

(GROUP INSURANCE)

ATTENDING PHYSICIAN'S STATEMENT

(This form has been approved by the California Medical Association and the Health Insurance Council)

INSURER): Father Eleutrio Ramos Diocese of Orange 2811 E. Villa Real Drive, Orange, CA 92667

(1) Patient's name Father Eleutrio Ramos Age 42

(2) Nature of sickness or injury [Describe complications, if any]

(3) Did this sickness or injury arise out of patient's employment? Yes No X If "Yes," explain

Is disability due to pregnancy? Yes No If "Yes," what was approximate date of commencement of pregnancy? 19

(4) Nature of surgical or obstetrical procedure, if any (Describe fully)

Date performed 19

Charge for this procedure \$

Where performed If in hospital, in-patient out-patient

(5) Give dates of treatments and fees charged:

Table with columns: DATES TREATED, TREATED AT (Home, Hospital, Office), FEE CHARGED. Rows include dates 1/3/84, 2/2/84, 2/9/84, 3/8/84 with associated fees and treatment descriptions.

(6) What other services, if any, did you provide patient? (Itemize, giving dates and fees) TOTAL FEE 84.00

(7) The patient has been unable to perform his regular or customary work from 19 through 19 If still unable to perform his regular or customary work, when should patient be able to resume such work? 19 If hospitalized, give name and address of hospital and dates and times of admission and discharge

(8) Remarks:

Date March 9, 1984 19

Signed [Signature] (Attending Physician) DEGREE

Address 100 E. Valencia Mesa Drive Fullerton CA 92635

Phone 50600360

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
3/16/84	031384 MEDICAL EXPENSE FOR REV. ELEUTERIO RAMOS	84.00	355000
3/16/84	CHECK NUMBER 101358	84.00	

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

DATE 3/16/84

101358  
CHECK NUMBER  
101358

PAY EXACTLY ~~99999999~~ 84 DOLLARS AND 00 CENTS

PAY TO THE ORDER OF

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

*Leory Gray*  
AUTHORIZED SIGNATURE

AMOUNT  
~~99999999~~ 84.00

⑈ 101358 ⑈ ⑆ 12200066 ⑆ ⑆ 0233 ⑈ 04006 ⑈

50600361

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  
2811 E VILLA REAL DR.  
ORANGE CA 92667

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

BILL FROM WEDNER	FDR 125.00 DATED 9/13-11/15/83 80.00- NOT COVERED 45.00 PAID AT 75% CHECK # 14466 PAID TO DOCTOR	33.75 S 33.75
MULVILLE	46.00 DATED 10/25-11/22/83 46.00 PAID AT 80% CHECK # 14467 PAID DIRECT	36.80 S 36.80
	323.00 DATED 9/25-11/16/83 4 VISITS TIMES \$10 CHECK # 14467 PAID DIRECT	40.00 S 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

Paid By Plan This Year

MA JHA CASTILLO  
HEFFERNAN, KEILER & DOBLE, INC  
PO BOX 7443  
SAN FRANCISCO, CALIFORNIA 94120  
PHONE 415 546-9300

MEDICAL 1983 959.80  
DENTAL 1983 553.50

50600368

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

17/18

CHECK #	GROUP NO.	CLAIMANT/EMPLOYEE NAME	DATE	DATE OF SERVICE	AMOUNT
14467	18		3/06/84		
GH09725-1/3		RAMOS, FR. ELVETERIO V.		10/25-11/22/83	36.80
PS 2725-1/3		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, KELLER & 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.  
18

