INSURANCE

CHECK REQUEST

PAYEE (VENDOR) DOUGLAS M. CARLSEN, DDS

VENDOR # 2637

AMOUNT $302.00

REASON DENTAL EXPENSE BALANCE FOR [redacted]

[redacted] AS OF 6/9/87

REQUESTED BY [signature] DATE 6/23/87

DEPARTMENTAL APPROVAL [signature]

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 $302.00

A/C AMOUNT

A/C AMOUNT

APPROVALS

Billing info on back

STATEMENT

DOUGLAS M. CARLSEN, D.D.S.
3615 RIO RANCHO BLVD., N.W., SUITE 101
CORRALES, NEW MEXICO 87048

TELEPHONE 897-1416

973-0647

RECEIPT NUMBER	DATE	PROFESSIONAL SERVICE	CHARGE		PAID		NEW BALANCE	
9940	3/5/86	3 pau - fgc #19	365	—	—		365	—
9838	3/19/86	fgc #2	350	—	—		715	—
	4/10/86	ROA ins. 3/5, 3/19	—		336	25	378	75
	6/30/86	ROA	—		378	75	—	
11646	12/2/86	[illegible]	20	—	—		20	—
	12/11/86	ROA	—		20	—	—	
12066	2/4/87	[illegible], perio I	77	—	—		77	—
12162	2/13/87	exam, perio II, Fl2	55	—	—		132	—
	3/10/87	ROA ins. 2/4, 2/13	—		47	—	85	—
12353	3/10/87	fgc #15	360	—	—		445	—
12491	3/25/87	amal #18	60	—	—		505	—
12596	4/7/87	amal #32	45	—	—		550	—
	4/21/87	ROA Ins. 3/25 + 4/7	—		68	—	482	—
	6/9/87	ROA Ins	—		180	—	302	—

1631

PAY LAST AMOUNT IN THIS COLUMN

BA - BROKEN APPOINTMENT
CB - CROWN OR BRIDGE SERVICE
DS - DENTURE SERVICE
E - EXTRACTION
EX - EXAMINATION
F - FILLING
OS - ORAL SURGERY
P - PROPHYLAXIS
RC - ROOT CANAL
S - SEDATIVE TREATMENT
X - X-RAYS
O - OFFICE CALL
GT - GINGIVAL TREATMENT

290 #1

50900222

ATE	PROFESSIONAL SERVICE	CHARGE	PAID	NEW BALANCE	PREVIOUS BALANCE
[illegible]	[illegible] # 18	60	—	505	445

THIS IS YOUR RECEIPT FOR THIS AMOUNT — THIS IS A STATEMENT OF YOUR ACCOUNT TO DATE

ATTENDING DENTIST'S STATEMENT

IC — FEE

- nitial Oral Exam $
- Periodic Oral Exam $
- ntraoral X-Rays, Complete $
- X-Ray, Single $
- X-Ray, Additional # $
- BW X-Rays, 2 $
- BW X-Rays, 4 $
- Panographic X-Ray $

'E

- Adult Prophylaxis $
- Child Prophylaxis $
- Fluoride Treatment, Child $
- Fluoride Treatment, Adult $
- Oral Hygiene Instruction $
- Sealant Application-Quadrant $

IVE

Tooth #	Surfaces	FEE
18	[illegible]	$ 100
		$
		$
		$
Pin Retention Tooth #		$
		$
		$
		$
Pin Retention-Tooth #		$
Pin Retention Tooth #		$
Acid Etch-Tooth #		$
Acid Etch-Tooth #		$
Acid Etch-Tooth #		$

	Tooth #	FEE
Gold Inlay		
Gold Onlay		
3/4 Gold Crown		
Stainless Steel Crown		
Cast Post & Core		
Steel Post & Composite		

CROWNS

		Tooth #	FEE
02920	Recement Crown		
02950	Crown Buildup		
02940	Sedative Restoration		
02960	Bonded Veneer		

ENDODONTICS

		Tooth #	FEE
03220	Vital Pulpotomy		
03310	Anterior		
03320	Bicuspid		
03330	Molar		
03960	Bleaching		

