

# Victim Comp Checks Issued to Service Providers in Last 12 Months

Updated Wednesday, October 21, 2020 3:11 PM

## EAGLE PARTNERS PLLC

Office of State Finance VendorID: 0000346540

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
10/16/2020	108490758	\$173.27	9/28/2019	ACCT: EP273268	Payment amount based on \$216.59 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment.
<i>Approx Mail Date:</i> 10/19/2020 <i>Mail To Address:</i> PO BOX 207339 DALLAS TX 75320-7339					<i>Patient Initials:</i> C.F. <i>Patient Birth Year:</i> 1983
8/12/2020	108456705	\$233.05	010901796	ACCT: EP292911	Payment amount based on \$291.31 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment.
<i>Approx Mail Date:</i> 8/15/2020 <i>Mail To Address:</i> PO BOX 207339 DALLAS TX 75320-7339					<i>Patient Initials:</i> D.J. <i>Patient Birth Year:</i> 1974
2/12/2020	108373736	\$104.00	4/16/2019	ACCT: EP194804	Payment amount based on \$130.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment.
<i>Approx Mail Date:</i> 2/15/2020 <i>Mail To Address:</i> PO BOX 207339 DALLAS TX 75320-7339					<i>Patient Initials:</i> L.V. <i>Patient Birth Year:</i> 1965

## RAY & MARTHA'S FUNERAL HOME

Office of State Finance VendorID: 0000315213

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
2/21/2020	108379769	\$4,202.90	9/20/18	ACCT: B.T.	Payment amount based on \$4,202.90 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 2/24/2020 <i>Mail To Address:</i> ESCHITI SERVICES LLC HOBART OK 73651					<i>Patient Initials:</i> B.Y. <i>Patient Birth Year:</i> 1985

## NES OKLAHOMA

Office of State Finance VendorID: 0000011142

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
6/15/2020	108432758	\$741.09	12/14/19 - 12/18/19	ACCT: APCIP856690	Payment amount based on \$2,517.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 36.80409% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment.
<i>Approx Mail Date:</i> 6/18/2020 <i>Mail To Address:</i> PO BOX 198962 ATLANTA GA 30384-8962					<i>Patient Initials:</i> W.E. <i>Patient Birth Year:</i> 1998

## GREEN CO ER PHYS TULSA PLLC

Office of State Finance VendorID: 0000271109

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
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\$1,277.32 03/27/20 ACCT: 2582003270021

Approx Mail Date: Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

Mail To Address: P O BOX 268938  
OKLAHOMA CITY OK 73126

Payment amount based on \$1,903.00 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 83.90154% among all providers. Patient Initials: J.C.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1986

4/14/2020 108406846 \$864.00 12/26/18 ACCT: 2591812260067

Approx Mail Date: 4/17/2020

Mail To Address: P O BOX 268938  
OKLAHOMA CITY OK 73126

Payment amount based on \$1,080.00 patient balance after insurance and insurance adjustments.

Patient Initials: D.S.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1988

GREEN COUNTRY EMERG PHYS GROUP TULSA

Office of State Finance VendorID: 0000271109

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$341.60 04/09/20 ACCT: M045666423

Approx Mail Date: Requested from OSF 10/15/20 Expected to be mailed by 10/29/20

Mail To Address: PO BOX 21050 DEPT 201  
TULSA OK 74121-1050

Payment amount based on patient balance after insurance and insurance adjustments.

Patient Initials: J.S.

Patient Birth Year: 1976

10/16/2020 108490773 \$907.20 12-25-19 ACCT: 020785510

Approx Mail Date: 10/19/2020

Mail To Address: PO BOX 21050 DEPT 201  
TULSA OK 74121-1050

Payment amount based on \$1,134.00 patient balance after insurance and insurance adjustments.

Patient Initials: G.M.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1965

8/26/2020 108464045 \$324.80 11/27/19 ACCT: M042744909

Approx Mail Date: 8/29/2020

Mail To Address: PO BOX 21050 DEPT 201  
TULSA OK 74121-1050

Payment amount based on \$406.00 patient balance after insurance and insurance adjustments.

Patient Initials: L.C.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1959

5/20/2020 108422000 \$1,191.20 10/27/2018 and 10/29/2018 ACCT: M040444706

Approx Mail Date: 5/23/2020

Mail To Address: PO BOX 21050 DEPT 201  
TULSA OK 74121-1050

Payment amount based on \$1,489.00 patient balance after insurance and insurance adjustments.

Patient Initials: S.R.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1991

5/19/2020 108421296 \$619.20 05/27/19 ACCT: 2581905270083

Approx Mail Date: 5/22/2020

Mail To Address: PO BOX 21050 DEPT 201  
TULSA OK 74121-1050

Payment amount based on \$774.00 patient balance after insurance and insurance adjustments.

Patient Initials: J.C.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1977

3/9/2020 108388699 \$2,078.40 12/09/19 and 12/22/19 ACCT: 2581912090046 - \$1,753.60; 2581912220046 - \$324.80

Approx Mail Date: 3/12/2020

Mail To Address: PO BOX 21050 DEPT 201  
TULSA OK 74121-1050

Payment amount based on \$2,598.00 patient balance after insurance and insurance adjustments.

Patient Initials: H.M.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1987



BETHEL MONUMENT COMPANY

Office of State Finance VendorID: 0000517091

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$1,969.18

4/5/2019

ACCT J.M.

Payment amount based on \$1,969.18 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 8/31/20 Expected to be mailed by 9/14/20

Patient Initials: J.M.

Mail To Address: 17900 HWY 102

Patient Birth Year: 2014

SHAWNEE OK 74801

SAINT FRANCIS OUTREACH SERVICES

Office of State Finance VendorID: 0000056512

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/25/2020

108438942

\$58.88

4/25/2019

ACCT: 482248916

Payment amount based on \$73.60 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/28/2020

Patient Initials: J.B.

Mail To Address: P O BOX 707001

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1989

TULSA OK 74170-7001

3/18/2020

108394591

\$12.36

09/13/19

ACCT: 3105108200

Payment amount based on \$166.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/21/2020

Patient Initials: S.S.

Mail To Address: P O BOX 707001

Total Bills exceed maximum award. Payment is prorated at 9.308603% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1984

TULSA OK 74170-7001

OU PHYSICIANS (TULSA)

Office of State Finance VendorID: 0000204167

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/26/2020

108464149

\$11,097.60

12/29/19

ACCT: 2322860

Payment amount based on \$13,872.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2020

Patient Initials: B.P.