CHECK NO.  
14467

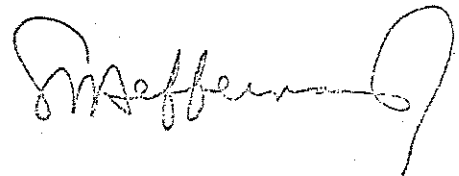
DATE  
3/06/84

AMOUNT  
\$ \*\*\*\*\*76.80\*

EXACTLY SEVENTY SIX AND 80/100 DOLLARS

TO  
OF

DIOCESE OF ORANGE



⑈014467⑈ ⑆12200066⑆ 02331⑈00041⑈

*The King 3/12/84*  
*15*

50600369

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

**HEALTH PLAN CLAIM SUMMARY**

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

DATE 12/13/83

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

380.00 DATED 8/03- 9/14/83

57.00- NOT COVERED

4 VISITS TIMES 310

CHECK # 13815 PAID TO GROUP

40.00 S

40.00

If you have any questions about this summary, please contact

Paid By Plan This Year

JDA MC MILLIAN  
HEFFERNAN, KEILER & DOBLE, INC  
104 WILSHIRE BLVD. STE 1230  
LOS ANGELES, CALIFORNIA 90048  
PHONE 213 655-4044

MEDICAL 1982

1,632.30

800 227-4141 MEDICAL 1983

883.00

DENTAL 1983

519.75

**50600373**

CLAIMANT

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

17/18

ECK #	GROUP NO.	CLAIMANT/EMPLOYEE NAME	DATE	AMOUNT
13815	18	RAMOS, FR. ELVETERIO V.	12/13/83	
-CLAIM NUMBER			DATE OF SERVICE	
S09725-1/3			8/03- 9/14/83	40.00

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.  
18

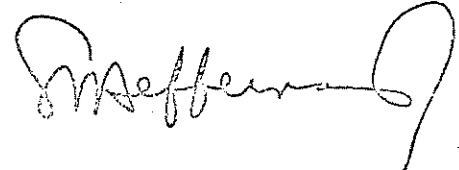
CHECK NO.  
13815

DATE  
12/13/83

AMOUNT  
\$\*\*\*\*\*40.00\*

YACTLY FORTY AND NO/100 DOLLARS  
TO THE  
OR

DIOCESE OF ORANGE



⑈013815⑈ ⑆12200066⑆ 02331⑈0004⑈

50600374

CHECK REQUEST

PAYEE (VENDOR) MAURICE F. MULVILLE, M.B.

VENDOR # 1383

AMOUNT \$ 46.00

REASON ROUTINE LAB WORK REV. ELEUTERIO RAMOS OCT. 25 &  
NOV. 25, 83

REQUESTED BY SK DATE 1/4/84

DEPARTMENTAL APPROVAL \_\_\_\_\_

DEPARTMENT \_\_\_\_\_

AUTOMOBILE		POSTAGE	062
FUEL	011	PRINTING	070
REPAIRS	012	PROMOTION/PUBLISHING	
BOOKS, MAGAZINES	021	OFFICE	061
DUES, SUBSCRIPTIONS	022	CHAPEL	063
EDUCATION	050	COMPUTER	065
PROFESSIONAL		TRAVEL & EXPENSE	100
CONSULTANT	092	WORKSHOP-ATTENDED	111
FACILITATOR	093	WORKSHOP-SPONSORED	112
LEGAL	094		

INVOICE DATE \_\_\_\_\_

BANK # \_\_\_\_\_

VENDOR # \_\_\_\_\_

CHECK COMMENTS \_\_\_\_\_

INVOICE # \_\_\_\_\_

INVOICE AMOUNT \_\_\_\_\_

DISTRIBUTION

A/C 355000 AMOUNT 46.00

A/C \_\_\_\_\_ AMOUNT \_\_\_\_\_

A/C \_\_\_\_\_ AMOUNT \_\_\_\_\_

APPROVALS

50600375

(GROUP INSURANCE)

ATTENDING PHYSICIAN'S STATEMENT

(This form has been approved by the California Medical Association and the Health Insurance Council)

INSURER: Father Eleutrio Ramos

Diocese of Orange 2811 E. Villa Real Drive  
Orange, CA 92667

(1) Patient's name Father Eleutrio Ramos Age 42

(2) Nature of sickness or injury (Describe complications, if any) [REDACTED]

(3) Did this sickness or injury arise out of patient's employment? Yes \_\_\_\_\_ No X  
If "Yes," explain \_\_\_\_\_