PERIODONTICS

		FEE
04320	Intracoronal Splinting	
04330	Occlusal Adj. limited	
04330	Cosmetic Contouring	
04331	Occlusal Adj., complete	
04340	Perio Scale, entire mouth	
04341	Perio Scale, less than 12	
04910	Perio Maint.	
09630	Home Fluoride	
09910	Application, Desensitizing Agent	

DENTURES

		FEE
05110	Complete Upper	
05120	Complete Lower	
05130	Immed. Upper	
05140	Immed. Lower	
05251	Upper Partial	
05231	Lower Partial	
05__		

BRIDGES

Bridge Pontics	Tooth #	FEE
062__		
062__		
062__		

Bridge Abutments	Tooth #	FEE
067__		
067__		
067__		
067__		
06930 Recement Bridge		

ORAL SURGERY

		Tooth #	FEE
07110	Single Tooth Extraction		
07120	Each Additional		
07210	Surgical Extraction		
07310	Alveoloplasty with Extract.		
07510	Incision & Drain., Intraoral		
07960	Frenectomy		

OTHER

		FEE
09110	Emerg. Treatment Pain	
09440	After Hours Call	
09430	Office Visit	

☐ THIS IS A PRE-TREATMENT ESTIMATE
(Circled fees are for services performed)

Treatment Completed $ ________ Treatment Estimate $ ________

Dentist's Signature ________ Date ________

I hereby assign to the doctor all insurance benefits otherwise payable to me understand that I am financially responsible for any charges not covered b this authorization.

PATIENTS AUTHORIZATION TO RELEASE INFORMATION. I authoriz the dentist to release any information required to process this claim.

Patients Signature ________ Date ________

INITIAL PLACEMENT OF PROSTHESIS ☐ Yes ☐ No | DATE OF PRIOR PLACEMENT / / | MISSING TEETH

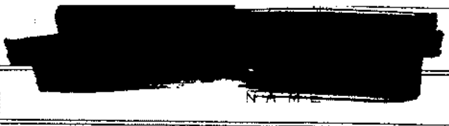
INSURANCE CARRIERS: THIS FORM HAS BEEN ADOPTED TO KEEP PAPER WORK COSTS DOWN. IF ANY ADDITIONAL FORMS OR BILLS ARE REQUIRE THEY WILL BE COMPLETED UPON RECEIPT OF $15.00.

S.S. # 551-82-7700 N.M. LICENSE # 1273
I.D. # 85-0270931

DOUGLAS M. CARLSEN, D.D.S.
3615 Rio Rancho Blvd., N.W. Suite 101
CORRALES, N.M. 87048
(505) 897-1416

12491

ATE	PROFESSIONAL SERVICE	CHARGE	PAID	NEW BALANCE	PREVIOUS BALANCE
/89	amal # 32	45	—	550	505



NAME

THIS IS YOUR RECEIPT FOR THIS AMOUNT ▲ ▲ THIS IS A STATEMENT OF YOUR ACCOUNT TO DATE

ATTENDING DENTIST'S STATEMENT

IC — FEE

- nitial Oral Exam $
- eriodic Oral Exam $
- ntraoral X-Rays, Complete $
- -Ray, Single $
- -Ray, Additional # $
- W X-Rays, 2 $
- W X-Rays, 4 $
- anographic X-Ray $

E

- cuit Prophylaxis $
- hild Prophylaxis $
- luoride Treatment, Child $
- luoride Treatment, Adult $
- ral Hygiene Instruction $
- ealant Application-Quadrant $

VE

ooth # — Surfaces

- $
- $
- $
- $
- in Retention Tooth # $
- $
- $
- $
- in Retention-Tooth # $
- n Retention Tooth # $
- cid Etch-Tooth # $
- cid Etch-Tooth # $
- cid Etch-Tooth # $

Tooth #

- old Inlay
- old Onlay
- 4 Gold Crown
- ainless Steel Crown
- ast Post & Core
- el Post & Composite

