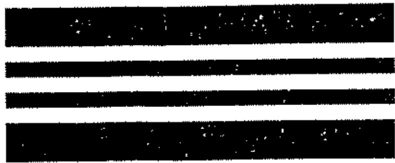
PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

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)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other

7. INSURED'S ADDRESS (No., Street)

CITY — STATE: CA

8. PATIENT STATUS: Single [X] Married Other; Employed Full-Time Student Part-Time Student

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code) ( )

ZIP CODE — TELEPHONE (INCLUDE AREA CODE) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY 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

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

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 r[...] government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE 4-17-01

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

SIGNED ______

14. [...]TE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

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

16. DATES PATI[...] WORK IN CURRENT OCCUPATION 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 NO $ CHARGES

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

1. 3. ___ . ___

2. 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 9 01						280 —	2 session				
1 16 01						280 —	"				
1 23 01					"	280 —	"				
1 30 01					"	280 —	"				
2 6 01					"	280 —	"				
2 13 01					"	280 —	"				

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

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 1680

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED Edna Moses DATE 4/20/01

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

EDNA L. MOSES
2443-A PORTOLA
VENTURA, CA 93003

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

M Edna Moses
5041 Rocoso Way
Santa Barbara CA 93111

PIN#

GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

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)

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

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

5. PATIENT'S ADDRESS (No., Street)

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

7. INSURED'S ADDRESS (No., Street)

CITY — STATE: CA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code)

ZIP CODE — TELEPHONE (INCLUDE AREA CODE) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM DD YY 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

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

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.

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SIGNED ______ DATE 4-17-01

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SIGNED ______

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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 [ ] NO $ CHARGES

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

1.

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
2	20	01								280 –	2	sessions			
2	27	01								280 –		"			
3	6	01							"	280 –		"			
3	13	01							"	280 –		"			
3	20	01							"	280 –		"			
3	27	01							"	280 –		"			

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

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 1680 –

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED Edna Moses DATE 4/20/01

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

EDNA L. MOSES
2443-A PORTOLA
VENTURA, CA 93003

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

Edna Moses
5041 Rocoso Way
Santa Barbara CA 93111

PIN#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

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3. PATIENT'S BIRTH DATE SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE CA

8. PATIENT STATUS Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 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. 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 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	4 3 01						280 —	2	session			
2	4 10 01						280 —		"			
3	4 17 01					"	280 —		"			
4												
5												
6												

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

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 840 —

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED Edna Moses DATE 4/20/01

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

EDNA MOSES
2443 - A PORTOLA
VENTURA, CA 93003

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

Edna Moses
5041 Rocoso Way
Santa Barbara CA 93111

PIN#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Msgr. John Urell

To: Ken Fineman (E-mail)
Subject: Edna Moses and [redacted]

Hello, Ken.

I have just gotten back from 10 days on the east coast and received a packet of materials from Edna Moses re: her work with [redacted] She mentioned in the paperwork that she was sending it to you as well.

When you have reviewed it, might you call me so that we can discuss this and see if the treatment is appropriate (according to you?).

I am also concerned that we haven't given an end date yet for counseling....we are still going two hours per week....every week....and this has been going on since September 2000. My concern is that he is getting the best help he can at $140/hour.

Thanks for your assistance with this. I really am in need of some professional direction in this case.

J Urell

5·1·01

50600865

COPY

EDNA L. MOSES, LCSW 05/04/2001 0-32754-54

Obligation	Description	Invoice	Vendor	Vendor Acct	Amount	Account Code
30894	COUNSELING EXPENS	MSGR.URELLOFFI			4,200.00	A1.0.00-5402.00-450
	*** Total ***				4,200.00	

ROMAN CATHOLIC BISHOP OF ORANGE
A CORPORATION SOLE

2811 E. VILLA REAL DRIVE
ORANGE, CA 92667

BANK OF AMERICA
ORANGE MAIN OFFICE
345 EAST CHAPMAN AVENUE

16-66/1220

32754

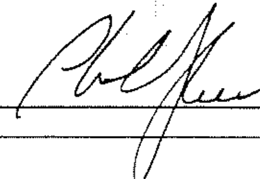
DATE	AMOUNT
05/04/2001	**************4,200.00

PAY ** Four Thousand Two Hundred Dollars and 00 Cents **

NOT VALID AFTER 6 MONTHS
$25,000 OR OVER REQUIRES TWO SIGNATURES

TO THE ORDER OF

EDNA L. MOSES, LCSW
5041 ROCOSO WAY
SANTA BARBARA CA 93111



⑈32754⑈ ⑆122000661⑆ 02331⑈04006⑈

50600866

Msgr. John Urell

o: Ken Fineman (E-mail)
Subject: [redacted] case

Hello, Ken. I hope that you are well and not too darn busy. That seems to be the state of our times, eh?

I am writing about [redacted]...looking for some assistance from you. I had emailed you on May 1st regarding the packet of information that Edna Moses had sent to me (and wrote that she had also sent them to you)....in hopes that I might get your thoughts on the new treatment technique that she is trying out. I want to get some kind of response back to Edna...some response that will put some parameters around the counseling she is providing for [redacted]

I will be in and out on Friday at Marywood....282 3110. And the same on Monday. Then, away from Monday noon thru Friday for the annual priest's retreat.

