FILED FOR RECORD
SKAMANIA CO. WASH
BY Skamania Co.

DEC 30 4 51 PM '93
P. Lowry
AUDITOR
GARY M. OLSON

118394

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 MONTY J. BUETTNER 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 5th day of February, 1993.

2. That the place of injury was Skamania County Auditor's Office

3. That the location and description of the defect which caused the injury are I asked an employee of Skamania County Auditor, when my Wife's insurance coverage would Start. I was given misinformation that led me to believe that the insurance coverage was immediately upon providing the Marriage Certificate.

4. That the injury is described as follows: A Medical bill Totaling $5646.37. After the amount was subtracted that I would have had to pay if it was covered by the insurance, the claim to the County is $5380.34 .

5. That the amount of damages claimed is as follows: $5646.37 minus 10% or 20% as Applicable totaling $5380.34 .

6. That the actual residence of the claimant at the time of presenting and filing this claim is PO Box 172, MP. 0.18-R View Dr. Stevenson Wa. 98648.

7. That the actual residence of the claimant for a period of six months immediately prior to the time that this claim accrued was PO Box 172, MP. 0.18-R View Dr. Stevenson Wa. 98648.

DATED: December 29th, 1993.

Monty J. Buettner
(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
Indexed
Indexed
Filmed
Mailed

MEMORANDUM

TO; Bob Lelck.
FROM; Monty Buettner.
DATE; 12/29/93.
SUBJECT; Payment of Doctor Bills.

As per the letter from Blue Cross dated Dec.16, 1993, below is the break down of what Blue Cross would have paid if my wife was eligible for payment.

	BLUE CROSS	EMPLOYEE
100%	$3146.36	$0
90%	$2105.69	$233.97
80%	$ 128.29	$ 32.06
TOTAL	$5380.34	$266.03

Enclosed is the County Claim form showing a claim of $5380.34 .

BlueCross BlueShield of Oregon

100 SW Market Street
PO Box 1271
Portland, Oregon 97207-1271

503/225-5221
1-800-452-7278

HMO Oregon
(Formerly Capitol Health Care)

December 16, 1993

Monty Buettner
PO Box 172
Stevenson, WA 98648

Re: 2390-536788779
Christian and Amelia

Dear Mr. Buettner:

Thank you for your recent inquiry regarding the claims for both Christian and Amelia.

Please keep in mind that all services are eligible as long as they are medically necessary, benefits have not been exhausted and the patient is eligible and on the contract at the time of service.

Your policy has a $100 calendar year deductible. Inpatient hospital benefits are paid at 100% of the usual and customary amount allowed. After the deductible is met, preferred doctors are paid at 90% and non preferred doctors at 80%, of the first $2,500.00 in eligible expenses, then benefits are at 100%.

The following is information on your specific providers:

Medical X-ray Consultants- Preferred

Woodland Park Hospital - Non-preferred

Robert Dyson MD - Preferred

Providence Medical Center - Preferred

Amelia and Christian have both met their 1993 deductible.

I hope this is helpful to you. Please feel free to contact me with any questions or concerns.

Sincerely,

Lori Spurlin

Lori Spurlin
Customer Service Representative

DR	DOCTOR NAME	I.D. NAME
00	ROBERT D. DYSON, MD	503-44-8530

INSURANCE COMPANY

I.D. NO. _____

GROUP NO. _____

ACCT 6051-3 DATE 10-11-93 6 BLUE CROSS OF OR
FOR: BUETTNER, AMELIA

ROBERT D. DYSON, MD
10373 NE HANCOCK ST, #129
PORTLAND OR 97220

MONTY BUETTNER
PO BOX 454
STEVENSON WA 98648

INSURANCE STATEMENT

IMPORTANT READ REVERSE SIDE

DATE	PATIENT	DR.	CODE-1	CODE-2	POS	DESCRIPTION	AMOUNT
			CPT	ICD•		PREVIOUS BALANCE	2047.50
						AMTS INCL IN PREV BAL HAVE *	
----	ITEM 022534						
02 25 93		00	76815	6566	11	LMT. ULTRASOUND OB	75.00*
04 15 93		00				PAID BY CHECK	75.00-
----	ITEM 062234						
06 22 93		00	90742	V224	11	INJECT RHO(D)GLOBULI	40.00*
				BLUE CROSS OF OREGON BILLED		40.00	
----	ITEM 081934						
08 19 93		00	59400	650•	21	OB FLAT FEE	2000.00*
				BLUE CROSS OF OREGON BILLED		2000.00	
----	ITEM 082034						
08 20 93		00	54150	V502	21	CIRCUMCISION-NEWBORN	75.00*
						...CONTINUED ON NEXT PAGE...	

