IOCESE OF ORANGE

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
CLAIM SERVICES PROVIDER

B

*you have any question bout this claim, or wish review of the decision, ease contact →

SANTA ANA GROUP CLAIM OFFICE
P.O.BOX C 11936
SANTA ANA, CALIFORNIA 92711
(714-547-5631)

AUGUST 28, 1984

DIOCESE OF ORANGE
2811 E VILLA REAL DR
ORANGE CA 92667

FR ELEUTERIO RAMOS
2811 E VILLA REAL DRIVE
ORANGE CA 92667

Keep This Statement For Tax Purposes
No Other Record Will Be Provided

tch No. 16-84-240-0008-D

*If Code Present See Memo Box Below

| Nature of Service/Provider | Date of Service From | To | Total Charge | Excluded Amount | *Code | Amount @ 100 % | Amount % @ | Amount % @ 80 % | Amount % @ 50 % |
|---|---|---|---|---|---|---|---|---|---|
| [redacted] | 6/13/84 | 7/18/84 | 161.50 | 41.50 | 76 | | | | 120.00 |

| | | | | |
|---|---|---|---|---|
| Totals | 161.50 | 41.50 | | 120.00 |
| Less Deductible | | | | 120.00 |
| Balance | | | | 50 |
| Percentage | | | | 60.00 |
| Benefit | | | | 60.00 |

ontrol No. 95545
Branch 001
mplc FR ELEUTERIO RAMOS
epe [redacted]

Relationship

| S | SC | F/C | P/M | LIAB | SSPR | A | B | C | D | SI | SCCC | IAS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

JTPATIENT DOCTOR VISITS FOR THIS ERVICE ARE LIMITED TO $60 PER CALL ND PAYABLE AT 50% UP TO A MAXIMUM ENEFIT OF $1500.

76 CHARGES IN EXCESS OF THE SCHEDULED BENEFITS.

50600326

DIOCESE OF ORANGE

THE PRUDENTIAL INSURANCE
COMPANY OF AMERICA
CLAIM SERVICES PROVIDER

B

you have any question
bout this claim, or wish
review of the decision,
ease contact →

SANTA ANA GROUP CLAIM OFFICE
P.O.BOX C 11936
SANTA ANA, CALIFORNIA 92711
(714-547-5631)

JUNE 21, 1984

DIOCESE OF ORANGE
2811 E VILLA REAL DR
ORANGE CA 92667

FR ELEUTERIO RAMOS
2811 E VILLA REAL DRIVE
ORANGE CA 92667

Keep This Statement For Tax Purposes
No Other Record Will Be Provided

tch No. 16-84-172-0210-D

*If Code Present See Memo Box Below

| Nature of Service/Provider | Date of Service From | To | Total Charge | Excluded Amount | *Code @ | Amount 100% @ | Amount % @ | Amount 80 % @ | Amount 50 % |
|---|---|---|---|---|---|---|---|---|---|
| [redacted] | 5/23/84 | | 95.00 | 35.00 | 76 | | | | 60.00 |

| | | | |
|---|---|---|---|
| Totals | 95.00 | 35.00 | 60.00 |
| Less Deductible | | | 60.00 |
| Balance | | | 50 |
| Percentage | | | 30.00 |
| Benefit | | | 30.00 |

ontrol No. 95545
mpl. FR ELEUTERIO RAMOS
epe [redacted]
Branch 001

Relationship

| F | SC | F/O | R/M | LIAB | SSPR | A | B | C | D | SI | SCCC | IRS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

OUTPATIENT DOCTOR VISITS FOR THIS SERVICE ARE LIMITED TO $60 PER CALL AND PAYABLE AT 50% UP TO A MAXIMUM BENEFIT OF $1500.