Is disability due to pregnancy? Yes \_\_\_\_\_ No X  
If "Yes," what was approximate date of commencement of pregnancy? \_\_\_\_\_ 19\_\_\_\_

(4) Nature of surgical or obstetrical procedure, if any (Describe fully) \_\_\_\_\_

Date performed \_\_\_\_\_ 19\_\_\_\_

Charge for this procedure \$ \_\_\_\_\_  
Where performed \_\_\_\_\_ If in hospital, in-patient \_\_\_\_\_ out-patient \_\_\_\_\_

(5) Give dates of treatments and fees charged:

DATES TREATED	TREATED AT (✓)			FEE CHARGED
	Home	Hospital	Office	
25, Oct. '83			X	20.00
			X	3.00
22, Nov. '83			X	20.00
			X	3.00
				TOTAL 46.00

(6) What other services, if any, did you provide patient? (Itemize, giving dates and fees) \_\_\_\_\_

(7) The patient has been unable to perform his regular or customary work from \_\_\_\_\_ 19\_\_\_\_ through \_\_\_\_\_ 19\_\_\_\_  
If still unable to perform his regular or customary work, when should patient be able to resume such work? \_\_\_\_\_ 19\_\_\_\_  
If hospitalized, give name and address of hospital and dates and times of admission and discharge \_\_\_\_\_

(8) Remarks: \_\_\_\_\_

December 30, 1983 19\_\_\_\_

Signed [Signature] (Attending Physician) DEGREE

Address 100 E. Valencia Mesa Dr. Ste. 203  
Fullerton, CA 92635

Phone 526 4669

50600376

INSURANCE

CHECK REQUEST

PAYEE (VENDOR) MAURICE F. MULVILLE, M.D.

VENDOR # 1382

AMOUNT \*23.00

REASON ROUTINE LAB WORK FOR REV ELEUTERIO RAMOS 9/13/83

REQUESTED BY [Signature] DATE 9/23/82

DEPARTMENTAL APPROVAL \_\_\_\_\_

AUTOMOBILE		POSTAGE	062
FUEL	011	PRINTING	070
REPAIRS	012	PROMOTION/PUBLISHING	
BOOKS, MAGAZINES	021	OFFICE	061
DUES, SUBSCRIPTIONS	022	CHAPEL	063
EDUCATION	050	COMPUTER	065
PROFESSIONAL		TRAVEL & EXPENSE	100
CONSULTANT	092	WORKSHOP-ATTENDED	111
FACILITATOR	093	WORKSHOP-SPONSORED	112
LEGAL	094		

INVOICE DATE \_\_\_\_\_

BANK # 110-101

VENDOR # \_\_\_\_\_

CHECK COMMENTS \_\_\_\_\_

INVOICE # \_\_\_\_\_

INVOICE AMOUNT \_\_\_\_\_

DISTRIBUTION

A/C 355000 AMOUNT \$ 23.00

A/C \_\_\_\_\_ AMOUNT \_\_\_\_\_

A/C \_\_\_\_\_ AMOUNT \_\_\_\_\_

APPROVALS

50600377

(GROUP INSURANCE)

ATTENDING PHYSICIAN'S STATEMENT

(This form has been approved by the California Medical Association and the Health Insurance Council)

(INSURER): Father Eleutrio Ramos

Diocese of Orange 2811 E. Villa Real Drive  
Orange, CA 92667

(1) Patient's name Father Eleutrio Ramos Age 43

(2) Nature of sickness or injury (Describe complications, if any) [REDACTED]

(3) Did this sickness or injury arise out of patient's employment? Yes \_\_\_\_\_ No X  
If "Yes," explain \_\_\_\_\_

Is disability due to pregnancy? Yes \_\_\_\_\_ No \_\_\_\_\_  
If "Yes," what was approximate date of commencement of pregnancy? \_\_\_\_\_ 19\_\_\_\_

(4) Nature of surgical or obstetrical procedure, if any (Describe fully) \_\_\_\_\_