I CERTIFY THAT THE SERVICES ABOVE HAVE BEEN RECEIVED BY MYSELF OR MY DEPENDENT.
I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

TOTAL AMOUNT

SIGNATURE _____ DATE _____

DR.	DOCTOR NAME	S.S. NAME
00	ROBERT D. DYSON, MD	503-44-8530

1 INSURANCE COMPANY

I.D. NO.

GROUP NO.

ACCT 6051-3 DATE 10-11-93
FOR: BUETTNER, AMELIA

6 BLUE CROSS OF OR

ROBERT D. DYSON, MD
10373 NE HANCOCK ST, #129
PORTLAND OR 97220

MONTY BUETTNER
PO BOX 454
STEVENSON WA 98648

INSURANCE STATEMENT

IMPORTANT READ REVERSE SIDE

DATE	PATIENT	DR.	CODE-1	CODE-2	POS	DESCRIPTION	AMOUNT
10 08 93		00				...CON'T FROM PREVIOUS PAGE.	
						BLUE CROSS PAYMENT	67.50-
						DUE FROM YOU 7.50	

2 I CERTIFY THAT THE SERVICES ABOVE HAVE BEEN RECEIVED BY MYSELF OR MY DEPENDENT.
I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

2047.50
TOTAL AMOUNT

SIGNATURE _____ DATE _____

MEDICAL X-RAY CONSULTANTS CORP.
503 N.E. 47th AVENUE - SUITE 101
PORTLAND, OREGON 97213-2286
PHONE 503 / 235-8579

PATIENT'S NAME: BUETTNER, AMELIA

93-0769428 | 01-01-11702319

DATE		DESCRIPTION OF SERVICE	DIAG	AMOUNT
042793	2	76805 US OBSTETRICAL/PELVIC-MD FE B/C REJECT, WAITING PERIOD NOT SATISFIED.	V22.1	85.00 FN

LOCATION OF SERVICE: PROVIDENCE MEDICAL CENTER
4805 NE GLISAN PORTLAND OR

BALANCE DUE: 85.00

REFERRING PHYSICIAN: DYSON, R D

REMARKS: BALANCE INDICATED IS DUE AND PAYABLE.
THANK YOU.
IF RECENTLY PAID, PLEASE DISREGARD.

ATTENDING PHYSICIAN: MORGAN, CHRISTOPHER J.

* PLACE OF SERVICE
1 HOSPITAL
2 EXTENDED CARE FACILITY
3 PHYSICIAN'S OFFICE
4 EMERGENCY ROOM

10/31/93

AR0066
PAGE 1

DETAIL DEMAND BILL

WOODLAND PARK HOSPITAL
10300 N.E.HANCOCK ST
PORTLAND OR 97220
503-257-5500

11/29/9
15:42:3

Patient No	Patient Name	Admit Date	Discharge Date	P/T	F/C	Serv	Attending Doctor
20638-02	BUETTNER AMELIA N	6/22/93	6/22/93	2	10	60	00602 DYSON ROBERT D

BUETTNER AMELIA N
PO BOX 172
STEVENSON WA 98648

Plan 1 : 70020
BLUE CROSS MDC OP
BUETTNER, MONTY
536788779
2390

Plan 2 :

Plan 3 :

Diagnosis : V22.1

Procedures :

DRG Code :

Med Rec # : 2063

Charge Code	NRV	----- Description -----	C P T Code	Service Date	Btc-Seq	Post Date	Qty	Unit Price	Extended Amount	Prof/Non-Cov Amount	Covered Amount
0040951	300	PLAZA DRAW	36415	6/22/93	392-004	6/24/93	1	6.00	6.00	.00	6.00
								*	6.00	.00	6.00
0042146	301	GLUCOSE 1 HR-POST 50 GMS	82950	6/22/93	392-004	6/24/93	1	16.16	16.16	.00	16.16
								*	16.16	.00	16.16
0042109	305	HEMATOCRIT\HEMOGLOBIN (O	85027	6/22/93	392-004	6/24/93	1	11.45	11.45	.00	11.45
								*	11.45	.00	11.45
								**	33.61	.00	33.61