76 CHARGES IN EXCESS OF THE SCHEDULED BENEFITS.

RECEIVED

CK# 2000166907
NATIONAL SERV. CNTR.
$30.00

50600331

IOCESE OF ORANGE

THE PRUDENTIAL INSURANCE
COMPANY OF AMERICA
CLAIM SERVICES PROVIDER

B

*you have any question*
*out this claim, or wish*
*eview of the decision,*
*ease contact*

SANTA ANA GROUP CLAIM OFFICE
P.O.BOX C 11536
SANTA ANA, CALIFORNIA 92711
(714-547-5631)

MAY 21, 1984

DIOCESE OF ORANGE
2811 E VILLA REAL DR
ORANGE CA 92667

FR ELEUTERIO RAMOS
2811 E VILLA REAL DRIVE
ORANGE CA 92667

Keep This Statement For Tax Purposes
No Other Record Will Be Provided

ch No. 16-84-139-0314-D

*If Code Present See Memo Box Below

| Nature of Service/Provider | Date of Service From | To | Total Charge | Excluded Amount | *Code | Amount @ 100% | Amount @ % | Amount @ 80% | Amount @ 50% |
|---|---|---|---|---|---|---|---|---|---|
| [redacted] | 3/28/84 | | 80.75 | 20.75 | 76 | | | | 60.00 |
| | 3/28/84 | | 14.25 | 14.25 | 19 | | | | |
| Totals | | | 95.00 | 35.00 | | | | | 60.00 |

ntrol No. 95545
Branch 001
npio FR ELEUTERIO RAMOS
:pen [redacted]

| | |
|---|---|
| Less Deductible | 60.00 |
| Balance | 50 |
| Percentage | 30.00 |
| Benefit | 30.00 |

Relationship

| IF | SC | F/C | R/M | LIAE | SSRR | A | B | C | D | SI | SCOC | IRS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

JTPATIENT DOCTOR VISITS FOR THIS ERVICE ARE LIMITED TO $60 PER CALL ND PAYABLE AT 50% UP TO A MAXIMUM ENEFIT OF $1500.

76 CHARGES IN EXCESS OF THE SCHEDULED BENEFITS.
19 DISCOUNT.

50600334

# HEALTH INSURANCE CLAIM FORM

of Southern California

Box 60465, Terminal Annex
Los Angeles, California 90060

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☒ OTHER

## 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) |
|---|---|---|
| Father Eleutrio Ramos | 03 \| 23 \| 40 | Eleutrio Ramos |
| 4. PATIENT'S ADDRESS (Street, city, state, ZIP code)<br>00 W. La Habra<br>La Habra, CA 90631 | 5. PATIENT'S SEX: MALE [X] FEMALE [ ]<br>7. PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ] | 6. INSURED'S I.D. No. or MEDICARE No. (include any letters)<br>NOO 04 0501<br>8. INSURED'S GROUP NO. (Or Group Name)<br>GR #97080 B |
| 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:<br>A. PATIENT'S EMPLOYMENT YES [ ] NO [X]<br>B. AN AUTO ACCIDENT YES [ ] NO [X] | 11. INSURED'S ADDRESS (Street, city, state, ZIP code)<br>Diocese of Orange<br>~~2811~~ 2811 E. Villa Real Drive<br>Orange, CA 92667 |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing)<br>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<br>SIGNED DATE | | 13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW<br>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. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO |
|---|---|---|
| 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 [redacted]
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 |
|---|---|---|---|---|---|---|
| 4,Apr.'84 | O | 90050 | Examined and treated | | 20.00 | |
| | | [redacted] | | | 3.00 | |
| | | [redacted] | | | 5.00 | |
| 3,May'84 | O | 90060 | Examined and treated | | 20.00 | |
| | | [redacted] | | | 3.00 | |
| | | | TO THE PRV 5/16/84 DK | | | |

| 25. SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing) | 26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [ ] NO [X] | 27. TOTAL CHARGE | 28. AMOUNT PAID | 29. BALANCE DUE |
|---|---|---|---|---|
| SIG. M.F. Mulville M.D. DATE 5/11/84 | 30. YOUR SOCIAL SECURITY NO. [redacted] | 51.00 | 00 | 51.00 |
| 32. YOUR PATIENT'S ACCOUNT NO. | 33. YOUR EMPLOYER I.D. NO. | 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.<br>M.F. Mulville M.D.<br>100 E. Valenica Mesa Drive<br>Fullerton, CA 92635<br>I.D. NO. 526 4669 | | |