Date performed \_\_\_\_\_ 19\_\_\_\_

Charge for this procedure \$ \_\_\_\_\_

Where performed \_\_\_\_\_ If in hospital, in-patient \_\_\_\_\_ out-patient \_\_\_\_\_

(5) Give dates of treatments and fees charged:

DATES TREATED	TREATED AT (✓)			FEE CHARGED
	Home	Hospital	Office	
13, Sept. '83 Examined and treated 90060			X	20.00
[REDACTED]			X	3.00

(6) What other services, if any, did you provide patient? (Itemize, giving dates and fees) \_\_\_\_\_ TOTAL CHARGES 23.00

(7) The patient has been unable to perform his regular or customary work from \_\_\_\_\_ 19\_\_\_\_ through \_\_\_\_\_ 19\_\_\_\_  
If still unable to perform his regular or customary work, when should patient be able to resume such work? \_\_\_\_\_ 19\_\_\_\_  
If hospitalized, give name and address of hospital and dates and times of admission and discharge \_\_\_\_\_

(8) Remarks: \_\_\_\_\_

Date September 16, 19 83

Signed [Signature]  
(Attending Physician) DEGREE

Address 100 E. Valencia Mesa Drive  
Fullerton, CA 92635

Phone 526 4669

**50600378**

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
9/30/83	92383 REV. E. RAMOS	23.00	355000
9/30/83	CHECK NUMBER 57320	23.00	

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

16-66  
 1220

057320

CHECK NUMBER  
 57320

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

DATE  
 9/30/83

PAY EXACTLY ~~\*\*\*\*\*~~ 23 DOLLARS AND 00 CENTS

**VOID**  
~~\*\*\*\*\*~~ 23.00

PAY TO THE ORDER OF

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

*Leon Ineza*  
 AUTHORIZED SIGNATURE

⑈057320⑈ ⑆122000681⑆ 02331⑈04006⑈

50600379

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

17/18

ECK # 12741 -CLAIM NUMBER	GROUP NO. 18 CLAIMANT/EMPLOYEE NAME	DATE 10/05/83 DATE OF SERVICE	AMOUNT
PH09725-1/3	RAMOS, FR. ELVETERIO V.	9/13/83	23.00

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

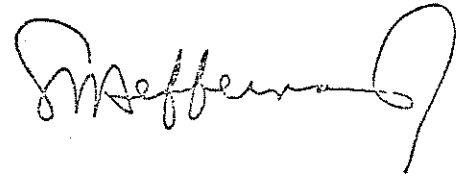
VOID AFTER 120 DAYS

GR. NO. 18	CHECK NO. 12741	DATE 10/05/83	AMOUNT \$*****23.00*
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BY EXACTLY TWENTY THREE AND NO/100 DOLLARS

TO  
OF

DIOCESE OF ORANGE



⑈012741⑈ ⑈122000661⑈ 02331⑈00041⑈

50600380

**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  
2311 E VILLA REAL DR.  
ORANGE 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

LILLA MC MILLIAN  
HEFFERNAN, KEILER & DOBLE, INC  
64 WILSHIRE BLVD. STE 1230  
LOS ANGELES, CALIFORNIA 90048  
PHONE 213 655-4044

MEDICAL 1982  
MEDICAL 1983  
DENTAL 1983

1,632.30

744.00  
459.75

**50600381**

ROMAN CATHOLIC BISHOP OF ORANGE

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
1/13/84	1984 REV. E. RAMOS	46.00	1355000
1/13/84	CHECK NUMBER 100333	46.00	

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

16-66  
1220

**100333**  
CHECK NUMBER  
100333

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

DATE  
1/13/84

PAY EXACTLY \*\*\*\*\*46 DOLLARS AND 00 CENTS

AMOUNT  
\*\*\*\*\*46.00

PAY TO THE ORDER OF

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

*George Meyer*  
AUTHORIZED SIGNATURE

⑈100333⑈ ⑆122000661⑆ 02331⑈04006⑈

50600382