Mail To Address: 4502 E. 41ST ST., 2H37

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1998

TULSA OK 74135

6/15/2020

108432777

\$115.36

09/17/19 - 09/24/19

ACCT: 2258410

Payment amount based on \$3,017.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/18/2020

Patient Initials: G.B.

Mail To Address: 4502 E. 41ST ST., 2H37

Total Bills exceed maximum award. Payment is prorated at 4.779422% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1967

TULSA OK 74135

UROLOGIC SPECIALISTS OF TULSA

Office of State Finance VendorID: 0000174514

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/15/2020

108432823

\$1,125.64

04/02/17 - 07/18/18

ACCT: 1-345345

Payment amount based on \$1,927.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/18/2020

Patient Initials: D.T.

Mail To Address: 6585 SOUTH YALE SUITE 640

Total Bills exceed maximum award. Payment is prorated at 73.01783% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1990

TULSA OK 74136

**HOSPITALIST MEDICINE PHYSICIANS OF TEXAS PLLC**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		<b>\$141.70</b>	01/23/20 - 01/24/20	ACCT: 1573867-QSNDP-14	
<i>Approx Mail Date:</i> Requested from OSF 9/15/20 Expected to be mailed by 9/29/20					Payment amount based on \$788.21 patient balance after insurance and insurance adjustments.
<i>Mail To Address:</i> PO BOX 743522					Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers. <i>Patient Initials:</i> S.G.
LOS ANGELES CA 90074-3522					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1983

**BETHEL MONUMENT CO INC**

*Office of State Finance VendorID:* 0000245007

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
7/8/2020	108441683	<b>\$4,443.68</b>	05/15/20	ACCT: L.R.T.	
<i>Approx Mail Date:</i> 7/11/2020					Payment amount based on \$4,443.68 patient balance after insurance and insurance adjustments.
<i>Mail To Address:</i> P O BOX 512					<i>Patient Initials:</i> L.T.
SEMINOLE OK 74818-0512					<i>Patient Birth Year:</i> 1983

**SCHAUDT'S FUNERAL SVS AND CREM.**

*Office of State Finance VendorID:* 0000291627

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/14/2020	108356572	<b>\$7,433.66</b>	11/11/2019	ACCT: W.R.	
<i>Approx Mail Date:</i> 1/17/2020					Payment amount based on \$7,433.66 patient balance after insurance and insurance adjustments.
<i>Mail To Address:</i> 5757 S. MEMORIAL DR.					<i>Patient Initials:</i> W.R.
TULSA OK 74145					<i>Patient Birth Year:</i> 1984

**CHRISTIAN PILGRIM, DDS**

*Office of State Finance VendorID:* 0000383839

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
9/18/2020	108476097	<b>\$1.93</b>	08/27/19	ACCT: 770	
<i>Approx Mail Date:</i> 9/21/2020					Payment amount based on \$117.00 patient balance after insurance and insurance adjustments.
<i>Mail To Address:</i> 717 SW 119TH					Total Bills exceed maximum award. Payment is prorated at 2.053886% among all providers. <i>Patient Initials:</i> P.C.
OKLAHOMA CITY OK 73170					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1987

**DURA MEDIC LLC**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		<b>\$212.00</b>	08/09/18	ACCT: 943609	
<i>Approx Mail Date:</i> Requested from OSF 9/15/20 Expected to be mailed by 9/29/20					Payment amount based on \$265.00 patient balance after insurance and insurance adjustments.
<i>Mail To Address:</i> P O BOX 2728					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> J.A.
AUSTIN TX 78768-2728					<i>Patient Birth Year:</i> 1998

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		\$126.06	02/29/20	ACCT: 371287030	
		<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20			Payment amount based on \$219.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> 2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Total Bills exceed maximum award. Payment is prorated at 71.95409% among all providers. <i>Patient Initials:</i> E.A. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1981
9/18/2020	108476144	\$339.20	12/24/19 - 12/29/19	ACCT: 369030895	
		<i>Approx Mail Date:</i> 9/21/2020			Payment amount based on \$424.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> 2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> B.P. <i>Patient Birth Year:</i> 1966
8/26/2020	108464078	\$123.20	8/25/15-8/26/15	ACCT:332305985-1	
		<i>Approx Mail Date:</i> 8/29/2020			Payment amount based on \$154.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> 2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> C.W. <i>Patient Birth Year:</i> 1994
7/28/2020	108449484	\$452.80	01/14/20 - 01/18/20	ACCT: 369638951-0	
		<i>Approx Mail Date:</i> 7/31/2020			Payment amount based on patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> 2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> W.G. <i>Patient Birth Year:</i> 1963
6/15/2020	108432743	\$155.98	03/19/20	ACCT: 371931659	
		<i>Approx Mail Date:</i> 6/18/2020			Payment amount based on patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> 2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Total Bills exceed maximum award. Payment is prorated at 99.47671% among all providers. <i>Patient Initials:</i> G.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1999
3/31/2020	108400194	\$53.60	09/27/19	ACCT: 366147369-0	
		<i>Approx Mail Date:</i> 4/3/2020			Payment amount based on \$67.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> 2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> A.K. <i>Patient Birth Year:</i> 1990
2/18/2020	108376689	\$19.59	02/04/19 AND 02/15/19	ACCT: 358984134-0 - \$16.38; 359222819-0 - \$3.21	
		<i>Approx Mail Date:</i> 2/21/2020			Payment amount based on \$55.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> 2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Total Bills exceed maximum award. Payment is prorated at 44.51862% among all providers. <i>Patient Initials:</i> J.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1969
2/18/2020	108376688	\$25.50	02/18/19	ACCT: 359348921	
		<i>Approx Mail Date:</i> 2/21/2020			Payment amount based on \$55.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> 2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Total Bills exceed maximum award. Payment is prorated at 57.94448% among all providers. <i>Patient Initials:</i> J.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1990

2/12/2020 108373775 \$21.60 8/13/2019 ACCT: 364673729-0

Payment amount based on \$27.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/15/2020

Patient Initials: A.F.

Mail To Address: 2738 E 51ST STREET, SUITE 240  
TULSA OK 74105-6271

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1983

UTICA PARK CLINIC

Office of State Finance VendorID: 0000224911

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/27/2020 108363811 \$184.80 11/18/2019 ACCT: 2058215

Payment amount based on \$231.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/30/2020

Patient Initials: J.S.