50600337

*PLACE OF SERVICE CODES

1-(H) -INPATIENT HOSPITAL
2-(OH)-OUTPATIENT HOSPITAL
3-(O) -DOCTOR'S OFFICE
4-(H)-PATIENT'S HOME
5- DAY CARE FACILITY (PSY)
6- NIGHT CARE FACILITY (PSY)
7-(NH) -NURSING HOME
8-(SNF) -SKILLED NURSING FACILITY
9- AMBULANCE
0-(OL)-OTHER LOCATIONS
A-(IL) -INDEPENDENT LABORATORY
B- OTHER MEDICAL/SURGICAL FACILITY

A CORPORATION SOLE
2811 E. VILLA REAL DRIVE
ORANGE, CA 92667

| PAYEE NAME | VENDOR NO. |
|---|---|
| MULVILLE M.D., MAURICE F. | 1382 |

| DATE | DESCRIPTION AND/OR INVOICE NO. | AMOUNT | REFERENCE |
|---|---|---|---|
| 5/18/84 | 051684 MEDICAL EXPENSES FOR REV. RAMOS-APRIL & MAY | 51.00 | 355000 |
| 5/18/84 | CHECK NUMBER 102315 | 51.00 | |

ROMAN CATHOLIC BISHOP OF ORANGE
A CORPORATION SOLE
2811 E. VILLA REAL DRIVE
ORANGE, CA 92667

16-66
1220

BANK OF AMERICA
ORANGE MAIN OFFICE
345 EAST CHAPMAN AVENUE
ORANGE, CA 92668

102315
CHECK NUMBER
102315

DATE
5/18/84

AMOUNT
**********51.00

PAY EXACTLY **********51 DOLLARS AND 00 CENTS

PAY TO THE ORDER OF

MULVILLE M.D., MAURICE F.
100 E. VALENCIA MESA DR.
FULLERTON, CA. 92635

AUTHORIZED SIGNATURE

⑈102315⑈ ⑆122000661⑆ 02331⑈04006⑈

50600338

DIOCESE OF ORANGE

THE PRUDENTIAL INSURANCE
COMPANY OF AMERICA
CLAIM SERVICES PROVIDER

B

SANTA ANA GROUP CLAIM OFFICE
P.O.BOX C 11936
SANTA ANA, CALIFORNIA 92711
(714-547-5631)

*you have any question about this claim, or wish review of the decision, lease contact*

MAY 25, 1984

DIOCESE OF ORANGE
2811 E VILLA REAL DR
ORANGE CA 92667

FR ELEUTERIO RAMOS
2811 E VILLA REAL DRIVE
ORANGE CA 92667

Keep This Statement For Tax Purposes
No Other Record Will Be Provided

*If Code Present See Memo Box Below

tch No. 16-84-145-0166-D

| Nature of Service/Provider | Date of Service From | To | Total Charge | Excluded Amount | *Code | Amount @ 100% | Amount @ % | Amount @ 80% | Amount @ 50% |
|---|---|---|---|---|---|---|---|---|---|
| [redacted] | 4/4/84 | | 28.00 | 5.00 | 02 | | | 23.00 | |
| | 5/3/84 | | 23.00 | | | | | 23.00 | |
| | | Totals | 51.00 | 5.00 | | | | 46.00 | |

ontrol No. 95545 Branch 001

mp FR ELEUTERIO RAMOS

epe [redacted]

Less Deductible 46.00
Balance 80
Percentage 36.80
Benefit 36.80

| Relationship | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| F | SC | F/O | B/M | LI/AB | SSPR | A | B | C | D | SI | SCOC | IRS |

PLEASE REFER TO OUR LETTER DATED APRIL 20, 1984 THAT WAS PREVIOUSLY SENT.

02 PLEASE SEE EXPLANATION IN LEFT HAND MESSAGE BOX.

50600339

**HEFFERNAN, KEILER & DOBLE, INC.**

HEALTH PLAN CLAIM SUMMARY

DATE 10/05/83

EMPLOYEE

CLAIMANT RAMOS, FR. ELVETERIO V.