Charges: 33.61 Payments: .00 Adjustments: .00 Balance: 33.61

AR0066
PAGE 1

D E T A I L D E M A N D B I L L

11/29/9
15:42:

WOODLAND PARK HOSPITAL
10300 N.E.HANCOCK ST
PORTLAND OR 97220
503-257-5500

Patient No	Patient Name	Admit Date	Discharge Date	P/T	F/C	Serv	Attending Doctor
20638-03	BUETTNER AMELIA N	8/12/93	8/12/93	2	10	60	00602 DYSON ROBERT D

BUETTNER MONTY
PO BOX 444
STEVENSON WA 98648

Plan 1 : 70020
BLUE CROSS MDC OP
BUETTNER, MONTY
536788779
2390

Plan 2 :

Plan 3 :

Diagnosis : V22.1

Procedures :

DRG Code :

Med Rec # : 2363

Charge Code	MPV	Description	C P T Code	Service Date	Btc-Seq	Post Date	Qty	Unit Price	Extended Amount	Prof/Non-Cov Amount	Covered Amount
0042119	306	BETA STREP CULT	(O 87081	8/12/93	375-010	8/13/93	1	18.83	18.83	.00	18.83
								*	18.83	.00	18.83
								**	18.83	.00	18.83

Charges: 18.83 Payments: .00 Adjustments: .00 Balance: 18.83

SISTERS OF PROVIDENCE

PLEASE REMIT TO:
PROVIDENCE MEDICAL CENTER
P.O. BOX 13991
PORTLAND, OREGON 97213-0991
503 / 331-4300

TYPE OF BILL	DATE OF BILL	PAGE NO
D-I/P	08/24/93	1

PLEASE REFER TO THIS NO. ON ALL INQUIRIES AND CORRESPONDENCE

PATIENT NAME	ADMISSION DATE	DISCHARGE DATE	PATIENT NUMBER
MELIA NICOLE BUETTNER	08/19/93	08/20/93	P9323-106766 9

URANCE COMPANY NAME(S)
05995 BLUE CROSS BS OR PPO

ARANTOR
ME AMELIA NICOLE BUETTNER
D 18-R VIEW DRIVE
DRESS PO BOX 454
STEVENSON WA 98648

AMOUNT ENCLOSED $ _____
☐ MASTER-CARD ☐ AMERICAN EXPRESS
☐ VISA ☐ DISCOVER CARD
CARD NO. _____
EXP. DATE ___/___
SIGNATURE _____

- QUESTIONS ABOUT YOUR BILL? CALL 8:00 AM - 5:30 PM MONDAY - FRIDAY AT 331-4300 OR OUTSIDE PORTLAND 1-800-772-9094.
- IF YOU RECEIVED X-RAY SERVICES, YOU WILL RECEIVE A SEPARATE BILLING FROM THE PHYSICIAN FOR READING THE X-RAY.

POSTING DATE	SERVICE CODE	ORD. NO.	SERVICE DESCRIPTION	QUANTITY	HOSPITAL CHARGE	TOTAL CHARGE
08/19	1011	4	ROOM 3K04 P	1	470.00	470.00
			TOTAL ROOM-BOARD/SEMI			470.00
08/19	1986		OXYTOCIN INJ	1	19.95	19.95
08/20	8053		MATERNITY ADMIT PACK (RD) MISC	1	25.00	25.00
			TOTAL PHARMACY			44.95
08/19	6165	1	ABC (AUTOMATED BLOOD COUNT)	1	22.00	22.00
08/19	7537	1	PHLEBOTOMY	1	8.00	8.00
08/20	7440	9	ABO (BLOOD GROUP)	1	16.20	16.20
08/20	7441	9	RH (D) TYPE	1	16.20	16.20
08/20	7457	10	ANTIBODY SCREEN	1	45.60	45.60
08/21	7459	12	FETAL SCREEN	1	35.80	35.80
			TOTAL LABORATORY OR LAB			143.80
08/20	7494	11	RHIG	1	48.60	48.60
08/20	7495	11	RHIG ADMINISTRATION	1	10.82	10.82
08/20	7591	11	COMPONENT PROCESSING FEE	1	12.00	12.00
			TOTAL BLOOD/STOR-PROC			71.42
08/20	39	7	3K POST PARTUM CARE DAILY	1	112.90	112.90
08/20	45	6	3K RECOVERY VAGINAL DELIVERY	1	195.00	195.00
08/20	53	5	3K VAGINAL DELIVERY	1	669.60	669.60
			TOTAL BIRTHING CENTER			977.50
			TOTAL CHARGES			1,707.67
3/25	A0050	458	BCBSO PPO Cont Adj	005		-116.67
9/18	A0050	36	BCBSO PPO Cont Adj	005		116.67
			TOTAL PAYMENTS/ADJUSTMENTS			0.00

