140450 V

B498
3322 Commercial Ave
So. Chgo Heights IL
60411

MIDWESTERN ACCOUNT CONSULTANTS, LTD.

SWORN STATEMENT AND NOTICE OF INTENTION TO
HOLD HOSPITAL LIEN

OCT. 22, , 19 90 .

TO: RON LAYER ADDRESS 5832 HOHMAN AVE. HAMMOND IN 46320

You are hereby notified that HAMMOND PATHOLOGIST (hereinafter called "CALIMANT") whose address is PO BOX 3246 MUNSTER IN 46321, intends to hold a Hospital Lien for all reasonable and necessary charges for hospital care, treatment, or maintenance of the above-listed patient as follows:

1. The patient was admitted to the hospital on JAN. 1, 19 90, and discharged from the hospital on JAN. 2, 19 90.
2. The amount due for hospital care during the above time period is two hundred sixty four dollars & thirty five cents Dollars.($ 264.35).
3. To the best claimant's knowledge the following names and addresses are those claimed by the patient or his legal representative to be liable for damages arising from the illness or injury causing the hospital stay:

(a) IRETTA KRAMER 7621 BARING ST. HAMMOND IN 46320

(b)

(c)

This lien is being filed pursuant to the Hospital Lien Law, I.C. 32-8-26 in the Office of the Recorder of Lake County in which the Claimant is located, within ninety (90) days after the patient was dischared from the hospital. The undersigned Claimant intends to hold a Hospital Lien as described above and that the facts and matters set forth in the foregoing statement are true and correct.

Lynne Denholm / Office Mgr.
(Signature)

LYNNE DENHOLM
(Printed)

STATE OF INDIANA / S.S. NO.
LAKE COUNTY
FILED FOR RECORD
DEC 24 10 13 AM
ROBERT
RECORDER

STATE OF ILLINOIS)
) SS:
COUNTY OF COOK)

Before me, a Notary Public in and for said County and State, personally appeared , who acknowledged the execution of the foregoing Sworn Statement and Notice of Intention to Hold Hospital Lien, and who, having been duly sworn, under the penalties of purjury, stated that the facts and matters therein set forth are true and correct.

Witness my hand and Notarial Seal this 14 day of December, 1990.

My Commission Expires

"OFFICIAL SEAL"
CAROL ANN RAYMOND
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 5/30/94

Residing in Illinois

Signature Carol Ann Raymond

Printed Carol Ann Raymond
Notary Public

600

STMT RE[redacted]NTS PROFESSIONAL COMPONENT OF LABORAT[redacted]AND/OR PATHOLOGY FEES.

LF MANUAL BILLED

SMP

892480

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO 0938-0008

[ ] MEDICARE (MEDICARE NO.)	[ ] MEDICAID (MEDICAID NO.)	[ ] CHAMPUS (SPONSOR'S SSN)	[ ] CHAMPVA (VA FILE NO.)	[ ] FECA BLACK LUNG (SSN)	[X] OTHER (CERTIFICATE SSN) MB

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): KRAMER, IRETTA A
2. PATIENT'S DATE OF BIRTH: 10 | 14 | 68
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): KRAMER, IERRENCE
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 7621 BARING ST HAMMOND, IN 46320
   TELEPHONE NO. (219) 845-6770
5. PATIENT'S SEX: MALE [ ] FEMALE [X]
6. INSURED'S I.D. NO (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS): MAC
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [X]
8. INSURED'S GROUP NO (OR GROUP NAME OR FECA CLAIM NO.): [ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
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. ACCIDENT: AUTO [ ] OTHER [ ]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE): EMPLOYED BY -
    TELEPHONE NO.
11.a. CHAMPUS SPONSOR'S:
    STATUS: ACTIVE DUTY [ ] RETIRED [ ] DECEASED [ ] BRANCH OF SERVICE
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. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.
    SIGNED: AUTHOR. & ASSIGN. ON FILE DATE: 01-01-90
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
    AUTHORIZATION ON FILE
    SIGNED (INSURED OR AUTHORIZED PERSON)