CROWNS — Tooth # — FEE

- 02920 Recement Crown
- 02950 Crown Buildup
- 02940 Sedative Restoration
- 02960 Bonded Veneer

ENDODONTICS

- 03220 Vital Pulpotomy
- 03310 Anterior
- 03320 Bicuspid
- 03330 Molar
- 03960 Bleaching

PERIODONTICS

- 04320 Intracoronal Splinting
- 04330 Occlusal Adj. limited
- 04330 Cosmetic Contouring
- 04331 Occlusal Adj., complete
- 04340 Perio Scale, entire mouth
- 04341 Perio Scale, less than 12
- 04910 Perio Maint.
- 09630 Home Fluoride
- 09910 Application, Desensitizing Agent

DENTURES

- 05110 Complete Upper
- 05120 Complete Lower
- 05130 Immed. Upper
- 05140 Immed. Lower
- 05251 Upper Partial
- 05231 Lower Partial
- 05

BRIDGES

Bridge Pontics — Tooth # — FEE

- 062
- 062
- 062

Bridge Abutments — Tooth # — FEE

- 067
- 067
- 067
- 067
- 06930 Recement Bridge

ORAL SURGERY — Tooth # — FEE

- 07110 Single Tooth Extraction
- 07120 Each Additional
- 07210 Surgical Extraction
- 07310 Alveoloplasty with Extract.
- 07510 Incision & Drain., Intraoral
- 07960 Frenectomy

OTHER

- 09110 Emerg. Treatment Pain
- 09440 After Hours Call
- 09430 Office Visit

☐ THIS IS A PRE-TREATMENT ESTIMATE
(Circled fees are for services performed)

Treatment Completed $ ______ Treatment Estimate $ ______

Dentist's Signature ______ Date ______

I hereby assign to the doctor all insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization.

PATIENTS AUTHORIZATION TO RELEASE INFORMATION. I authorize the dentist to release any information required to process this claim

Patients Signature ______ Date ______

INITIAL PLACEMENT OF PROSTHESIS ☐ Yes ☐ No | DATE OF PRIOR PLACEMENT / / | MISSING TEETH

INSURANCE CARRIERS: THIS FORM HAS BEEN ADOPTED TO KEEP PAPER-WORK COSTS DOWN. IF ANY ADDITIONAL FORMS OR BILLS ARE REQUIRED THEY WILL BE COMPLETED UPON RECEIPT OF $15.00.

S.S. # 551-82-7700 N.M. LICENSE # 1273
I.D. # 85-0270931

DOUGLAS M. CARLSEN, D.D.S.
3615 Rio Rancho Blvd., N.W. Suite 101
CORRALES, N.M. 87048
(505) 897-1416

12596

9/87	490-15	0160	—	44.5	85	[redacted]
TE	PROFESSIONAL SERVICE	CHARGE	PAID	NEW BALANCE	PREVIOUS BALANCE	NAME

THIS IS YOUR RECEIPT FOR THIS AMOUNT ▲ ▲ THIS IS A STATEMENT OF YOUR ACCOUNT TO DATE

ATTENDING DENTIST'S STATEMENT

C	FEE
itial Oral Exam	$
eriodic Oral Exam	$
traoral X-Rays, Complete	$
Ray, Single	$
Ray, Additional #	$
N X-Rays, 2	$
N X-Rays, 4	$
nographic X-Ray	$

:

	FEE
lult Prophylaxis	$
ild Prophylaxis	$
uoride Treatment, Child	$
uoride Treatment, Adult	$
al Hygiene Instruction	$
alant Application-Quadrant	$

E

oth #	Surfaces	
		$
		$
		$
		$
Retention Tooth #		$
		$
		$
		$
Retention-Tooth #		$
Retention Tooth #		$
d Etch-Tooth #		
d Etch-Tooth #		$
d Etch-Tooth #		$

	Tooth #	
d Inlay		
d Onlay -6C	15	(360)
Gold Crown		
nless Steel Crown		
t Post & Core		
t Post & Composite		