Mail To Address: DEPT 1304  
TULSA OK 74182

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2000

1/21/2020 108360267 \$2.03 02/15/19 1613882

Payment amount based on \$30.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/24/2020

Patient Initials: J.S.

Mail To Address: DEPT 1304  
TULSA OK 74182

Total Bills exceed maximum award. Payment is prorated at 8.465149% among all providers.

Patient Birth Year: 1970

Acceptance of payment may require a provider write-off. EOB will accompany payment.

INTEGRIS

Office of State Finance VendorID: 0000245453

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$20,000.00 04/27/19 - 05/31/19 ACCT: 601998728 - \$8,771.58;  
108987747 - \$63.99; 109203373 - \$19.04; 601920463 - \$11,145.40

Payment amount based on \$26,473.18 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

Total Bills exceed maximum award. Payment is prorated at 94.43523% among all providers.

Patient Initials: K.C.

Mail To Address: PO BOX 258877 DEPT #88801  
OKLAHOMA CITY OK 73125

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1969

10/16/2020 108490782 \$872.24 4-6-19 ACCT: 604866268

Payment amount based on \$1,090.30 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/19/2020

Patient Initials: K.B.

Mail To Address: PO BOX 258877 DEPT #88801  
OKLAHOMA CITY OK 73125

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1993

10/16/2020 108490783 \$1,795.57 3-3-19 ACCT: 601776069

Payment amount based on \$2,244.46 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/19/2020

Patient Initials: M.Z.

Mail To Address: PO BOX 258877 DEPT #88801  
OKLAHOMA CITY OK 73125

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1978

9/18/2020 108476136 \$3,087.05 01/05/20 ACCT: 110610257 - \$128.80;  
602564302 - \$2,958.25

Payment amount based on patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/21/2020

Patient Initials: R.A.

Mail To Address: PO BOX 258877 DEPT #88801  
OKLAHOMA CITY OK 73125

Patient Birth Year: 1981

9/18/2020	108476135	\$3,555.90	10/29/18	ACCT: 601471461 - \$3,427.10; 107831761 - \$128.80	Payment amount based on \$4,444.88 patient balance after insurance and insurance adjustments.		
	<i>Approx Mail Date:</i> 9/21/2020						<i>Patient Initials:</i> R.L.
	<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125			DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1983
8/26/2020	108464056	\$1,142.74	03/01/20	ACCT: 2742356	Payment amount based on \$1,428.43 patient balance after insurance and insurance adjustments.		
	<i>Approx Mail Date:</i> 8/29/2020						<i>Patient Initials:</i> T.E.
	<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125			DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1985
8/26/2020	108464055	\$20,000.00	10/04/17	ACCT: 600594570	Payment amount based on \$75,429.99 patient balance after insurance and insurance adjustments.		
	<i>Approx Mail Date:</i> 8/29/2020				Total Bills exceed maximum award. Payment is prorated at 33.14332% among all providers.		<i>Patient Initials:</i> J.M.
	<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125			DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1991
7/28/2020	108449473	\$11,739.79	04/21/20 - 04/24/20	ACCT: 111399757 - \$1,529.36; 602813681 - \$9,916.43; 111397844 - \$246.96; 111416912 - \$47.04	Payment amount based on patient balance after insurance and insurance adjustments.		
	<i>Approx Mail Date:</i> 7/31/2020						<i>Patient Initials:</i> Z.Z.
	<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125			DEPT #88801			<i>Patient Birth Year:</i> 1957
7/28/2020	108449472	\$12,951.54	04/27/19	ACCT: 601920431	Payment amount based on \$16,189.43 patient balance after insurance and insurance adjustments.		
	<i>Approx Mail Date:</i> 7/31/2020						<i>Patient Initials:</i> A.N.
	<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125			DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1992
7/28/2020	108449471	\$8,542.54	07/26/18 - 08/31/18	ACCT: 601251870 - \$4,052.53; 602047713 - \$3,371.45; 601263422 - \$263.04; 601255573 - \$193.27; 109584187 - \$276.17; 107421743 - \$55.44; 107345992-\$55.44; 107345789 - \$55.44; 107303715 - \$57.12; 107282219 - \$162.64	Payment amount based on \$10,678.18 patient balance after insurance and insurance adjustments.		
	<i>Approx Mail Date:</i> 7/31/2020						<i>Patient Initials:</i> R.Z.
	<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125			DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1976
6/15/2020	108432731	\$599.34	08/01/19 - 03/24/20	ACCT: 602102499 - \$204.96; 602495923 - \$246.21; 602594322 - \$57.37; 108665532 - \$90.80	Payment amount based on \$2,481.98 patient balance after insurance and insurance adjustments.		
	<i>Approx Mail Date:</i> 6/18/2020				Total Bills exceed maximum award. Payment is prorated at 30.18452% among all providers.		<i>Patient Initials:</i> B.D.
	<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125			DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1999