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. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16.a. IF 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 OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY): MAJMUDAR, D M
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED 01-01-90 DISCHARGED 01-02-90
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE): ST. MARGARET HOSPITAL
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
    1. 6349 - SPON ABORTION UNCOMPLIC
    2.
    3.
    4.
    B. EPSDT YES [ ] NO [ ]
    FAMILY PLANNING YES [ ] NO [ ]
    PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM TO	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. DAYS OR UNITS	G.* T.O.S	H. LEAVE BLANK
010190 0101	IH	8001226	SMA/12		8 95		5	
010190 0101	IH	8452026	UREA NITROGEN		2 45		5	
010190 0101	IH	8294826	GLUCOSE, FASTING		245		5	
010190 0101	IH	8573026	PARTIAL THROM. TM		4 75		5	
010190 0101	IH	8561026	PROTHROMBIN TIME		245		5	
010190 0101	IH	8445026	SGOT		335		5	
010190 0101	IH	8299826	HCG-SERUM, QUAL		385		5	
010190 0101	IH	8502226	CBC		345		5	
010190 0101	IH	8830526	GROSS/MICRO GRP 4		14950		5	
010190 0101	IH	8100026	URINALYSIS		235		5	
010190 0101	IH	8799926	CHLAMYDIA		895		5	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF).
    HAMMOND PATHOLOGIST
    DATE: 10-15-90 [signature]
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [ ] NO [ ]
27. TOTAL CHARGE: CONT.
28. AMOUNT PAID: 60
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO
    HAMMOND PATHOLOGIST
    8045 EUCLID
    P.O. BOX 3246
    MUNSTER, IN 46321
    704880 (219)836-0497
32. YOUR PATIENT'S ACCOUNT NO.
    D003197512 SMP PRESIDENT OF ASSOCIATION
33. YOUR EMPLOYER I.D. NO.
    35-1640762

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

STMT REPRESENTS PROFESSIONAL COMPONENT OF LABORATORY AND/OR PATHOLOGY FEES.

LF MANUAL BILLED

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(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO 0938-0008

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3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): KRAMER, TERRENCE

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 7621 BARING ST HAMMOND, IN 46320

TELEPHONE NO. (219) 845-6770

5. PATIENT'S SEX: MALE ☐ FEMALE ☒

6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS): MAC

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

8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

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. ACCIDENT: AUTO ☐ OTHER ☐

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE): EMPLOYED BY -

TELEPHONE NO.

11.a. CHAMPUS SPONSOR'S STATUS: ACTIVE DUTY ☐ RETIRED ☐ DECEASED ☐ BRANCH OF SERVICE

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. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED: AUTHOR. & ASSIGN. TO FILE DATE: 01-01-90

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AUTHORIZATION ON FILE

SIGNED (INSURED OR AUTHORIZED PERSON)

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

1. 6349 - SPON ABORTION UNCOMPLIC
2.
3.
4.

B. EPSDT YES ☐ NO ☐ FAMILY PLANNING YES ☐ NO ☐

PRIOR AUTHORIZATION NO.

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010190	0101	IH	8000426	ELECTROLYTE PROFILE/-4 TEST		645		5	
010190	0101	IH	8708226	CULTURE, G.C.		645		5	
010290	0102	IH	8603126	GROUP, RH, COOMB-I		285		5	
010290	0102	IH	8830426	GROSS/MICRO GRP 3		5610		5	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

HAMMOND PATHOLOGIST

DATE: 10-15-90

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

27. TOTAL CHARGE: 26435

28. AMOUNT PAID: 00

29. BALANCE DUE: 264.35

30. YOUR SOCIAL SECURITY NO.

31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

HAMMOND PATHOLOGIST
8045 EUCLID
P.O. BOX 3246
MUNSTER, IN 46321
I.D. NO. 704880 (219) 836-0497

32. YOUR PATIENT'S ACCOUNT NO. 0003197512 SMP

33. YOUR EMPLOYER I.D. NO. 35-1640762

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS: PRESIDENT OF ASSOCIATION

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

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