CLAIMANT NO. 09725

GROUP DIOCESE OF ORANGE

GROUP NO. 17/ 18

REV. ELEUTERIO RAMOS
C/O AL PESQUEIRA
2811 E VILLA REAL DR.
OARNGE CA 92667

This is an explanation of how we have handled the bills listed below.

| | | | | |
|---|---|---|---|---|
| BILL FROM | FOR | | | |
| TORMEY, DDS | 948.00 | DATED 9/13- 9/23/83 | | |
| | 235.00- | NOT COVERED | | |
| | 413.00 | PAID AT 75% | 309.75 | S |
| | 300.00 | PAID AT 50% | 150.00 | S |
| | | CHECK # 12740 PAID TO DOCTOR | 459.75 | |
| MULVILLE, MD | 23.00 | DATED 9/13/83 | | |
| | 23.00 | PAID AT 100% | 23.00 | S |
| | | CHECK # 12741 PAID DIRECT | 23.00 | |
| | | TOTAL PAID ON THIS SUMMARY | 482.75 | |

$235.00-EXCEEDS DENTAL ALLOWANCE

If you have any questions about this summary, please contact

Paid By Plan This Year

L A MC MILLIAN
H RNAN, KEILER & DOBLE, INC
6 + WILSHIRE BLVD. STE 1230
LOS ANGELES, CALIFORNIA 90048
PHONE 213 655-4044 800 227-4141

| | |
|---|---|
| MEDICAL 1982 | 1,632.30 |
| MEDICAL 1983 | 744.00 |
| DENTAL 1983 | 459.75 |

50600340

**HEFFERNAN, KEILER & DOBLE, INC.**

HEALTH PLAN CLAIM SUMMARY

REV. ELEUTERIO RAMOS
C/O AL PESQUEIRA
2811 E VILLA REAL DR.
OARNGE CA 92667

DATE 11/02/83

EMPLOYEE

CLAIMANT RAMOS, FR. ELVETERIO V.

CLAIMANT NO. 09725

GROUP DIOCESE OF ORANGE

GROUP NO. 17/ 18

This is an explanation of how we have handled the bills listed below.

| BILL FROM | FOR | | |
|---|---|---|---|
| LA HABRA RAD | 54.00 | DATED 10/03/83 | |
| | 54.00 | PAID AT 100% | 54.00 S |
| | | CHECK # 13188 ENCLOSED | 54.00 |

If you have any questions about this summary, please contact

L A MC MILLIAN
HEFFERNAN, KEILER & DOBLE, INC
6 WILSHIRE BLVD. STE 1230
LOS ANGELES, CALIFORNIA 90048
PHONE 213 655-4044 800 227-4141

Paid By Plan This Year

| | |
|---|---|
| MEDICAL 1982 | 1,632.30 |
| MEDICAL 1983 | 343.00 |
| DENTAL 1983 | 519.75 |

50600341

Diocese of Orange Medical Fund
c/o HEFFERNAN, KEILER & DOBLE, INC.
P.O. BOX 7443
SAN FRANCISCO, CALIFORNIA 94120

17/18

HECK # 13188 GROUP NO. 18 DATE 11/02/83

| CLAIM NUMBER | CLAIMANT/EMPLOYEE NAME | DATE OF SERVICE | AMOUNT |
|---|---|---|---|
| GH09725-1/3 | RAMOS, FR. ELVETERIO V. | 10/03/83 | 54.00 |

DETACH AND RETAIN THIS STATEMENT

Diocese of Orange Medical Fund
c/o HEFFERNAN, KEILER & DOBLE, INC.
P.O. BOX 7443
SAN FRANCISCO, CALIFORNIA 94120

BANK OF AMERICA
345 East Chapman Avenue
Orange, California 92666

16.66/1220

VOID AFTER 120 DAYS

| GR. NO. | CHECK NO. | DATE | AMOUNT |
|---|---|---|---|
| 18 | 13188 | 11/02/83 | $ *****54.00* |

PAY EXACTLY FIFTY FOUR AND NO/100 DOLLARS

TO THE ORDER OF

REV. ELEUTERIO RAMOS
C/O AL PESQUEIRA
2811 E VILLA REAL DR.
ORANGE CA 92667

⑈013188⑈ ⑆122000661⑆ 02331⑈0004⑆

50600342

**HEFFERNAN, KEILER & DOBLE, INC.**

HEALTH PLAN CLAIM SUMMARY

DATE 10/25/83

EMPLOYEE

CLAIMANT RAMOS, FR. ELVETERIO V.