IDENTIFICATION NO.
93-0366906

THANK YOU!

ACCOUNT BALANCE 1,707.67

SISTERS OF PROVIDENCE

PLEASE REMIT TO:
PROVIDENCE MEDICAL CENTER
P.O. BOX 13991
PORTLAND, OREGON 97213-0991
503 / 331-4300

TYPE OF BILL	DATE OF BILL	PAGE NO
O-I/P	08/24/93	1

PLEASE REFER TO THIS NO. ON ALL INQUIRIES AND CORRESPONDENCE

PATIENT NAME	ADMISSION DATE	DISCHARGE DATE	PATIENT NUMBER
HRISTIAN DAVID BUETTNER	08/19/93	08/20/93	P9323-107152 9

URANCE COMPANY NAME(S)
05995 BLUE CROSS BS OR PPO

ARANTOR
ME
D
DRESS

AMELIA NICOLE BUETTNER
18-R VIEW DRIVE
PO BOX 454
STEVENSON WA 98648

AMOUNT ENCLOSED $ _____

☐ MASTER-CARD ☐ AMERICAN EXPRESS
☐ VISA ☐ DISCOVER CARD

CARD NO. _____

EXP. DATE ____/____

SIGNATURE _____

- QUESTIONS ABOUT YOUR BILL? CALL 8:00 AM - 5:30 PM MONDAY - FRIDAY AT 331-4300 OR OUTSIDE PORTLAND 1-800-772-9094.
- IF YOU RECEIVED X-RAY SERVICES, YOU WILL RECEIVE A SEPARATE BILLING FROM THE PHYSICIAN FOR READING THE X-RAY.

POSTING DATE	SERVICE CODE	ORD. NO.	SERVICE DESCRIPTION	QUANTITY	HOSPITAL CHARGE	TOTAL CHARGE
08/19	5000	3	ROOM 3K04 B	1	299.00	299.00
			TOTAL NURSERY			299.00
08/19	2055		PHYTONADIONE INJ	1	22.00	22.00
08/19	4266		ERYTHROMYCIN 0.5% OINT OPH	1	9.95	9.95
			TOTAL PHARMACY			31.95
08/20	2095	9	BILIRUBIN TOTAL	1	35.20	35.20
08/20	7440	4	ABO (BLOOD GROUP)	1	16.20	16.20
08/20	7441	4	RH (D) TYPE	1	16.20	16.20
08/20	7455	5	DIRECT COOMBS	1	19.00	19.00
			TOTAL LABORATORY OR LAB			86.60
08/20	1115	8	3K CIRCUMCISION	1	89.00	89.00
08/20	47	6	3K NEWBORN CARE INITIAL	1	126.30	126.30
08/20	49	7	3K SUPPLIES 0-48 HR	1	97.40	97.40
			TOTAL BIRTHING CENTER			312.70
			TOTAL CHARGES			730.25
09/25	A0050	458	BCBSO PPO Cont Adj	005		-249.25
09/30	A0050	37	BCBSO PPO Cont Adj	005		249.25
			TOTAL PAYMENTS/ADJUSTMENTS			0.00

IDENTIFICATION NO.
93-0369906

THANK YOU!

