LINCARE

PO BOX 15389
LENEXA, KS 66285-5389

CUSTOMER ID	INVOICE NUMBER	INVOICE DATE	AMOUNT DUE UPON RECEIPT	AMOUNT ENCLOSED
503-6643	BB0T0S0L	05/19/2012	$38.27	

FOR CREDIT CARD PAYMENT CHECK ONE: ☐ MasterCard ☐ VISA ☐ DISCOVER ☐ AMERICAN EXPRESS

Card Number: CCV Code *:

Card Holder Signature : Exp. Date:

MAKE CHECKS PAYABLE TO LINCARE INC
OR CALL (877)754-7690 TO PAY BY PHONE

☐ Check box if address or insurance information has changed. Please indicate changes on the reverse side.

Name: DAVID DAMMON 90-27-69-15

03837 LIN1P01
DAVID DAMMON
117 NORTH QUEENS
SLIDELL, LA 70458-1029

LINCARE INC
PO BOX 15389
LENEXA, KS 66285-5389

Fax 913-754-7996
Attn: Kathy

BB0T0S0L0000000005036643000003827120519902769158

RETURN THE ABOVE STUB WITH YOUR PAYMENT. PLEASE INDICATE ACCOUNT NUMBER ON CHECK.

SERVICE DATE	SERVICE CODE	DESCRIPTION	QTY	AMOUNT BILLED	INSURANCE ALLOWED AMOUNT	INSURANCE AMOUNT DUE	TAX INCLUDED IN CUSTOMER DUE AMOUNT	CUSTOMER AMOUNT DUE	REMARK CODE
		CUSTOMER BEGINNING BALANCE						**16.00**	
04/26/12	A7030	FULL FACE MASK	1	536.48	139.72	111.78	1.27	27.94	
04/26/12	A7031	FF REPLACEMENT CUSHION	1	198.41	51.67	41.34	.47	10.33	
03/26/12	A7032	NASAL CUSHION/GEL FLAP	2	230.53	60.02	.00	.00	-12.00	65
03/26/12	A7038	CPAP FILTER	2	29.16	7.98	.00	.00	-1.60	65
04/13/12	A7036	CPAP CHIN STRAP	1	43.99	11.99	.00	.00	-2.40	65
	65	**REMARK CODE DESCRIPTION** TRANSFER BAL TO CORRECT PAYEE							
								TOTAL	**$38.27**

TOTAL INSURANCE PENDING
-$24.66

CURRENT BALANCE	PAST DUE BALANCE	TOTAL AMOUNT DUE UPON RECEIPT
$38.27	$.00	$38.27

PRIMARY INSURANCE: TRICARE SOUTH REGION
SECONDARY INSURANCE: CUSTOMER PAY
TERTIARY/COURTESY:

FEDERAL ID: 59-2852900

WE HEREBY CERTIFY THAT THESE GOODS WERE PRODUCED IN COMPLIANCE WITH ALL APPLICABLE REQUIREMENTS OF SECTION 6,7 AND 12 OF THE FAIR LABOR STANDARDS ACT AS AMENDED AND OF REGULATIONS AND ORDERS OF THE U.S DEPARTMENT OF LABOR ISSUED UNDER SECTION 14 THEREOF.

MESSAGE:
PLEASE BE SURE TO CONTACT US PROMPTLY IF YOU HAVE LOST OR CHANGED YOUR INSURANCE COVERAGE.
AS AN ADDED COMPLIMENTARY SERVICE, OUR OFFICE WILL ACCEPT YOUR CREDIT CARD OR CHECK OVER THE PHONE.
CALL OUR OFFICE TODAY TO DISCUSS AUTO-PROCESS OPTIONS FOR MAKING YOUR PAYMENT.