CLAIMANT NO. 09725

GROUP DIOCESE OF ORANGE

GROUP NO. 17/ 18

REV. ELEUTERIO RAMOS
C/O AL PESQUEIRA
2811 E VILLA REAL DR.
OARNGE CA 92667

This is an explanation of how we have handled the bills listed below:

| | | | | |
|---|---|---|---|---|
| BILL FROM | FOR | | | |
| TORMEY, DDS | 948.00 | DATED 9/13- 9/23/83 | | |
| | 948.00- | NOT COVERED | | |
| TUCKER MD | 45.00 | DATED 10/03/83 | | |
| | 45.00 | PAID AT 100% | 45.00 | S |
| | | CHECK # 12992 PAID TO DOCTOR | 45.00 | |
| | | TOTAL PAID ON THIS SUMMARY | 45.00 | |

DUPLICATE CHARGES SEE WORKSHEET DATED 10/5/83

If you have any questions about this summary, please contact

Paid By Plan This Year

LI A MC MILLIAN
HEFFERNAN, KEILER & DOBLE, INC
64 WILSHIRE BLVD. STE 1230
LOS ANGELES, CALIFORNIA 90048
PHONE 213 655-4044 800 227-4141

| | |
|---|---|
| MEDICAL 1982 | 1,632.30 |
| MEDICAL 1983 | 789.00 |
| DENTAL 1983 | 518.75 |

50600343

CLAIMANT

**HEFFERNAN, KEILER & DOBLE, INC.**

HEALTH PLAN CLAIM SUMMARY

REV. ELEUTERIO RAMOS
C/O AL PESQUEIRA
2811 E VILLA REAL DR.
OARNGE CA 92667

DATE 10/11/83

EMPLOYEE

CLAIMANT RAMOS, FR. ELVETERIO V.

CLAIMANT NO. 9725

GROUP DIOCESE OF ORANGE

GROUP NO. 17/ 18

This is an explanation of how we have handled the bills listed below.

BILL FROM
WEDNER, DDS

FOR
140.00 DATED 9/14/83
60.00- NOT COVERED
80.00 PAID AT 75% 60.00 S
CHECK # 12816 PAID TO DOCTOR 60.00

$60 EXCEEDS USUAL AND CUSTOMARY FEES

If you have any questions about this summary, please contact

LI \ MC MILLIAN
HE..ERNAN, KEILER & DOBLE, INC
64 WILSHIRE BLVD. STE 1230
LOS ANGELES, CALIFORNIA 90048
PHONE 213 655-4044 800 227-4141

Paid By Plan This Year

| | |
|---|---|
| MEDICAL 1982 | 1,632.30 |
| MEDICAL 1983 | 744.00 |
| DENTAL 1983 | 519.75 |

50600344

**HEFFERNAN, KEILER & DOBLE, INC.**

HEALTH PLAN CLAIM SUMMARY

DATE 3/06/84

EMPLOYEE

CLAIMANT RAMOS, FR. ELVETERIO V.