You could certainly email me any remarks. Thanks so much.

John Urell

5/30/07

50600867

DIOCESE OF ORANGE

OFFICE OF VICAR GENERAL /
MODERATOR THE CURIA
MARYWOOD CENTER
P.O BOX 14195
2811 E. VILLA REAL DRIVE
ORANGE, CALIFORNIA 92863-1595
PHONE (714) 282-3000
EMAIL: msgr.jurell@rcbo.org
FAX (714) 282-3029

June 23, 2001

Edna Moses, LCSW
5041 Rocoso Way
Santa Barbara, California 93111

Dear Edna,

I wanted to let you know that I will be out of town from July 3rd through August 6th, attending a theological updating program out of the country. I wanted you to know this just in case you would try to get a hold of me during that time in order to discuss [redacted]

I am sending a copy of this same letter to Dr. Ken Fineman in case you need to speak with him.

Kindly give my regards to [redacted] reminding him that he is in my prayers.

With personal regards, I am

Sincerely yours in Christ,

COPY

Reverend Monsignor John Urell, V.G.
Vicar General / Moderator of the Curia

C: Ken Fineman, Ph.D.

DIOCESE OF ORANGE

OFFICE OF VICAR GENERAL /
MODERATOR THE CURIA
MARYWOOD CENTER
P.O BOX 14195
2811 E. VILLA REAL DRIVE
ORANGE, CALIFORNIA 92863-1595
PHONE (714) 282-3000
EMAIL: msgr.jurell@rcbo.org
FAX (714) 282-3029

October 8, 2001

Edna Moses, LCSW
5041 Rocoso Way
Santa Barbara, California 93111

Dear Edna,

Not having heard from you as to the progress being made by [redacted] I thought it best to write and to ask for some information from you.

I last wrote to you on June 23, 2001 that I was going to be gone for the month of July. The last time I heard from you was in a letter dated April 14, 2001 in which you wrote about the EMDR treatment that you were considering for [redacted]

How is [redacted] doing now? What is the progress that you and he are seeing and experiencing? What treatment is being done at this time? What treatment plan is envisioned for the future...and for how long?

I am concerned also about diocesan payment for counseling for [redacted] in that you have not sent a bill since mid April (paid by the diocese on May 4, 2001 in the amount of $4,200.00). As I have stated before, I need to provide oversight for diocesan money that is spent in this way and, not hearing from you in such a long time, I have no idea what billed amount will be coming. (As you know, the diocese has paid $13,720.00 to you for counseling with [redacted] from March 16, 2000 through April 14, 2001)

Following the direction of our Finance Director and established procedures, I would like to receive a monthly bill from you for your professional services for [redacted] This bill would contain the schedule of meetings you have both had (as you have done in the past). We are also going to have to have a conversation as to the length of time that the diocese will continue to pay for [redacted] counseling in order for me to do proper budgeting and get clearance for continued coverage.

I look forward to hearing from you in order that we can discuss these issues. Thank you for your attention and for your work with [redacted]

Sincerely yours in Christ,

COPY

Reverend Monsignor John Urell, V.G.
Vicar General / Moderator of the Curia

October 22, 2001 11:30PM

Monsignor,

Edna Moses called, she has not been ignoring you but she has had the flu. Her number is [redacted] and said call only if urgent, she will probably be in sessions.... She will try to call you again maybe the end of the week. She does suggest that you contact [redacted] (anytime after 2:00) on his cell phone [redacted]

Robbie

DIOCESE OF ORANGE

OFFICE OF VICAR GENERAL /
MODERATOR THE CURIA
MARYWOOD CENTER
P.O BOX 14195
2811 E. VILLA REAL DRIVE
ORANGE, CALIFORNIA 92863-1595
PHONE (714) 282-3000
EMAIL: msgr.jurell@rcbo.org
FAX (714) 282-3029

November 6, 2001

Edna Moses, LCSW
5041 Rocoso Way
Santa Barbara, California 93111

Dear Edna,

Enclosed is a check in the amount of $5,320.00 for counseling services for [redacted] from May 1, 2001 through October 23, 2001.

As you have agreed, from now you will send monthly billings to me for your services.

I await your promised letter regarding [redacted] progress and future treatment plans.