CROWNS

		Tooth #	FEE
02920	Recement Crown		
02950	Crown Buildup		
02940	Sedative Restoration		
02960	Bonded Veneer		

ENDODONTICS

		Tooth #	FEE
03220	Vital Pulpotomy		
03310	Anterior		
03320	Bicuspid		
03330	Molar		
03960	Bleaching		

PERIODONTICS

		FEE
04320	Intracoronal Splinting	
04330	Occlusal Adj. limited	
04330	Cosmetic Contouring	
04331	Occlusal Adj., complete	
04340	Perio Scale, entire mouth	
04341	Perio Scale, less than 12	
04910	Perio Maint.	
09630	Home Fluoride	
09910	Application, Desensitizing Agent	

DENTURES

		FEE
05110	Complete Upper	
05120	Complete Lower	
05130	Immed. Upper	
05140	Immed. Lower	
05251	Upper Partial	
05231	Lower Partial	
05__		

BRIDGES

Bridge Pontics	Tooth #	FEE
062__		
062__		
062__		

Bridge Abutments	Tooth #	FEE
067__		
067__		
067__		
067__		
06930 Recement Bridge		

ORAL SURGERY

		Tooth #	FEE
07110	Single Tooth Extraction		
07120	Each Additional		
07210	Surgical Extraction		
07310	Alveoloplasty with Extract.		
07510	Incision & Drain., Intraoral		
07960	Frenectomy		

OTHER

		FEE
09110	Emerg. Treatment Pain	
09440	After Hours Call	
09430	Office Visit	

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Treatment Completed $ ______ Treatment Estimate $ ______

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S.S. # 551-82-7700 N.M. LICENSE # 1273
I.D. # 85-0270931

DOUGLAS M. CARLSEN, D.D.S.
3615 Rio Rancho Blvd., N.W. Suite 101
CORRALES, N.M. 87048
(505) 897-1416

12353

50900225

PLAN ADMINISTERED BY
THE Great-West Life ASSURANCE COMPANY

FOR SERVANTS OF THE PARACLETE

EXPLANATION OF BENEFITS

SERVICE DESCRIPTION	DATES	CHARGE	COVERED EXPENSES @ 50 %	@ %	@ %	NOT COVERED	SE NO
CARLSEN DDS CROWNS	MAR 10/87	360.00	360.00				
TOTALS		360.00	360.00				
DEDUCTIBLE			0.00				
BALANCE			360.00				
PAYABLE @			50 PCT				
BENEFIT			180.00				

TOTAL BENEFIT $180.00

C.O.B.

DEDUCTIBLE MET TO DATE
INDIVIDUAL $100.00

NET PAYABLE $180.00

NOTES

6/9/87

FORM QG1201 (Rev. 07.

PAID TO CARLSEN DDS 180.00

PAID TO

237,056765,001,001,023712

DOUGLAS M CARLSEN DDS
3615 RIO RANCHO BLVD NW #101
CORRALES, NM. 87048

DIRECT INQUIRIES TO
GREAT-WEST LIFE ASSURANCE CO.
EDGE BENEFIT PAYMENTS
PO BOX 1130
DENVER, CO. 80201

PLAN NUMBER	PLAN NAME	DATE	CK. NO.
56765 - 001	SERVANTS OF THE PARACLETE	JUN 04 1987	90629943

EMPLOYEE	EMPLOYEE I.D. NO.	LOCATION
[redacted]	E000000105	

PATIENT	CLAIM NO.	PATIENT NO.
[redacted]	187	

ADMINISTERED BY
THE Great-West Life ASSURANCE COMPANY FOR SERVANTS OF THE PARACLETE

EXPLANATION OF BENEFITS

SERVICE DESCRIPTION	DATES	CHARGE	COVERED EXPENSES @	%	@	%	@	%	NOT COVERED	SEE NOTE
RLSEN DDS										
CROWNS	FEB 23/87	720.00							720.00	R01
[illegible] WORK	FEB 23/87	360.00							360.00	R01
TOTALS		1,080.00								