CLAIMANT NO. 09725

GROUP DIOCESE OF ORANGE

GROUP NO. 17/ 18

REV. ELEUTERIO RAMOS
C/O AL PESQUEIRA
2911 E VILLA REAL DR.
OARNGE CA 92667

This is an explanation of how we have handled the bills listed below.

| BILL FROM | FOR | | |
|---|---|---|---|
| WEDNER | 125.00 | DATED 9/13-11/15/83 | |
| | 80.00- | NOT COVERED | |
| | 45.00 | PAID AT 75% | 33.75 S |
| | | CHECK # 14466 PAID TO DOCTOR | 33.75 |
| MULVILLE | 46.00 | DATED 10/25-11/22/83 | |
| | 46.00 | PAID AT 80% | 36.80 S |
| | | CHECK # 14467 PAID DIRECT | 36.80 |
| A HACKER CLINI | 323.00 | DATED 9/25-11/16/83 | |
| | | 4 VISITS TIMES $10 | 40.00 S |
| | | CHECK # 14467 PAID DIRECT | 40.00 |
| | TOTAL PAID ON THIS SUMMARY | | 110.55 |

80.00 OCCLUSAL ADJ NOT COVERED.

If you have any questions about this summary, please contact

M CHA CASTILLO
HF FERNAN, KEILER & DOBLE, INC
PO BOX 7443
SAN FRANCISCO, CALIFORNIA 94120
PHONE 415 546-9300

Paid By Plan This Year

| | |
|---|---|
| MEDICAL 1983 | 959.80 |
| DENTAL 1983 | 553.50 |

50600345

Diocese of Orange Medical Fund
c/o HEFFERNAN, KEILER & DOBLE, INC.
P.O. BOX 7443
SAN FRANCISCO, CALIFORNIA 94120

17/18

ECK # 14467 GROUP NO. 18 DATE 3/06/84

| CLAIM NUMBER | CLAIMANT/EMPLOYEE NAME | DATE OF SERVICE | AMOUNT |
|---|---|---|---|
| 3H09725-1/3 | RAMOS, FR. ELVETERIO V. | 10/25-11/22/83 | 36.80 |
| S09725-1/3 | RAMOS, FR. ELVETERIO V. | 9/25-11/16/83 | 40.00 |
| | | TOTAL | 76.80 |

DETACH AND RETAIN THIS STATEMENT

Diocese of Orange Medical Fund
c/o HEFFERNAN, KEILER & DOBLE, INC.
P.O. BOX 7443
SAN FRANCISCO, CALIFORNIA 94120

BANK OF AMERICA
345 East Chapman Avenue
Orange, California 92666

16-66/1220

VOID AFTER 120 DAYS

| GR. NO. | CHECK NO. | DATE | AMOUNT |
|---|---|---|---|
| 18 | 14467 | 3/06/84 | $ *****76.80* |

AY (ACTLY SEVENTY SIX AND 80/100 DOLLARS

TO
OF
DIOCESE OF ORANGE

⑈014467⑈ ⑆122000661⑆ 02331⑈0004⑈

In Kind
3/12/84

50600346

IOCESE OF ORANGE

Group Health Statement

B

If you have any questions about this claim, or wish a review of the decision, please contact =>

SANTA ANA GROUP CLAIM OFFICE
P.O.BOX C 11936
SANTA ANA, CALIFORNIA 92711
(714-547-5631)

Date MARCH 22, 1984

DIOCESE OF ORANGE
2811 E VILLA REAL DR
ORANGE CA 92667

FR ELEUTERIO RAMOS
2811 E VILLA REAL DRIVE
ORANGE CA 92667

atch # 16-84-081-0165-D

* If Code Present See Memo Box Below

| lature of ervice/Provider | Date Of Service From | To | Total Charge | Ineligible Amount | *Code | Amount @ 100% | Amount @ % | Amount @ 80% | Amount @ 50% |
|---|---|---|---|---|---|---|---|---|---|
| [redacted] | 2/22/84 | | 95.00 | 95.00 | 60 | | | | |
| | | Totals | 95.00 | 95.00 | | | | | |
| | | | | Less Deductible | | | | | |
| | | | | Balance | | | | | |
| | | | | Percentage | | | % | % | % |
| | | | | Benefit | | | | | |
| | | | | | | | | Total | .00 |

ontrol No. 95545 Branch 001

mployee FR ELEUTERIO RAMOS

eper nt Relationship

dentification # [redacted]