6/3/2020	108427428	\$3,240.18	04/27/19 AND 05/4/19	ACCT: 109157629 - \$35.06; 601920432 - \$3,205.12	Payment amount based on \$4,050.23 patient balance after insurance and insurance adjustments.		
						<i>Approx Mail Date:</i> 6/6/2020	<i>Patient Initials:</i> J.N.
						<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125	<i>Patient Birth Year:</i> 1972
				DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
5/19/2020	108421308	\$10,683.40	02/20/19	ACCT: 663814	Payment amount based on \$13,354.25 patient balance after insurance and insurance adjustments.		
						<i>Approx Mail Date:</i> 5/22/2020	<i>Patient Initials:</i> M.W.
						<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125	<i>Patient Birth Year:</i> 1972
				DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
4/22/2020	108410348	\$600.00	12/04/18	ACCT: 601549742	Payment amount based on \$750.00 patient balance after insurance and insurance adjustments.		
						<i>Approx Mail Date:</i> 4/25/2020	<i>Patient Initials:</i> K.S.
						<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125	<i>Patient Birth Year:</i> 1978
				DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
3/10/2020	108389623	\$1,484.26	11/20/2018-8/30/2019	ACCT: 210739	Payment amount based on \$1,855.33 patient balance after insurance and insurance adjustments.		
						<i>Approx Mail Date:</i> 3/13/2020	<i>Patient Initials:</i> E.C.
						<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125	<i>Patient Birth Year:</i> 1988
				DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
2/21/2020	108379720	\$5,069.41	12/16/18	ACCT: 1963885	Payment amount based on \$6,336.76 patient balance after insurance and insurance adjustments.		
						<i>Approx Mail Date:</i> 2/24/2020	<i>Patient Initials:</i> A.H.
						<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125	<i>Patient Birth Year:</i> 1999
				DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
2/21/2020	108379719	\$1,384.70	05/18/19	ACCT: 601973563	Payment amount based on \$1,730.88 patient balance after insurance and insurance adjustments.		
						<i>Approx Mail Date:</i> 2/24/2020	<i>Patient Initials:</i> A.A.
						<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125	<i>Patient Birth Year:</i> 1970
				DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
2/21/2020	108379718	\$1,018.25	12/01/18 - 12/02/18	ACCT: 601552212 - \$901.77; 108039560 - \$116.48	Payment amount based on \$1,272.81 patient balance after insurance and insurance adjustments.		
						<i>Approx Mail Date:</i> 2/24/2020	<i>Patient Initials:</i> K.S.
						<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125	<i>Patient Birth Year:</i> 1991
				DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
2/12/2020	108373759	\$1,338.08	9/2/2019	ACCT: 602236533	Payment amount based on \$1,672.60 patient balance after insurance and insurance adjustments.		
						<i>Approx Mail Date:</i> 2/15/2020	<i>Patient Initials:</i> K.G.
						<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125	<i>Patient Birth Year:</i> 1995
				DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
1/27/2020	108363744	\$329.28	3/13/2019	ACCT: 601802560	Payment amount based on \$411.60 patient balance after insurance and insurance adjustments.		
						<i>Approx Mail Date:</i> 1/30/2020	<i>Patient Initials:</i> M.Z.
						<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125	<i>Patient Birth Year:</i> 1980
				DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		

1/14/2020	108356524	\$2,053.74	5/23/2019	ACCT: 601984979	Payment amount based on \$2,567.18 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.W.
	<i>Approx Mail Date:</i> 1/17/2020					<i>Patient Birth Year:</i> 1974
	<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125				DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.

**RADIOLOGY ASSOCIATES**

*Office of State Finance VendorID:* 0000266907

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
8/12/2020	108456764	\$244.00	1/6/20	ACCT: 128870	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.O. <i>Patient Birth Year:</i> 1988
	<i>Approx Mail Date:</i> 8/15/2020					
	<i>Mail To Address:</i> 3330 NW 56TH ST STE 206 OKLAHOMA CITY OK 73112-4426					
7/28/2020	108449536	\$940.00	04/21/20 - 04/22/20	ACCT: 161321	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> Z.Z. <i>Patient Birth Year:</i> 1957
	<i>Approx Mail Date:</i> 7/31/2020					
	<i>Mail To Address:</i> 3330 NW 56TH ST STE 206 OKLAHOMA CITY OK 73112-4426					
7/27/2020	108449009	\$25.37	12/31/2018 - 5/9/2019	ACCT: 204888	Payment amount based on \$31.71 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.M. <i>Patient Birth Year:</i> 1991
	<i>Approx Mail Date:</i> 7/30/2020					
	<i>Mail To Address:</i> 3330 NW 56TH ST STE 206 OKLAHOMA CITY OK 73112-4426					
2/21/2020	108379767	\$98.40	05/18/19	ACCT: 418863	Payment amount based on \$123.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.A. <i>Patient Birth Year:</i> 1970
	<i>Approx Mail Date:</i> 2/24/2020					
	<i>Mail To Address:</i> 3330 NW 56TH ST STE 206 OKLAHOMA CITY OK 73112-4426					
2/21/2020	108379766	\$20.00	12/01/18	ACCT: 394960	Payment amount based on \$25.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.S. <i>Patient Birth Year:</i> 1991
	<i>Approx Mail Date:</i> 2/24/2020					
	<i>Mail To Address:</i> 3330 NW 56TH ST STE 206 OKLAHOMA CITY OK 73112-4426					
1/14/2020	108356566	\$20.53	5/23/2019	ACCT: 419315	Payment amount based on \$25.66 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.W. <i>Patient Birth Year:</i> 1974
	<i>Approx Mail Date:</i> 1/17/2020					
	<i>Mail To Address:</i> 3330 NW 56TH ST STE 206 OKLAHOMA CITY OK 73112-4426					

**THE SESSIONS GROUP**

*Office of State Finance VendorID:* 0000508631

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
8/21/2020	108462115	\$192.80	1/23/20	ACCT: M4574	Payment amount based on \$241.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> D.L. <i>Patient Birth Year:</i> N/A
	<i>Approx Mail Date:</i> 8/24/2020					
	<i>Mail To Address:</i> P.O. BOX 55066 LITTLE ROCK AR 72215-5066					



1/21/2020 108360019 \$8,483.83 10/07/16 ACCT: 459686301

Payment amount based on \$10,604.79 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/24/2020

Patient Initials: M.B.

Mail To Address: PO BOX 842350  
DALLAS TX 75284

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1976

COMMUNITY HOSPITAL

Office of State Finance VendorID: 0000258452

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

9/4/2020 108468944 \$691.39 3/6/20 ACCT: 3272033

Payment amount based on \$864.24 patient balance after insurance and insurance adjustments.

Patient Initials: T.G.

Approx Mail Date: 9/7/2020

Mail To Address: PO BOX 248823  
OKLAHOMA CITY OK 73124-8823

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1969

8/12/2020 108456687 \$1,161.58 12/2/2019 ACCT: 3251437

Payment amount based on \$1,451.98 patient balance after insurance and insurance adjustments.

Patient Initials: D.J.

Approx Mail Date: 8/15/2020

Mail To Address: PO BOX 248823  
OKLAHOMA CITY OK 73124-8823

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1974

5/19/2020 108421261 \$5,552.58 12/02/18 AND 1/29/19 ACCT: 3172771 - \$4,610.00; 3184677 - \$531.46; 3184620 - \$411.12

Payment amount based on \$6,940.73 patient balance after insurance and insurance adjustments.

Patient Initials: M.G.

Approx Mail Date: 5/22/2020

Mail To Address: PO BOX 248823  
OKLAHOMA CITY OK 73124-8823

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1974

2/12/2020 108373716 \$827.84 4/16/2019 ACCT: 3201263

Payment amount based on \$1,034.80 patient balance after insurance and insurance adjustments.

Patient Initials: L.V.

