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FILED FOR RECORD
SKAMANIA CO. WASH
BY U.S. MAIL
PORTLAND CARDIO THORACIC CLINIC
Sep 9 10 47 AM '86
A. Rees, Dep.
AUDITOR
BARY M. OLSON

FORM OF CLAIM FOR DAMAGES

TO THE BOARD OF COUNTY COMMISSIONERS of Skamania County, Washington:

PLEASE TAKE NOTICE that in accordance with Chapter 36.45 of the Revised Code of Washington, I PORTLAND CARDIO THORACIC CLINIC, P.C. hereby present you with my claim for damages against the County of Skamania, State of Washington, with the information required to be given by RCW 36.45.020 as follows:

1. That the injury for which I claim damages against the County of Skamania, State of Washington, occurred on or about the 14 day of August, 19 86.

2. That the place of injury was Carson, Washington 98610

3. That the location and description of the defect which caused the injury are

4. That the injury is described as follows: Mark L. Setzer - Gunshot wound to the right chest.

5. That the amount of damages claimed is as follows: $ 1,996.50

6. That the actual residence of the claimant at the time of presenting and filing this claim is 2800 N. Vancouver Ave. # 242 Portland, Oregon 97227

7. That the actual residence of the claimant for a period of six months immediately prior to the time that this claim accrued was

DATED: September 9, 19 86.

Health Ins. Claim Form submitted via mail
(Claimant)

NOTE: Personal Property (Car, etc.) damages are to be accompanied by estimated repair costs. Additional information required by No.s 2-4 of this form may be attached on the back of this Claim for Damages.

Registered S
Indexed, Dir S
Indirect S
Filed
Mailed

HEALTH INSURANCE CLAIM FORM

PAGE 1
08/29/86
OTHER INSURANCE

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

[ ] MEDICAID [ ] MEDICARE [ ] CHAMPUS [X] OTHER

FORM APPROVED
OMB NO 86-R0012

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)
SETZER, MARK L.	06 29 69	SETZER, MARK L.
4 PATIENT'S ADDRESS (Street, city, state, ZIP code)	**5 PATIENT'S SEX**	**6 INSURED'S I.D. MEDICARE AND/OR MEDICAID NO (Include any letters)**
HOOD RIVER, OR	MALE [X] FEMALE [ ]	
	7 PATIENT'S RELATIONSHIP TO INSURED SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]	**8 INSURED'S GROUP NO (Or Group Name)** M.V.A.
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)** HOOD RIVER, OR

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 and Request Payment of MEDICARE Benefits Either to Myself or to the Party Who Accepts Assignment Below

SIGNED SIGNATURE ON FILE DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

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 [ ]	16A IF AN 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) Guy Gorrell M.D.		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) Emanuel Hospital		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 NUMBERS 1 2 3 ETC OR DX CODE

A. Gunshot wound to the right chest

B. EPSDT YES [ ] NO [ ] FAMILY PLANNING YES [ ] NO [ ]

PRIOR AUTHORIZATION NO ___

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 DAYS OR UNITS	G * T O S	H LEAVE BLANK
08/14/86	1	32480	LOBECTOMY (0009266)		1996.50	1		
			SEE OPERATIVE REPORT					

25 SIGNATURE OF PHYSICIAN OR SUPPLIER
(I certify that the statements on the reverse apply to this bill and are made a part hereof.)
JONATHAN G. HILL, MD 08/29/86
SIGNED DATE

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [ ] NO [X]

27 TOTAL CHARGE 1996.50

28 AMOUNT PAID .00

29 BALANCE DUE 1996.50

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.
PORTLAND CARDIO-THORACIC CLINIC, P.C.
2800 N. VANCOUVER AVE. #242
PORTLAND, OREGON 97227
ID NO 282-3238

32 YOUR PATIENT'S ACCOUNT NO
0000454-01 DR:06 INS: 06

33 YOUR EMPLOYER I.D. NO
93-0630169

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

REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 5-80
APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION & CHAMPUS

Form AMA-OP-400
Form HCFA-1500 (4-80)
Form CHAMPUS-301

HEALTH INSURANCE CLAIM FORM

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown.In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured", i.e., items 3, 6, 7 ,8, 9 and 11.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE AND CHAMPUS)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refers to 5 USC 5536).

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422 510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE AND CHAMPUS INFORMATION

We are authorized by HCFA and CHAMPUS to ask you for information needed in the administration of the Medicare and CHAMPUS programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086.

The information we obtain to complete Medicare and CHAMPUS claims is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare or CHAMPUS and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or Federal agencies as necessary to administer the Medicare and CHAMPUS programs.

For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under Social Security or CHAMPUS law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of Medicare or CHAMPUS claims. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877(a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate, and complete.