ACCOUNT NAME: DAVID DAMMON
CUSTOMER ID: 503-6643
INVOICE DATE: 05/19/2012
INVOICE NUMBER: BB0T0S0L

LINCARE

BILLING INQUIRIES: (877)754-7690
SERVICE INQUIRIES: (888)649-5472

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LINCARE

PO BOX 15389
LENEXA, KS 66285-5389

CUSTOMER ID	INVOICE NUMBER	INVOICE DATE	AMOUNT DUE UPON RECEIPT	AMOUNT ENCLOSED
503-6643	BB0M4HYW	03/19/2012	$13.62	

FOR CREDIT CARD PAYMENT CHECK ONE: ☐ MasterCard ☐ VISA ☐ DISCOVER ☐ AMERICAN EXPRESS

Card Number: CCV Code *:

Card Holder Signature : Exp. Date:

MAKE CHECKS PAYABLE TO LINCARE INC
OR CALL (877)754-7690 TO PAY BY PHONE

☐ Check box if address or insurance information has changed. Please indicate changes on the reverse side.

Name: DAVID DAMMON 90-27-69-15

03630 LIN1P01

DAVID DAMMON
117 NORTH QUEENS
SLIDELL, LA 70458-1029

LINCARE INC
PO BOX 15389
LENEXA, KS 66285-5389

BB0M4HYW00000000503664300000136212031990276915O

RETURN THE ABOVE STUB WITH YOUR PAYMENT. PLEASE INDICATE ACCOUNT NUMBER ON CHECK.

SERVICE DATE	SERVICE CODE	DESCRIPTION	QTY	AMOUNT BILLED	INSURANCE ALLOWED AMOUNT	INSURANCE AMOUNT DUE	TAX INCLUDED IN CUSTOMER DUE AMOUNT	CUSTOMER AMOUNT DUE	REMARK CODE
		CUSTOMER BEGINNING BALANCE						**44.65**	
02/23/12	A7032	NASAL CUSHION/GEL FLAP	2	230.53	60.02	48.02	.54	12.00	
02/23/12	A7038	CPAP FILTER	2	29.16	7.98	6.38	.07	1.60	
01/23/12	A7032	NASAL CUSHION/GEL FLAP	2	230.53	60.02	.00	.00	-12.00	92
01/23/12	A7034	NASAL APPL DEVICE	1	334.55	87.13	.00	.00	-17.42	92
01/23/12	A7035	CPAP HEADGEAR	1	98.64	28.01	.00	.00	-5.60	92
01/23/12	A7037	CPAP TUBING	1	109.01	30.38	.00	.00	-6.08	92
01/23/12	A7038	CPAP FILTER	2	29.16	7.98	.00	.00	-1.60	92
01/23/12	A7039	CPAP FILTER	1	37.05	9.71	.00	.00	-1.93	92
		REMARK CODE DESCRIPTION							
	92	CREDIT BALANCE TRANSFER							
								TOTAL	**$13.62**

TOTAL INSURANCE PENDING
$0.00

CURRENT BALANCE	PAST DUE BALANCE	TOTAL AMOUNT DUE UPON RECEIPT
$13.60	$.02	$13.62

PRIMARY INSURANCE: TRICARE SOUTH REGION
SECONDARY INSURANCE: CUSTOMER PAY
TERTIARY/COURTESY:

FEDERAL ID: 59-2852900

WE HEREBY CERTIFY THAT THESE GOODS WERE PRODUCED IN COMPLIANCE WITH ALL APPLICABLE REQUIREMENTS OF SECTION 6,7 AND 12 OF THE FAIR LABOR STANDARDS ACT AS AMENDED AND OF REGULATIONS AND ORDERS OF THE U.S DEPARTMENT OF LABOR ISSUED UNDER SECTION 14 THEREOF.

MESSAGE:
JANUARY 1, 2012 BEGINS A NEW DEDUCTIBLE SEASON FOR MANY INSURANCE COMPANIES.

ATTN: PLEASE NOTIFY OUR OFFICE IMMEDIATELY IF YOU ELECT TO ENROLL IN ANOTHER INSURANCE PLAN.

ACCOUNT NAME: DAVID DAMMON
CUSTOMER ID: 503-6643
INVOICE DATE: 03/19/2012
INVOICE NUMBER: BB0M4HYW

LINCARE

BILLING INQUIRIES: (877)754-7690
SERVICE INQUIRIES: (888)649-5472

PGBA, LLC
TRICARE SOUTH REGION
P.O. BOX 7032
CAMDEN, SC 29020-7032

TRICARE SUMMARY EXPLANATION OF BENEFITS
This is a statement of the action taken on your TRICARE claims.
Keep this notice for your records.