Approx Mail Date: 2/15/2020

Mail To Address: PO BOX 248823  
OKLAHOMA CITY OK 73124-8823

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1965

VALIR REHABILITATION HOSPITAL

Office of State Finance VendorID: 0000278414

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

9/18/2020 108476210 \$5,017.66 09/30/19 - 10/14/19 ACCT: 002033313

Payment amount based on \$27,911.50 patient balance after insurance and insurance adjustments.

Patient Initials: S.G.

Approx Mail Date: 9/21/2020

Mail To Address: 700 N W 7TH STREET  
OKLAHOMA CITY OK 73102

Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1983

CEDAR RIDGE HOSPITAL

Office of State Finance VendorID: 0000259972

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

2/12/2020 108373698 \$147.33 10/29/2019 ACCT: 3073440020

Payment amount based on \$184.16 patient balance after insurance and insurance adjustments.

Patient Initials: M.L.

Approx Mail Date: 2/15/2020

Mail To Address: 6505 NE 50TH STREET  
OKLAHOMA CITY OK 73141

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2003

CARL L. SYLVESTER, MD, PC

Office of State Finance VendorID: 0000328632

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$23.16 10/9/2018 - 10/24/2018 ACCT: 6597032

Payment amount based on \$28.95 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 7/16/20 Expected to be mailed by 7/30/20

Patient Initials: H.H.

Mail To Address: DEPT. 96-0392 OKLAHOMA CITY OK 73196

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1989

STILLWATER RADIOLOGY

Office of State Finance VendorID: 0000366930

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$61.60 08/08/20 ACCT: SW100052501101

Payment amount based on \$77.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

Patient Initials: E.Q.

Mail To Address: 4721 W. 6TH AVE STE 130 STILLWATER OK 74074

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1989

8/17/2020 108459281 \$188.80 08/25/19 ACCT: SW100064463401

Payment amount based on \$236.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/20/2020

Patient Initials: A.B.

Mail To Address: 4721 W. 6TH AVE STE 130 STILLWATER OK 74074

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1999

6/3/2020 108427506 \$188.80 12/30/19 ACCT: 00052596901

Payment amount based on \$236.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/6/2020

Patient Initials: C.L.

Mail To Address: 4721 W. 6TH AVE STE 130 STILLWATER OK 74074

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1990

SMITH-GALLO FUNERAL HOME

Office of State Finance VendorID: 0000476297

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$7,266.15 07/22/20 ACCT: L.H.

Payment amount based on \$7,266.15 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/8/20 Expected to be mailed by 10/22/20

Patient Initials: L.H.

Mail To Address: 220 N 1ST ST GUTHRIE OK 73044-3113

Patient Birth Year: 1964

4/14/2020 108406897 \$7,500.00 02/27/20 ACCT: A.S.

Payment amount based on \$7,968.75 patient balance after insurance and insurance adjustments.

Approx Mail Date: 4/17/2020

Patient Initials: A.S.

Mail To Address: 220 N 1ST ST GUTHRIE OK 73044-3113

Patient Birth Year: 1989

RIVERSIDE GARDENS CEMETERY

Office of State Finance VendorID: 0000310575

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$3,150.00 07/01/20 ACCT: A.C.

Payment amount based on \$3,150.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/8/20 Expected to be mailed by 10/22/20

Patient Initials: A.C.

Mail To Address: 4720 NE 36TH ST.  
OKLAHOMA CITY OK 73121

Patient Birth Year: 2004

9/25/2020 108480228 \$2,050.00 3/20/20 ACCT: T.M.

Payment amount based on \$2,050.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/28/2020

Patient Initials: T.M.

Mail To Address: 4720 NE 36TH ST.  
OKLAHOMA CITY OK 73121

Patient Birth Year: 1988

1/29/2020 108366051 \$450.00 12/19/19 ACCT: 1131

Payment amount based on \$450.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/1/2020

Patient Initials: C.P.

Mail To Address: 4720 NE 36TH ST.  
OKLAHOMA CITY OK 73121

Patient Birth Year: 1983

1/27/2020 108363785 \$450.00 1/19/2019 ACCT: R.S.

Payment amount based on \$450.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/30/2020

Patient Initials: R.S.

Mail To Address: 4720 NE 36TH ST.  
OKLAHOMA CITY OK 73121

Patient Birth Year: 2003

CARING HANDS HEALTH CARE

Office of State Finance VendorID: 0000256018

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/18/2020 108434617 \$443.33 7/18/2019-10/22/2019 ACCT:L.L

Payment amount based on \$554.16 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/21/2020

Patient Initials: L.L.

Mail To Address: PO BOX 1992  
MCALESTER OK 74501

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1957

ST JOHN ANESTHESIA SERVICES

Office of State Finance VendorID: 0000263808

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/18/2020 108394598 \$396.00 09/05/19 ACCT: 2557858

Payment amount based on \$495.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/21/2020

Patient Initials: T.H.

Mail To Address: DEPT 2889  
TULSA OK 74182-2889

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1979

3/18/2020 108394597 \$309.33 06/18/19 ACCT: 15780745

Payment amount based on \$1,530.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/21/2020

Patient Initials: J.H.

Mail To Address: DEPT 2889  
TULSA OK 74182-2889

Total Bills exceed maximum award. Payment is prorated at 25.27231% among all providers.  
Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1971

LOCUST GROVE FUNERAL HOME

Office of State Finance VendorID: 0000289510

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

2/21/2020 108379738 \$2,741.00 05/01/19 ACCT: M.S.S. Payment amount based on \$2,741.00 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 2/24/2020 *Patient Initials:* M.S.  
*Mail To Address:* PO BOX 517 *Patient Birth Year:* 1973  
 LOCUST GROVE OK 74352

**OKLAHOMA SPORTS AND ORTHOPEDIC INSTITUTE**

*Office of State Finance VendorID:* 0000264704

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
2/21/2020	108379757	\$224.00	10/22/18 - 07/02/19	ACCT: 66366	
<i>Approx Mail Date:</i> 2/24/2020					<i>Patient Initials:</i> C.M.
<i>Mail To Address:</i> PO BOX 5995					<i>Patient Birth Year:</i> 1980
NORMAN OK 73070					

Payment amount based on \$280.00 patient balance after insurance and insurance adjustments.  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**PONCA CITY MEDICAL CENTER**