60 PLEASE SUBMIT A STATEMENT FROM THE DOCTOR ADVISING THE COMPLETE DIAGNOSIS.

DIOCESE OF ORANGE

0000035

COMB 81494

**FR ELEUTERIO RAMOS
***

Requested from [redacted]

4/11/84

50600350

DIOCESE OF ORANGE

THE PRUDENTIAL INSURANCE
COMPANY OF AMERICA
CLAIM SERVICES PROVIDER

B

SANTA ANA GROUP CLAIM OFFICE
P.O.BOX C 11936
SANTA ANA, CALIFORNIA 92711
(714-547-5631)

*If you have any question about this claim, or wish review of the decision, please contact →

MAY 9, 1984

DIOCESE OF ORANGE
2811 E VILLA REAL DR
ORANGE CA 92667

FR ELEUTERIO RAMOS
2811 E VILLA REAL DRIVE
ORANGE CA 92667

Keep This Statement For Tax Purposes
No Other Record Will Be Provided

*If Code Present See Memo Box Below

itch No. 16-84-129-0410-0

| Nature of Service/Provider | Date of Service From | To | Total Charge | Excluded Amount | *Code | Amount @ 100% | Amount @ % | Amount @ 80% | Amount @ 50% |
|---|---|---|---|---|---|---|---|---|---|
| [redacted] | 2/22/84 | | 80.75 | 20.75 | 76 | | | | 60.00 |
| [redacted] | 2/22/84 | | 14.25 | 14.25 | 19 | | | | |
| Totals | | | 95.00 | 35.00 | | | | | 60.00 |
| | | | | | Less Deductible | | | | 31.00 |
| | | | | | Balance | | | | 29.00 |
| | | | | | Percentage | | | | 50 |
| | | | | | | | | | 14.50 |
| | | | | | | | | | 14.50 |

ontrol No. 95545 Branch 001

mplr FR ELEUTERIO RAMOS

eper [redacted]

Relationship

| F | SC | F/D | F/M | LIAB | SGPR | Benefit A | B | C | D | SI | SDOC | IRS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

OUTPATIENT DOCTOR VISITS FOR THIS SERVICE ARE LIMITED TO $60 PER CALL AND PAYABLE AT 50% UP TO A MAXIMUM BENEFIT OF $1500.

76 CHARGES IN EXCESS OF THE SCHEDULED BENEFITS.
19 DISCOUNT.

50600351

Diocese of Orange Medical Fund
c/o HEF[illegible] [illegible]ILER & DOBLE, INC.
[illegible] [illegible]X 7443
SAN[illegible] [illegible], CALIFORNIA 94120

17/

CHECK # 14652 GROUP NO. 18 DATE 4/03/84

| CLAIM NUMBER | CLAIMANT/EMPLOYEE NAME | DATE OF SERVICE | AMOUNT |
|---|---|---|---|
| PS09725-1/3 | RAMOS, FR. ELVETERIO V. | 11/30/83 | 10.00 |

50600357

DETACH AND RETAIN THIS STATEMENT

**HEFFERNAN, KEILER & DOBLE, INC.**

HEALTH PLAN CLAIM SUMMARY

DATE 4/03/84

EMPLOYEE

CLAIMANT RAMOS, FR. ELVETERIO V.

CLAIMANT NO. 09725

GROUP DIOCESE OF ORANGE

GROUP NO. 17/ 18

REV. ELEUTERIO RAMOS
C/O AL PESQUEIRA
2811 E VILLA REAL DR.
OARNGE CA 92667

This is an explanation of how we have handled the bills listed below.

BILL FROM [redacted]

FOR
95.00 DATED 11/30/83
14.25- NOT COVERED
1 VISIT TIMES $10 10.00 S
CHECK # 14652 PAID TO GROUP 10.00

A2/630/83

If you have any questions about this summary, please contact

JUDY MA
HEFFERNAN, KEILER & DOBLE, INC
P O BOX 7443
SAN FRANCISCO, CALIFORNIA 94120
PHONE 415 546-9300

Paid By Plan This Year

| | |
|---|---|
| MEDICAL 1983 | 969.80 |
| DENTAL 1983 | 553.50 |

50600358