I understand that the payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES:

- 1 – (IH) – 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
- C – (RTC) – Residential Treatment Center
- D – (STF) – Specialized Treatment Facility

TYPE OF SERVICE CODES:

- 1 – Medical Center
- 2 – Surgery
- 3 – Consultation
- 4 – Diagnostic X-Ray
- 5 – Diagnositc Laboratory
- 6 – Radiation Therapy
- 7 – Anesthesia
- 8 – Assistance at Surgery
- 9 – Other Medical Service
- 0 – Blood or Packed Red Cells
- A – Used DME
- M – Alternate Payment for Maintenance Dialysis
- Y – Second Opinion on Elective Surgery
- Z – Third Opinion on Elective Surgery

CF:UHCF 3/82

H E A L T H L I N K

MEDICAL RECORD REPORT

EMANUEL HOSPITAL

PATIENT NAME	NUMBER	
SETZER, Mark L.	0114199	OP REPORT
ATTENDING PHYSICIAN	DATE	
Guy Correll, M.D.	8/15/86	35A

PREOPERATIVE DIAGNOSIS: Gunshot wound to the right chest entering approximately anterior axillary line 3rd intercostalspace and exiting medial to the scapula at the level of the 5th rib.

POSTOPERATIVE DIAGNOSIS: Same.

TITLE OF OPERATION: Exploratory thoracotomy with right upper lobectomy.

SURGEON: Jonathan Hill, M.D.
ASSISTANT: Guy Correll, M.D.
Bruce Farmer, M.D.

INDICATIONS: The patient is an approx. 17 y/o male who was apparently shot in the chest by police for unclear reasons. The patient was admitted directly to the operating room from Life Flight after being hypotensive in the field. On admission to the O.R., the patient had the described gunshot wound with placement of a chest tube which had yielded approx. 800 c.c. of blood. Chest x-ray demonstrated significant upper lobe contusion with continued hemothorax. The patient continued to bleed at a rate of approx. 150 c.c. in 15 mintues. Because of this it was felt the patient should undergo a thoracotomy.

PROCEDURE: Patient was turned and positioned for a posterolateral thoracotomy. Prepped and sterilely draped. Sharp incision was made through the skin. Electrocautery was used to divide the sub-q tissues and the latisimus dorsi muscle. The serratus muscle was mobilized and removed anteriorly. Chest cavity was entered on the superior border of the 6th rib. On entering the chest cavity it was noted the right upper lobe was suffused with clot and blood. There was a large entrance wound in the right upper lobe with exit in the right upper lobe. Entrance wound in the chest was approx. the anterior axillary line at the third rib level with multiple rib fragments at that site. The exit was described with a fracture of the 5th rib posteriorly. The patient was noted to have a large air leak and continued bleeding from the lobe. It was felt that the lobe had been primarily destroyed

continued

PATIENT NAME	NUMBER	
SETZER, Mark L.	0114199	OP REPORT
ATTENDING PHYSICIAN	DATE	
Guy Gorrell, M.D.	8/15/36	35A

and involved in hematoma and that a right upper lobectomy would be the most expedient procedure. Pleura was then isolated over the level of the hilum. Right apical anterior artery segment was identified. The veins going to the right upper lobe were then identified and ligated in sequence using 00 silk proximally and distally and 00 silk stick ties. During the course of the procedure the patient began to have a declining pO2. Right upper lobe bronchus was identified and isolated at this point. Subsequently, TA-30 stapler was placed and the bronchus was excluded. Anesthesia, Dr. Axel, then performed and fiberoptic bronchoscopy to help clear the airway during the course of the operation periond. Once the bronchus was divided, further attention was given to isolate several arterial branches to the right upper lobe. Once this was done, it was then removed. There was an incomplete fissure between the right middle and upper lobes. This was removed and divided using blunt dissection. Once the right upper lobe was removed, the area was irrigated. There was noted to be a small air leak at the bronchus level. This was oversewn using 000 Dexon. The bronchial stump was then protected with a portion of pleura. This was tacked into place using 000 Dexon. The right middle lobe was tacked to the right lower lobe to prevent torsion. The inferior pulmonary ligament was mobilized. Chest tube had previously been placed. The chest cavity was once again irrigated and subsequently closed. Marcaine was used for intercostal block. Ribs were approximated using #1 Dexon. The muscle layers were closed using 00 PDS. Sub-q tissues were closed using running 000 PDS and the skin was stapled. The patient was then positioned for an epidural catheter which was performed by Dr. Axel of Anesthesia. He was subsequently taken to the ICU in satisfactory condition.

JB/ss
D: 8/15/86
T: 8/18/86
#11

JONATHAN HILL, M.D.

PORTLAND CARDIO - THORACIC CLINIC, P.C.
PHYSICIANS & SURGEONS
SUITE 242, 2800 N. VANCOUVER AVENUE
PORTLAND, OREGON 97227

PORT. AND OR 972
PM 1
8 SEP
1986

ALWAYS USE
ZIP CODE

Skamania County Court House
Stevenson, WA 98648

Attn: Gary Olsen

SEP 1986
RECEIVED
SKAMANIA COUNTY
AUDITOR