HUMANA MILITARY
HEALTHCARE SERVICES
★★★★★
www.humana-military.com

TRICARE
South

DAVID P DAMMON
117 N QUEENS DRIVE
SLIDELL LA 70458-1029

145943 010303
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This is not a bill. Any amount you may owe your provider should not be sent directly to us.

April 18, 2012

SUMMARY EXPLANATION OF BENEFITS

This summary information is for claims processed for David Dammon, covered under sponsor ID *****2519. You will receive this summary if you had claim activity this reporting period. A reporting period represents approximately 28 days of claim activity. If you have questions about these claims, please visit our user-friendly Web site at www.myTRICARE.com any time to check on the status of your claims. You can also call our customer service center at 1-800-403-3950 Monday thru Friday from 8 am to 6 pm.

This EOB outlines the amount you need to pay your provider. If there is a difference, use this summary to discuss the charges with your provider.

Patient Name: David P Dammon **Claims Processed from 03/17/12 to 04/18/12**

Provider of Service:	Amount We Paid Your Provider:	Amount Your Provider May Bill You:
HANS E SCHULLER AND DENNIS DALE LLC	$ 203.88	$ 0.00
LINCARE INC	68.03	0.00
OCHSNER CLINIC SLIDELL	711.96	0.00
OCHSNER FOUNDATION HOSPITAL	33.78	0.00
SLIDELL MEMORIAL HOSPITAL	740.65	0.00
Total Paid This Reporting Period:	$ 1,758.30	
Total Patient Responsibility:		$ 0.00

This reporting period we applied $0.00 to your individual and family deductibles. We applied $0.00 to your catastrophic cap for the fiscal year beginning October 2011.

As of April 14, 2012, a total of $0.00 of your $150.00 individual deductible and $150.00 of your $300.00 family deductible has been applied. A total of $3,000.00 of your $3,000.00 catastrophic cap has been applied. Any claims processed after this date could affect these totals.

The TRICARE program is honored to serve you. Thank you for your commitment to the United States Uniformed Services.

CN: 120418S0010715

TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

The following important information shows how much we covered and how much you may owe your provider for services David Dammon received.

Sponsor Name: David P Dammon **Patient Name:** David P Dammon **Sponsor SSN:** ***-**-2519

Provider: **HANS E SCHULLER AND DENNIS DALE LLC**
Claim #: **2076X04RR-00-00**

Amount Other Insurance Paid: **0.00**
Amount You Paid: **0.00**

Amount Your Provider May Bill You: **0.00**
Amount Paid To Your Provider: **88.72**
Amount Paid To You: **0.00**

Date(s) of Service Begin	Date(s) of Service End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
03/08/12	03/08/12	Medical care (99214)		1, 2, 3	120.00	88.72	31.28	0.00	0.00	0.00
TOTAL:					120.00	88.72	31.28	0.00	0.00	0.00

Provider: **HANS E SCHULLER AND DENNIS DALE LLC**
Claim #: **2103X45DW-00-00**

Amount Other Insurance Paid: **0.00**
Amount You Paid: **0.00**

Amount Your Provider May Bill You: **0.00**
Amount Paid To Your Provider: **115.16**
Amount Paid To You: **0.00**

Date(s) of Service Begin	Date(s) of Service End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
03/29/12	03/29/12	Physician services (95811)		1, 2, 3	480.00	115.16	364.84	0.00	0.00	0.00
TOTAL:					480.00	115.16	364.84	0.00	0.00	0.00

Provider: **LINCARE INC**
Claim #: **2088X0Y39-00-00**

Amount Other Insurance Paid: **0.00**
Amount You Paid: **0.00**

Amount Your Provider May Bill You: **0.00**
Amount Paid To Your Provider: **68.03**
Amount Paid To You: **0.00**

Date(s) of Service Begin	Date(s) of Service End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
03/26/12	03/26/12	Medical supplies (A7032)		1, 2, 3	230.53	60.03	170.50	0.00	0.00	0.00
03/26/12	03/26/12	Medical supplies (A7038)		1, 3	29.16	8.00	21.16	0.00	0.00	0.00
TOTAL:					259.69	68.03	191.66	0.00	0.00	0.00

CN: 120418S0010715

PGBA, LLC
TRICARE SOUTH REGION
P.O. BOX 7032
CAMDEN, SC 29020-7032

TRICARE SUMMARY EXPLANATION OF BENEFITS
This is a statement of the action taken on your TRICARE claims.
Keep this notice for your records.