DEDUCTIBLE
BALANCE
PAYABLE @
BENEFIT

TOTAL BENEFIT $0.00

DEDUCTIBLE MET TO DATE
INDIVIDUAL $100.00

NET PAYABLE $0.00

R01 INITIAL PROSTHESIS MUST REPLACE AT LEAST ONE TOOTH EXTRACTED WHILE INSURED

FORM WG1201 (05/86)

237,056765,001,001,023714

5/5/87

DOUGLAS M CARLSEN DDS
3615 RIO RANCHO BLVD NW #101
CORRALES, NM. 87048

PLAN NUMBER	PLAN NAME	LOCATION
56765 - 001	SERVANTS OF THE PARACLETE	

EMPLOYEE	EMPLOYEE I.D. NO.
[redacted]	E000000105

PATIENT	RELATIONSHIP	CLAIM NO.	DATE
[redacted]	EMPLOYEE	187	APR 29 1987

DIRECT INQUIRIES TO

GREAT-WEST LIFE ASSURANCE CO.
EDGE BENEFIT PAYMENTS
PO BOX 1130
DENVER, CO. 80201

50900227

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

PAYEE NAME	VENDOR NO.
CARLSON, DOUGLAS DDS	2637

DATE	DESCRIPTION AND/OR INVOICE NO.	AMOUNT	REFERENCE
6/26/87	062287 [redacted] 6/9/87	302.00	355000
6/26/87	CHECK NUMBER 123361	302.00	

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

123361
CHECK NUMBER
123361

DATE
6/26/87

AMOUNT
*******302.00

PAY EXACTLY *******302 DOLLARS AND 00 CENTS

PAY TO THE ORDER OF

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

CARLSON, DOUGLAS DDS
3615 RIO RANCHO BLVD. #101
CORRALES, NM
87048

AUTHORIZED SIGNATURE

DANNY PADUA (213) 691-7876

⑈123361⑈ ⑆122000661⑆ 02331⑈04006⑈

509 00228

INSURANCE

CHECK REQUEST

PAYEE (VENDOR) S/B DOUGLAS M. CARLSEN, D.D.S. ~~SERVANTS OF THE PARACLETE~~

VENDOR # 1301

AMOUNT $378.75

REASON MEDICAL/THERAPEUTIC EXPENSES FOR [redacted] [redacted] REDUCED BY INSURANCE PAYMENTS

REQUESTED BY DK DATE 6/6/86

DEPARTMENTAL APPROVAL MPd.

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 $378.75

A/C AMOUNT

A/C AMOUNT

APPROVALS

50900229

Billing info on back

STATEMENT

DOUGLAS M. CARLSEN, D.D.S.
3615 RIO RANCHO BLVD., N.W., SUITE 101
CORRALES, NEW MEXICO 87048

TELEPHONE 897-1416

[redacted]

RECEIPT NUMBER	DATE	PROFESSIONAL SERVICE	CHARGE	PAID	NEW BALANCE
9940	3/5/86	3 pin - fac # 19	365 -	—	365 -
9838	3/19/86	fac # 2	350 -	—	715 -
	4/10/86	ROA ins. 3/5, 3/19	—	336 25	378 75
		All ins is now in			
		The balance is 378.25			

1631

PAY LAST AMOUNT IN THIS COLUMN

BA - BROKEN APPOINTMENT
CB - CROWN OR BRIDGE SERVICE
DS - DENTURE SERVICE
E - EXTRACTION
EX - EXAMINATION
F - FILLING
OS - ORAL SURGERY
P - PROPHYLAXIS
RC - ROOT CANAL
S - SEDATIVE TREATMENT
X - X-RAYS
O - OFFICE CALL
GT - GINGIVAL TREATMENT

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

PAYEE NAME	VENDOR NO.
SERVANTS OF THE PARACLETE	1301

DATE	DESCRIPTION AND/OR INVOICE NO.	AMOUNT	REFERENCE
6/13/86	060986 MEDICAL REIMBURSEMENT-[redacted]	378.75	355000
6/13/86	CHECK NUMBER 115848	378.75	