ACCOUNT BALANCE 730.25

SISTERS OF PROVIDENCE

PLEASE REMIT TO:
PROVIDENCE MEDICAL CENTER
P.O. BOX 13991
PORTLAND, OREGON 97213-0991
503 / 331-4300

TYPE OF BILL	DATE OF BILL	PAGE NO
D--I/P	08/29/93	1

PLEASE REFER TO THIS NO. ON ALL INQUIRIES AND CORRESPONDENCE

PATIENT NAME	ADMISSION DATE	DISCHARGE DATE	PATIENT NUMBER
HRISTIAN DAVID BUETTNER	08/24/93	08/25/93	P9323-606674

INSURANCE COMPANY NAME(S)
05995 BLUE CROSS BS OR PPO

GUARANTOR NAME AND ADDRESS

AMELIA NICOLE BUETTNER
18-R VIEW DRIVE
PO BOX 454
STEVENSON WA 98648

AMOUNT ENCLOSED $ _____

☐ MASTER CARD ☐ AMERICAN EXPRESS
☐ VISA ☐ DISCOVER CARD

CARD NO. _____

EXP. DATE ___ / ___

SIGNATURE _____

- QUESTIONS ABOUT YOUR BILL? CALL 8:00 AM - 5:30 PM MONDAY - FRIDAY AT 331-4300 OR OUTSIDE PORTLAND 1-800-772-9094.
- IF YOU RECEIVED X-RAY SERVICES, YOU WILL RECEIVE A SEPARATE BILLING FROM THE PHYSICIAN FOR READING THE X-RAY.

POSTING DATE	SERVICE CODE	ORD. NO.	SERVICE DESCRIPTION	QUANTITY	HOSPITAL CHARGE	TOTAL CHARGE
08/24	5000	3	ROOM 3K38 B	1	299.00	299.00
			TOTAL NURSERY			299.00
08/24	2100	1	BILIRUBIN TOTAL/DIRECT	1	70.50	70.50
08/25	7537	1	PHLEBOTOMY	1	8.00	8.00
			TOTAL LABORATORY OR LAB			78.50
08/25	1007	4	3K PHOTOTHERAPY DAILY	1	26.40	26.40
			TOTAL BIRTHING CENTER			26.40
			TOTAL CHARGES			403.90
8/30	A0050	494	BCBSO PPO Cont Adj	005		77.10
9/30	A0050	37	BCBSO PPO Cont Adj	005		-77.10
			TOTAL PAYMENTS/ADJUSTMENTS			0.00

IDENTIFICATION NO.
93-0386006

THANK YOU!

ACCOUNT BALANCE 403.90

WPPA6002
PAGE 1

DETAIL BILL - FINAL

WOODLAND PARK HOSPITAL
10300 N.E.HANCOCK ST
PORTLAND OR 97220
503-257-5500

3/01/
3:33:

Patient No	Patient Name	Admit Date	Discharge Date	P/T	F/C	Serv	Attending Doctor
0020638-00	BUETTNER AMY AMELIA	2/25/93	2/25/93	2	70	60	00602 DYSON ROBERT D

BUETTNER MONTY
PO BOX 444
STEVENSON WA 98648

Plan 1 : 70020
BLUE CROSS MDC OP
BUETTNER, MONTY
536788779
2390

Plan 2 :

Plan 3 :

Diagnosis : 285.9

Procedures :

DRG Code :

Med Rec # : 206

Charge Code	Service Date	Rev Cd	Description	CPT Code	Qty	Unit Price	Extended Amount	Prof/Non-Cov Amount	Covered Amount	
0040541	2/25/93	300	PRENATAL PROFILE III	80055	1	37.66	37.66	.00	37.66	
0040950	2/25/93	300	MAIN LAB DRAW	36415	1	6.00	6.00	.00	6.00	
							43.66	.00	43.66	*
0040086	2/25/93	302	HIV SCREEN	(OP) 86311	1	27.50	27.50	.00	27.50	
							27.50	.00	27.50	*
							71.16	.00	71.16	**

Charges: 71.16 Payments: .00 Adjustments: .00 Balance: 71.16

WPPA5002
PAGE 1

D E T A I L B I L L - FINAL
WOODLAND PARK HOSPITAL
10300 N.E.HANCOCK ST
PORTLAND OR 97220
503-257-5500

3/29/91
3:01:3

Patient No	Patient Name	Admit Date	Discharge Date	P/T	F/C	Serv	Attending Doctor
0020638-01	BUETTNER AMELIA N	3/25/93	3/25/93	2	70	60	00602 DYSON ROBERT D