HUMANA MILITARY
HEALTHCARE SERVICES
★★★★★
www.humana-military.com

TRICARE
South

DAVID P DAMMON
117 NORTH QUEENS
SLIDELL LA 70458-1029

178229 014270
0001 of 0002

This is not a bill. Any amount you may owe your provider should not be sent directly to us.

May 18, 2012

SUMMARY EXPLANATION OF BENEFITS

This summary information is for claims processed for David Dammon, covered under sponsor ID *****2519. You will receive this summary if you had claim activity this reporting period. A reporting period represents approximately 28 days of claim activity. If you have questions about these claims, please visit our user-friendly Web site at www.myTRICARE.com any time to check on the status of your claims. You can also call our customer service center at 1-800-403-3950 Monday thru Friday from 8 am to 6 pm.

This EOB outlines the amount you need to pay your provider. If there is a difference, use this summary to discuss the charges with your provider.

Patient Name: David P Dammon

Claims Processed from 04/19/12 to 05/18/12

Provider of Service:	**Amount We Paid Your Provider:**	**Amount Your Provider May Bill You:**
LINCARE INC	$ 203. 37	$ 0. 00
Total Paid This Reporting Period:	$ 203. 37	
Total Patient Responsibility:		$ 0. 00

This reporting period we applied $0.00 to your individual and family deductibles. We applied $0.00 to your catastrophic cap for the fiscal year beginning October 2011.

As of May 4, 2012, a total of $0.00 of your $150.00 individual deductible and $150.00 of your $300.00 family deductible has been applied. A total of $3,000.00 of your $3,000.00 catastrophic cap has been applied. Any claims processed after this date could affect these totals.

The TRICARE program is honored to serve you. Thank you for your commitment to the United States Uniformed Services.

CN: 120518S0015028

TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

The following important information shows how much we covered and how much you may owe your provider for services David Dammon received.

Sponsor Name: David P Dammon **Patient Name:** David P Dammon **Sponsor SSN:** ***-**-2519

Provider: **LINCARE INC**	Amount Other Insurance Paid: **0.00**	Amount Your Provider May Bill You: **0.00**
Claim #: **2110X12RJ-00-00**	Amount You Paid: **0.00**	Amount Paid To Your Provider: **11.99**
		Amount Paid To You: **0.00**

Date(s) of Service Begin	Date(s) of Service End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
04/13/12	04/13/12	Medical supplies (A7036)		1, 2, 3	43.99	11.99	32.00	0.00	0.00	0.00
TOTAL:					43.99	11.99	32.00	0.00	0.00	0.00

Provider: **LINCARE INC**	Amount Other Insurance Paid: **0.00**	Amount Your Provider May Bill You: **0.00**
Claim #: **2119X08C7-00-00**	Amount You Paid: **0.00**	Amount Paid To Your Provider: **191.38**
		Amount Paid To You: **0.00**

Date(s) of Service Begin	Date(s) of Service End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
04/26/12	04/26/12	Medical supplies (A7030)		1, 2, 3	536.48	139.71	396.77	0.00	0.00	0.00
04/26/12	04/26/12	Medical supplies (A7031)		1, 3	198.41	51.67	146.74	0.00	0.00	0.00
TOTAL:					734.89	191.38	543.51	0.00	0.00	0.00

REMARKS:

1. CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

2. HAVE YOU CONSIDERED USING THE TRICARE PHARMACY HOME DELIVERY SERVICE? IT CAN SAVE YOU UP TO 66% ON THE COST OF YOUR MEDICATIONS. CALL 1-877-363-1433 OR CHECK ONLINE AT WWW.EXPRESS-SCRIPTS.COM/TRICARE FOR MORE INFORMATION.

3. CHOOSING NETWORK PROVIDERS CAN SAVE YOU MONEY AND TIME. USE THE PROVIDER LOCATOR AT WWW.HUMANA-MILITARY.COM TO FIND THE NETWORK PROVIDERS YOU NEED CLOSE TO YOU.

CN: 120518S0015028