*Office of State Finance VendorID:* 0000056230

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
6/15/2020	108432787	\$18,006.14	12/14/19 - 02/03/20	ACCT: D009275660 - \$13,971.45; D009278292 - \$803.15; D009278011 - \$1,413.28; D009282807 - \$692.35; D009296732 - \$165.47; D009275660 - \$960.44	
<i>Approx Mail Date:</i> 6/18/2020					<i>Patient Initials:</i> W.E.
<i>Mail To Address:</i> PO BOX 504295					<i>Patient Birth Year:</i> 1998
ST. LOUIS MO 63160					

Payment amount based on \$61,155.40 patient balance after insurance and insurance adjustments.  
 Total Bills exceed maximum award. Payment is prorated at 36.80409% among all providers.  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**OHH PHYSICIANS, LLC**

*Office of State Finance VendorID:* 0000345589

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$186.40	06/13/19	ACCT: 14467046	
<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20					<i>Patient Initials:</i> M.J.
<i>Mail To Address:</i> PO BOX 268919					<i>Patient Birth Year:</i> 1976
OKLAHOMA CITY OK 73126-8919					

Payment amount based on \$233.00 patient balance after insurance and insurance adjustments.  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**KAY COUNTY CLINIC COMPANY, LLC**

*Office of State Finance VendorID:* 0000274060

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
6/15/2020	108432740	\$874.47	12/14/20 AND 01/20/20	ACCT: 2388272	
<i>Approx Mail Date:</i> 6/18/2020					<i>Patient Initials:</i> W.E.
<i>Mail To Address:</i> PO BOX 9223					<i>Patient Birth Year:</i> 1998
BELFAST ME 04915					

Payment amount based on \$2,970.00 patient balance after insurance and insurance adjustments.  
 Total Bills exceed maximum award. Payment is prorated at 36.80409% among all providers.  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**ADVANCED IMAGING OF TULSA***Office of State Finance VendorID:* 0000374309

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
5/19/2020	108421209	\$2,609.42	06/30/16 AND 11/15/16	ACCT: 14484-1/P1447441184	Payment amount based on \$5,400.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 5/22/2020					<i>Patient Initials:</i> B.P.
<i>Mail To Address:</i> 6757 S. YALE AVE. TULSA OK 74136					<i>Patient Birth Year:</i> 1943

**TEXOMA MEDICAL CENTER***Office of State Finance VendorID:* 0000282701

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/9/2020	108388810	\$2,028.08	12/25/18	ACCT: 27486950	Payment amount based on \$2,535.10 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/12/2020					<i>Patient Initials:</i> M.V.
<i>Mail To Address:</i> PO BOX 844768 DALLAS TX 75284-4768					<i>Patient Birth Year:</i> 1993

**LAWTON EMERGENCY GROUP***Office of State Finance VendorID:* 0000277801

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/9/2020	108388734	\$2,868.80	01/12/18 AND 01/18/18	ACCT: 14X46226614 - \$2,316.80; 14X46383445 - \$552.00	Payment amount based on \$3,586.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/12/2020					<i>Patient Initials:</i> M.B.
<i>Mail To Address:</i> PO BOX 400 SAN ANTONIO TX 78292-0400					<i>Patient Birth Year:</i> 1985
3/10/2020	108389658	\$535.20	12/15/2016	ACCT: 14X36935898	Payment amount based on \$669.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/13/2020					<i>Patient Initials:</i> R.C.
<i>Mail To Address:</i> PO BOX 400 SAN ANTONIO TX 78292-0400					<i>Patient Birth Year:</i> 1985

**Tulsa Sunshine Center***Office of State Finance VendorID:* 0000307057

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
10/16/2020	108490746	\$142.56	2/2/18-10/22/18	ACCT: C.F.	Payment amount based on \$178.20 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 10/19/2020					<i>Patient Initials:</i> A.M.
<i>Mail To Address:</i> 2221 W. Detroit Street Broken Arrow OK 74012					<i>Patient Birth Year:</i> 2007

**ST MARY'S REGIONAL MEDICAL CENTER***Office of State Finance VendorID:* 0000078683

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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7/28/2020	108449568	\$14,595.40	11/09/19	ACCT: 314382649	Payment amount based on \$18,244.25 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> H.M.
						<i>Patient Birth Year:</i> 1988
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
<i>Approx Mail Date:</i> 7/31/2020						
<i>Mail To Address:</i> FILE 749344 LOS ANGELES CA 90074-9344						
3/18/2020	108394609	\$5,641.40	11/14/18	ACCT: 313452112	Payment amount based on \$7,051.75 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.G.
						<i>Patient Birth Year:</i> 1978
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
<i>Approx Mail Date:</i> 3/21/2020						
<i>Mail To Address:</i> FILE 749344 LOS ANGELES CA 90074-9344						

**SAMARITAN COUNSELING AND GROWTH**

*Office of State Finance VendorID:* 0000014912

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
8/26/2020	108464186	\$240.00	4/2/20-4/24/20	ACCT: R.S.	Payment amount based on \$240.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> D.S.
						<i>Patient Birth Year:</i> N/A
<i>Approx Mail Date:</i> 8/29/2020						
<i>Mail To Address:</i> 245 SE MADISON BLVD BARTLESVILLE OK 74006						

**CARE COMMUNICATIONS, LLC**

*Office of State Finance VendorID:* 0000056512

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		\$287.24	02/29/20	ACCT: 3127129520	Payment amount based on \$499.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> E.A.
					Total Bills exceed maximum award. Payment is prorated at 71.95409% among all providers.	<i>Patient Birth Year:</i> 1981
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20						
<i>Mail To Address:</i> 6600 S YALE AVE STE 1400 TULSA OK 74136-3331						
9/18/2020	108476190	\$208.80	01/22/20	ACCT: 3122300060	Payment amount based on \$261.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> B.P.
						<i>Patient Birth Year:</i> 1966
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
<i>Approx Mail Date:</i> 9/21/2020						
<i>Mail To Address:</i> 6600 S YALE AVE STE 1400 TULSA OK 74136-3331						
8/26/2020	108464180	\$1,128.80	06/19/19 - 09/03/19	ACCT: 3106421320 - \$142.40; 3106607670 - \$142.40; 3111766870 - \$261.60; 3111766860 - \$239.20; 3111766850 - \$343.20	Payment amount based on \$1,411.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.B.
						<i>Patient Birth Year:</i> 1987
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
<i>Approx Mail Date:</i> 8/29/2020						
<i>Mail To Address:</i> 6600 S YALE AVE STE 1400 TULSA OK 74136-3331						