VOID
WG PAYEE

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

16-66
1220

115848

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

CHECK NUMBER
115848

DATE
6/13/86

AMOUNT
*******378.75

PAY EXACTLY *******378 DOLLARS AND 75 CENTS

PAY TO THE ORDER OF

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

SERVANTS OF THE PARACLETE
JEMEZ SPRINGS, NM 87025

AUTHORIZED SIGNATURE

⑈115848⑈ ⑆122000661⑆ 02331⑈04006⑈

D.J. & ASSOCIATE 3) 691-7870

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

PAYEE NAME	VENDOR NO.
CARLSON, DOUGLAS DDS	2637

DATE	DESCRIPTION AND/OR INVOICE NO.	AMOUNT	REFERENCE
6/27/86	060786 MEDICAL [illegible]	378.75	565000
6/27/86	CHECK NUMBER 116271	378.75	

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

15-66
1220

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

116271
CHECK NUMBER

DATE 6/27/86

PAY EXACTLY *******378 DOLLARS AND 75 CENTS

AMOUNT
**********378.75

PAY TO THE ORDER OF

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

CARLSON, DOUGLAS DDS
3615 RIO RANCHO BLVD. #101
CORRALES, NM
87048

NON-NEGOTIABLE
AUTHORIZED SIGNATURE

(213) 691-7870 DJ

CHECK REQUEST

PAYEE (VENDOR) Checkerboard Area Health System

VENDOR # n/a 2063

AMOUNT $ 77.00

REASON Medical Services:

DEPARTMENTAL APPROVAL

AUTOMOBILE		PRINTING	070
FUEL	011		
REPAIRS	012	PROM. & PUBL.	080
BOOKS, MAGS, SUBS.	021	SUPPLIES	
		OFFICE	061
DUES	022	CHAPEL	063
		COMPUTER	065
EDUCATION	050		
		TRAVEL & EXPENSE	100
PROFESSIONAL FEES			
CONSULTANT	092	WORKSHOP ATTENDED	111
FACILITATOR	093		
LEGAL	094	WORKSHOP SPONSORED	112
POSTAGE	062		

INVOICE DATE

BANK# 110101

VENDOR # 2063

CHECK COMMENTS

INVOICE # 031186

INVOICE AMOUNT $ 77.00

DISTRIBUTION

? A/C# 355000 AMT $ 77.00

A/C# AMT $

A/C# AMT $

A/C# AMT $

APPROVAL

50900260

STATEMENT OF ACCOUNT - MEDICAL

ACCOUNT NUMBER C91724 | BILLING DATE 01/31/86 | PREVIOUS BALANCE $77.00

DESCRIPTION	REFERENCE #	DATE	CHARGE	CREDIT	BALANCE
Service for [redacted]					

Make Check Payable To	CURRENT DUE	30 DAYS PAST DUE	60 DAYS PAST DUE	90 DAYS PAST DUE	120 DAYS PAST DUE		
	$0.00	$0.00	$0.00	$77.00	$0.00	TOTAL BALANCE	$77.00
						AMOUNT DUE	$77.00

CHECKERBOARD AREA HEALTH SYSTEM P.O. BOX 128 JEMEZ SPGS, NM 87025 (505)829-3591

50900261

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

PAYEE NAME	VENDOR NO.
CHECKERBOARD AREA HEALTH	2063

DATE	DESCRIPTION AND/OR INVOICE NO.	AMOUNT	REFERENCE
3/14/86	031186 [redacted]	77.00	355000
3/14/86	CHECK NUMBER 114281	77.00	

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

16-66
1220

114281

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

CHECK NUMBER
114281

DATE
3/14/86

PAY EXACTLY ********77 DOLLARS AND 00 CENTS

AMOUNT
*********77.00

PAY TO THE ORDER OF

NOT VALID AFTER 6 MONTHS

CHECKERBOARD AREA HEALTH
SYSTEMS
P.O. BOX 638
CUBA, NM

NOT NEGOTIABLE

AUTHORIZED SIGNATURE

87013

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