BUETTNER MONTY
PO BOX 444
STEVENSON WA 98648

Plan 1 : 70020
BLUE CROSS NOC OP
BUETTNER, MONTY
536788779
2390

Plan 2 :

Plan 3 :

Diagnosis : V22.1

Procedures :

DRG Code :

Med Rec # : 20638

Charge Code	Service Date	Rev Cd	Description	CPT Code	Qty	Unit Price	Extended Amount	Prof/Non-Cov Amount	Covered Amount	
0040951	3/25/93	300	PLAZA DRAW	36415	1	6.00	6.00	.00	6.00	
							6.00	.00	6.00	*
0042128	3/25/93	301	ALPHA FETO-PROTEIN PROGRAM	82105	1	83.19	83.19	.00	83.19	
							83.19	.00	83.19	*
							89.19	.00	89.19	**

Charges: 89.19 Payments: .00 Adjustments: .00 Balance: 89.19

SISTERS OF PROVIDENCE

PLEASE REMIT TO:
PROVIDENCE MEDICAL CENTER
P.O. BOX 13991
PORTLAND, OREGON 97213-0991
503 / 331-4300

TYPE OF BILL: D-O/P | DATE OF BILL: 05/01/93 | PAGE NO: 1

PLEASE REFER TO THIS NO. ON ALL INQUIRIES AND CORRESPONDENCE

PATIENT NAME	ADMISSION DATE	DISCHARGE DATE	PATIENT NUMBER
MELIA NICOLE BUETTNER	04/27/93	04/27/93	P9311-703319

INSURANCE COMPANY NAME(S)
05995 BLUE CROSS BS OR PPO

GUARANTOR NAME AND ADDRESS
AMELIA NICOLE BUETTNER
18-R VIEW DRIVE
PO BOX 454
STEVENSON WA 98648

AMOUNT ENCLOSED $ _____
☐ MASTER CARD ☐ AMERICAN EXPRESS
☐ VISA ☐ DISCOVER CARD
CARD NO. _____
EXP. DATE ____/____
SIGNATURE _____

- QUESTIONS ABOUT YOUR BILL? CALL 8:00 AM - 5:30 PM MONDAY - FRIDAY AT 331-4300 OR OUTSIDE PORTLAND 1-800-772-9094.
- IF YOU RECEIVED X-RAY SERVICES, YOU WILL RECEIVE A SEPARATE BILLING FROM THE PHYSICIAN FOR READING THE X-RAY.

POSTING DATE	SERVICE CODE	ORD. NO.	SERVICE DESCRIPTION	QUANTITY	HOSPITAL CHARGE	TOTAL CHARGE
04/27	6410	1	US OBSTETRICAL	1	175.60	175.60
			TOTAL ULTRASOUND			175.60
			TOTAL CHARGES			175.60
5/02	A0050	640	BCBSO PPO Cont Adj	005		-35.12
9/09	A0052	543	Blue Cross Commercial Cont Adj	005		35.12
			TOTAL PAYMENTS/ADJUSTMENTS			0.00

IDENTIFICATION NO. 93-0388606

THANK YOU!