8/26/2020	108464178	\$2,481.67	07/17/18 - 08/13/18	ACCT: 3081159783 - \$97.34; 3081543250 - \$292.01; 3081619890 - \$264.80; 3081619850 - \$118.79; 3081543260 - \$48.68; 3081159742 - \$1,012.82; 3081159792 - \$160.54; 3081619860 - \$340.68; 3081619870 - \$146.01	Payment amount based on \$10,759.00 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 8/29/2020					Total Bills exceed maximum award. Payment is prorated at 28.83237% among all providers. <i>Patient Initials:</i> I.M.	
<i>Mail To Address:</i> 6600 S YALE AVE STE 1400 TULSA OK 74136-3331					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1996	
6/15/2020	108432803	\$915.19	03/19/20	ACCT: 500023750 - \$359.71; 3120244480 - \$555.48	Payment amount based on patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 6/18/2020					Total Bills exceed maximum award. Payment is prorated at 99.47671% among all providers. <i>Patient Initials:</i> G.M.	
<i>Mail To Address:</i> 6600 S YALE AVE STE 1400 TULSA OK 74136-3331					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1999	
5/19/2020	108421373	\$436.80	07/11/19, 07/25/19, 09/04/19	ACCT: 3103142320 - \$85.60; 3103142330 - \$208.80; 3105526960 - \$142.40	Payment amount based on \$546.00 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 5/22/2020						<i>Patient Initials:</i> T.P.
<i>Mail To Address:</i> 6600 S YALE AVE STE 1400 TULSA OK 74136-3331					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1964	
5/19/2020	108421374	\$703.89	07/05/19 - 07/12/19	ACCT: 3104094001 - \$257.20; 3104199360 - \$341.77; 3104199370 - \$36.88; 3104199350 - \$68.04	Payment amount based on \$2,214.00 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 5/22/2020					Total Bills exceed maximum award. Payment is prorated at 39.7409% among all providers. <i>Patient Initials:</i> M.H.	
<i>Mail To Address:</i> 6600 S YALE AVE STE 1400 TULSA OK 74136-3331					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1970	
3/10/2020	108389700	\$37.58	4/26/2019 & 4/27/2019	ACCT: 605720330	Payment amount based on \$46.98 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 3/13/2020						<i>Patient Initials:</i> K.B.
<i>Mail To Address:</i> 6600 S YALE AVE STE 1400 TULSA OK 74136-3331					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1985	
2/18/2020	108376749	\$771.82	02/03/19 AND 02/09/19	ACCT: 3102738470 - \$184.96; 3102738460 - \$586.86	Payment amount based on \$1,665.00 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 2/21/2020					Total Bills exceed maximum award. Payment is prorated at 57.94448% among all providers. <i>Patient Initials:</i> J.S.	
<i>Mail To Address:</i> 6600 S YALE AVE STE 1400 TULSA OK 74136-3331					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1990	
1/29/2020	108366074	\$2,079.20		ACCT: 3102218381 - \$344.00; 3102218401 - \$248.80; 3102218411 - \$476.80; 3102218391 - \$515.20; 3102317210 - \$323.20; 3102317200 - \$171.20	Payment amount based on \$2,599.00 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 2/1/2020						<i>Patient Initials:</i> T.S.
<i>Mail To Address:</i> 6600 S YALE AVE STE 1400 TULSA OK 74136-3331					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1998	

**FLETCHER FUNERAL HOME**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		<b>(\$1,008.89)</b>	11/22/19	RESCIND PREVIOUS AWARD	Payment amount based on (\$1,008.89) patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> Requested from OSF 6/30/20 Expected to be mailed by 7/14/20						<i>Patient Initials:</i> P.M.
<i>Mail To Address:</i> 410 W COLE ST FLETCHER OK						<i>Patient Birth Year:</i> 1999
		<b>\$1,000.89</b>	11/22/19	ACCT: P.M.	Payment amount based on \$1,000.89 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> Requested from OSF 2/14/20 Expected to be mailed by 2/28/20						<i>Patient Initials:</i> P.M.
<i>Mail To Address:</i> 410 W COLE ST FLETCHER OK						<i>Patient Birth Year:</i> 1999

**STROUD REGIONAL MEDICAL CENTER**

*Office of State Finance VendorID:* 0000336862

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
6/18/2020	108434747	<b>\$962.01</b>	9/2/19	ACCT: 41972	Payment amount based on \$1,202.51 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 6/21/2020						<i>Patient Initials:</i> J.S.
<i>Mail To Address:</i> PO BOX 12913 OKLAHOMA CITY OK 73157-2913						<i>Patient Birth Year:</i> 1983
2/21/2020	108379788	<b>\$480.00</b>	10/21/18	ACCT: 37332	Payment amount based on \$600.00 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 2/24/2020						<i>Patient Initials:</i> C.M.
<i>Mail To Address:</i> PO BOX 12913 OKLAHOMA CITY OK 73157-2913						<i>Patient Birth Year:</i> 1980
2/21/2020	108379787	<b>\$4,971.25</b>	11/22/19	ACCT: 42380	Payment amount based on \$6,214.06 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 2/24/2020						<i>Patient Initials:</i> C.H.
<i>Mail To Address:</i> PO BOX 12913 OKLAHOMA CITY OK 73157-2913						<i>Patient Birth Year:</i> 1991

**SOLUTIONS PRACTICE MANAGEMENT**

*Office of State Finance VendorID:* 0000314682

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
8/26/2020	108464196	<b>\$262.96</b>	10/26/19 - 11/07/19	ACCT: F00000095020 - \$221.13; W00000283619 - \$41.83	Payment amount based on \$987.00 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 8/29/2020						<i>Patient Initials:</i> S.H.
<i>Mail To Address:</i> 2210 DUNCAN REGIONAL LOOP RD DUNCAN OK 73533-1594						<i>Patient Birth Year:</i> 1967
					Total Bills exceed maximum award. Payment is prorated at 33.30311% among all providers.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	

