONAL CORPORATION

STACE L. WILLIAMS ◊
BOARD CERTIFIED PERSONAL INJURY TRIAL LAW
TEXAS BOARD OF LEGAL SPECIALIZATION

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LUBBOCK, TEXAS
(Principal Office)

ARLINGTON, TEXAS
(Dallas/Fort Worth Metroplex)

EL PASO, TEXAS

◊ Member Texas Bar
* Member Oklahoma Bar

Kmart Corporation
c/o Trumbull Services
P.O. BOX 426
Windsor, Connecticut 06095

RE: Our Client : Regina Dalton
Date of Loss : 09-30-01

Dear Sir/Madam,

Please be advised that this firm represents Ms. Regina Dalton in reference to a claim for personal injuries arising from a slip/fall accident occurring on or about September 30, 2001 at K-Mart located at 4650 S. Cooper Street, Arlington, Texas 76017.

Please find enclosed the completed "Proof of Claim" form, a copy of the attorney/client agreement, and medical billing/records regarding the personal injuries Regina suffered as a result of this accident.

Please direct all future correspondence to my office. If you have any questions, I can be reached Monday through Friday at (817) 860-9000. Thank you.

Sincerely,

Paul D. Thorson
Attorney at Law

PDT/cs
enclosures