ACCOUNT BALANCE 175.60

SISTERS OF PROVIDENCE

PLEASE REMIT TO:
PROVIDENCE MEDICAL CENTER
P.O. BOX 13991
PORTLAND, OREGON 97213-0991
503 / 331-4300

TYPE OF BILL	DATE OF BILL	PAGE NO
0-0/P	06/11/93	1

PLEASE REFER TO THIS NO. ON ALL INQUIRIES AND CORRESPONDENCE

PATIENT NAME	ADMISSION DATE	DISCHARGE DATE	PATIENT NUMBER
MELIA NICOLE BUETTNER	06/07/93	06/07/93	P9315-804964

INSURANCE COMPANY NAME(S)
05995 BLUE CROSS BS OR PPO

GUARANTOR NAME / ADDRESS

AMELIA NICOLE BUETTNER
18-R VIEW DRIVE
PO BOX 454
STEVENSON WA 98648

AMOUNT ENCLOSED $ _____

☐ MASTER CARD ☐ AMERICAN EXPRESS
☐ VISA ☐ DISCOVER CARD

CARD NO. _____

EXP. DATE ____/____

SIGNATURE _____

- QUESTIONS ABOUT YOUR BILL? CALL 8:00 AM - 5:30 PM MONDAY - FRIDAY AT 331-4300 OR OUTSIDE PORTLAND 1-800-772-9094.
- IF YOU RECEIVED X-RAY SERVICES, YOU WILL RECEIVE A SEPARATE BILLING FROM THE PHYSICIAN FOR READING THE X-RAY.

POSTING DATE	REVENUE CODE	ORD. NO.	SERVICE DESCRIPTION	QUANTITY	HOSPITAL CHARGE	TOTAL CHARGE
06/07	4080	1	CULTURE-ROUTINE AEROBIC	1	30.00	30.00
06/07	6875	1	URINALYSIS	1	17.25	17.25
			TOTAL LABORATORY OR LAB			47.25
06/07	5	2	3K 0-2 HR FMC CARE	1	133.90	133.90
			TOTAL BIRTHING CENTER			133.90
			TOTAL CHARGES			181.15
6/12	A0050	926	BCBSO PPO Cont Adj	005		-36.23
7/16	A0050	162	BCBSO PPO Cont Adj	005		36.23
			TOTAL PAYMENTS/ADJUSTMENTS			0.00

IDENTIFICATION NO. 93-0388908

THANK YOU!

181.15

SISTERS OF PROVIDENCE

PLEASE REMIT TO:
PROVIDENCE MEDICAL CENTER
P.O. BOX 13991
PORTLAND, OREGON 97213-0991
503 / 331-4300

TYPE OF BILL	DATE OF BILL	PAGE NO
D-RLS	08/28/93	1

PLEASE REFER TO THIS NO. ON ALL INQUIRIES AND CORRESPONDENCE

PATIENT NAME	ADMISSION DATE	DISCHARGE DATE	PATIENT NUMBER
RISTIAN DAVID BUETTNER	08/24/93	08/24/93	P9323-605429

INSURANCE COMPANY NAME(S)
05995 BLUE CROSS BS OR PPO

GUARANTOR NAME
ADDRESS

AMELIA NICOLE BUETTNER
18-R VIEW DRIVE
PO BOX 454
STEVENSON WA 98648

AMOUNT ENCLOSED $ _____
☐ MASTER CARD ☐ AMERICAN EXPRESS
☐ VISA ☐ DISCOVER CARD
CARD NO. _____
EXP. DATE ___/___
SIGNATURE _____

- QUESTIONS ABOUT YOUR BILL? CALL 8:00 AM - 5:30 PM MONDAY - FRIDAY AT 331-4300 OR OUTSIDE PORTLAND 1-800-772-9094.
- IF YOU RECEIVED X-RAY SERVICES, YOU WILL RECEIVE A SEPARATE BILLING FROM THE PHYSICIAN FOR READING THE X-RAY.

SERVICE DATE	SERVICE CODE	ORD. NO.	SERVICE DESCRIPTION	QUANTITY	HOSPITAL CHARGE	TOTAL CHARGE
08/24	2100	1	BILIRUBIN TOTAL/DIRECT	1	35.00	35.00
			TOTAL LABORATORY OR LAB			35.00
			TOTAL CHARGES			35.00
8/24	I0050	11	Blue Cross BS OR Payment	005		0.00
8/29	A0050	493	BCBSO PPO Cont Adj	005		-7.00
			TOTAL PAYMENTS/ADJUSTMENTS			-7.00

IDENTIFICATION NO. 93-6000000

THANK YOU!

28.00

SKAMANIA COUNTY AUDITOR 12068
GARY M. OLSON

Date: 12/30/1993 16:51

Type: CLAIM FOR DAMAGES

Receipt #: 36308

Amount: $ .00

Input by: PL
From: SKAMANIA COUNTY
Memo: $5,380.34 MEDICAL BILL

Auditor file#: 118394

Return to: SKAMANIA COUNTY

Grantor:	Grantee:	Parcel:
SKAMANIA COUNTY	BUETTNER, MONTY J	
12069		