Sincerely yours in Christ,

COPY

Reverend Monsignor John Urell, V.G.
Vicar General / Moderator of the Curia

EDNA MOSES, LCSW 11/02/2001 1-37297-56

Obligation	Description	Invoice	Vendor	Vendor Acct	Amount	Account Code
36808	COUNSELING EXPENSE				5,320.00	A1.0.00-5402.00-450
	*** Total ***				5,320.00	

AN ARTIFICIAL WATER MARK IN A CRISSCROSS PATTERN IS PRESENT ON THE REVERSE SIDE - TO VIEW WATER MARK HOLD AT AN ANGLE

ROMAN CATHOLIC BISHOP OF ORANGE
A CORPORATION SOLE

2811 E. VILLA REAL DRIVE
ORANGE, CA 92667

BANK OF AMERICA
ORANGE MAIN OFFICE
345 EAST CHAPMAN AVENUE

16-66/1220

37297

DATE	AMOUNT
11/02/2001	**************5,320.00

PAY ** Five Thousand Three Hundred Twenty Dollars and 00 Cents **

NOT VALID AFTER 6 MONTHS
$25,000 OR OVER REQUIRES TWO SIGNATURES

TO THE ORDER OF

EDNA MOSES, LCSW
5041 ROCOSO WAY
SANTA BARBARA CA 93111

⑈037297⑈ ⑆122000661⑆ 02331⑈04006⑈

50600872

From the Desk of

Edna Moses LCSW

Dear Monsignor John Wall:

Enclosed please find, therapy bills for [redacted]

I am sorry I have waited such a long time and I will bill the Diocese from now per your request on a monthly basis. A letter will be mailed in the immediate future discussing Joey's progress and further treatment plans

Sincerely

Edna Moses, LCSW

OCT 29 2001

$5320

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

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)

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5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

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

PATIENT AND INSURED INFORMATION

SECOND FOLD

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 DATE 10-16-01

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SIGNED 10-16-01

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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 NO $ CHARGES

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

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

WHCF-10-ENV / WHCF-10

FIRST FOLD

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 9 25 01				90806		DSM IV	140 .—					
2 10 16 01				90806			280 .—					
3 10 23 01				90806			280 .—					
4												
5												
6												

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

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 700 .—

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED Edna Moses LCSW DATE 10/23/01

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

2443-A PORTOLA RD
VENTURA, CA 93111

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 805-683-6702

Edna Moses LCSW
5041 Rocoso Way
Santa Barbara CA 93111

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

50600874

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

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)

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

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same

5. PATIENT'S ADDRESS (No., Street)

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

7. INSURED'S ADDRESS (No., Street)

CITY STATE CA

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY 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

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

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.

SIGNED DATE 7-17-01

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

PATIENT AND INSURED INFORMATION

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 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 NO $ CHARGES

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

1. 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
7 31 01				90806	DSM IV	280 -					
8 14 01				90806		280 -					
8 21 01				90806		280 -					
8 28 01				90806	"	140 -					
9 4 21				90806	"	140 -					
9 18 21				90806	"	140 -					

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

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 1260 -

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

Edna Moses LCSW 10/23/01

SIGNED DATE

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

2443-A PORTOLA
VENTURA, CA 93003

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 805-683-6702

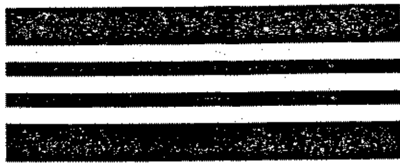
Edna Moses LCSW
5041 Rocoso Way
Santa Barbara CA 93111

PIN#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE 50600875 FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA



APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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 (ID)

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

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

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same

5. PATIENT'S ADDRESS (No., Street)

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

7. INSURED'S ADDRESS (No., Street)

CITY STATE CA

8. PATIENT STATUS Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY 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

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

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.

SIGNED DATE 7-17-01

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

PHYSICIAN OR SUPPLIER INFORMATION

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 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 NO $ CHARGES

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

1.

2.

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	6 19 01				90806	DSM IV	280 –					
2	6 26 01				90806		280 –					
3	7 3 01				90806		280 –					
4	7 10 01				90806	"	280 –					
5	7 17 01				90806	"	280 –					
6	7 24 01				90806	"	280 –					

25. FEDERAL TAX I.D. NUMBER SSN EIN 10-58-4126 [X]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 1680 –

29. AMOUNT PAID $

30. BALANCE DUE $ 1680 –

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.)

SIGNED Edna Moses LCSW DATE 10/24/01

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

2443-A PORTOLA RD, VENTURA, CA 93003

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 805-683-6402

Edna Moses LCSW
5041 Rocoso Way
Santa Barbara CA 93111

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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)

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

3. PATIENT'S BIRTH DATE MM DD YY — SEX M X F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ✓ Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY — STATE

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code)

ZIP CODE — TELEPHONE (INCLUDE AREA CODE) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY — 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

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

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.

SIGNED — DATE 10-16-01

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 10-16-01

PATIENT AND INSURED INFORMATION

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

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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 NO — $ CHARGES

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

1. — 3.

2. — 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	3 1 01				90806		DSM IV	280 —					
2	3 8 01				90806			280 —					
3	3 13 01				90806			280 —					
4	3 29 01				90806			280 —					
5	6 5 01				90806			280 —					
6	6 12 01				90806			280 —					

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 1680 00

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED Edna Moses DATE 10/23/01

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

2443-A PORTOLA RD.
VENTURA, CA 93003

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 805-683-6702

Edna Moses LCSW
5041 Rocoso Way
Santa Barbara CA 93111

PIN#

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD — FIRST FOLD — WHCF-10 ENV / WHCF-10 ENV/SS