**NRHS RADIOLOGY ASSOCIATES**

*Office of State Finance VendorID:* 0000291219

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
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<b>7/27/2020</b>	<b>108448995</b>	<b>\$14.21</b>	9/23/2018	ACCT: 270870	Payment amount based on \$17.76 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> H.H.
<i>Approx Mail Date:</i> 7/30/2020					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1989
<i>Mail To Address:</i> P O BOX 269065 OKLAHOMA CITY OK 73126-9065						
<b>5/19/2020</b>	<b>108421335</b>	<b>\$565.60</b>	09/25/19	ACCT: 34609	Payment amount based on \$707.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> N.N.
<i>Approx Mail Date:</i> 5/22/2020					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1979
<i>Mail To Address:</i> P O BOX 269065 OKLAHOMA CITY OK 73126-9065						
<b>1/21/2020</b>	<b>108360176</b>	<b>\$716.00</b>	05/22/19	ACCT: N0887366872	Payment amount based on \$895.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> T.G.
<i>Approx Mail Date:</i> 1/24/2020					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1984
<i>Mail To Address:</i> P O BOX 269065 OKLAHOMA CITY OK 73126-9065						

**AHS OKLAHOMA HEART LLC**

*Office of State Finance VendorID:* 0000469000

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
<b>5/19/2020</b>	<b>108421211</b>	<b>\$24.16</b>	01/17/19 AND 02/07/19	ACCT: 1079612	Payment amount based on \$50.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> B.P.
<i>Approx Mail Date:</i> 5/22/2020					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1943
<i>Mail To Address:</i> PO BOX 108819 OKLAHOMA CITY OK 73101						

**OKLAHOMA HEART HOSPITAL**

*Office of State Finance VendorID:* 0000324629

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		<b>\$5,098.33</b>	06/12/19	ACCT: 2019321551	Payment amount based on \$6,372.91 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> M.J.
<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1976
<i>Mail To Address:</i> PO BOX 248870 OKLAHOMA CITY OK 73124						

**EMP OF TULSA COUNTY**

*Office of State Finance VendorID:* 0000294051

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
<b>8/26/2020</b>	<b>108464026</b>	<b>\$1,237.24</b>	10/06/19	ACCT: 11074936	Payment amount based on \$1,546.55 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> B.G.
<i>Approx Mail Date:</i> 8/29/2020					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1965
<i>Mail To Address:</i> 6161 S YALE AVE TUSLA OK 74136-1902						
<b>5/19/2020</b>	<b>108421283</b>	<b>\$655.01</b>	07/05/19 AND 07/19/19	ACCT: 10543859	Payment amount based on \$2,060.26 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> M.H.
<i>Approx Mail Date:</i> 5/22/2020					Total Bills exceed maximum award. Payment is prorated at 39.7409% among all providers.	<b>Patient Birth Year:</b> 1970
<i>Mail To Address:</i> 6161 S YALE AVE TUSLA OK 74136-1902						

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		\$967.14	02/29/20	ACCT: 36640462V6385	
		<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20			Payment amount based on \$1,680.13 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084			Total Bills exceed maximum award. Payment is prorated at 71.95409% among all providers. <i>Patient Initials:</i> E.A.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1981
8/11/2020	108455894	\$739.67	11/9/19	ACCT: 11257705A6385	
		<i>Approx Mail Date:</i> 8/14/2020			Payment amount based on \$924.59 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> C.C.
					<i>Patient Birth Year:</i> 1968
7/28/2020	108449452	\$53.64	10/29/16- 05/13/17	ACCT: 47013148	
		<i>Approx Mail Date:</i> 7/31/2020			Payment amount based on \$67.05 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> L.C.
					<i>Patient Birth Year:</i> N/A
6/15/2020	108432714	\$1,201.94	03/19/20	ACCT: 11985370	
		<i>Approx Mail Date:</i> 6/18/2020			Payment amount based on patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084			Total Bills exceed maximum award. Payment is prorated at 99.47671% among all providers. <i>Patient Initials:</i> G.M.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1999
6/15/2020	108432713	\$2,458.09	10/03/19	ACCT: 33664297V6385 - \$1,207.10; 33664300V6385 - \$1,250.99	
		<i>Approx Mail Date:</i> 6/18/2020			Payment amount based on \$5,121.99 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084			Total Bills exceed maximum award. Payment is prorated at 59.98875% among all providers. <i>Patient Initials:</i> Z.V.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1992
3/31/2020	108400172	\$1,197.69	09/27/19	ACCT: 1713496A6385	
		<i>Approx Mail Date:</i> 4/3/2020			Payment amount based on \$1,497.11 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> A.K.
					<i>Patient Birth Year:</i> 1990
3/10/2020	108389593	\$23.74	7/8/2019	ACCT: 8043416A6385	
		<i>Approx Mail Date:</i> 3/13/2020			Payment amount based on \$29.68 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> K.B.
					<i>Patient Birth Year:</i> 1955
2/18/2020	108376648	\$794.56	02/04/19	ACCT: 9621035A6385	
		<i>Approx Mail Date:</i> 2/21/2020			Payment amount based on \$2,230.99 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084			Total Bills exceed maximum award. Payment is prorated at 44.51862% among all providers. <i>Patient Initials:</i> J.L.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1969

2/18/2020 108376647 \$1,172.99 02/03/19 AND 02/18/19 ACCT: 7121846 - \$478.99; 9614487 - \$694.00 Payment amount based on \$2,530.41 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 2/21/2020  
*Mail To Address:* PO BOX 18921 BELFAST ME 04915-4084  
 Total Bills exceed maximum award. Payment is prorated at 57.94448% among all providers. *Patient Initials:* J.S.  
 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1990

1/21/2020 108360098 \$3.59 12/15/17 ACCT: 6746860A6385 Payment amount based on \$52.95 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 1/24/2020  
*Mail To Address:* PO BOX 18921 BELFAST ME 04915-4084  
 Total Bills exceed maximum award. Payment is prorated at 8.465149% among all providers. *Patient Initials:* J.S.  
 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1970

**ANESTHESIA MEDICAL PROFESSIONALS**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$687.05	02/20/19	ACCT: 108392/458805 - \$455.05; 458808 - \$132.00; 456809 - \$100.00	
<i>Approx Mail Date:</i> Requested from OSF 5/12/20 Expected to be mailed by 5/26/20					<i>Patient Initials:</i> M.W.
<i>Mail To Address:</i> PO BOX 2054 LOWELL AR 72745					<i>Patient Birth Year:</i> 1972

**ORTHOPEDIC AND TRAUMA SERVICE OF OKLAHOMA**

*Office of State Finance VendorID:* 0000295367

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
6/15/2020	108432771	\$2,697.57	05/12/17 - 01/17/18	ACCT: 13026	
<i>Approx Mail Date:</i> 6/18/2020					<i>Patient Initials:</i> D.T.
<i>Mail To Address:</i> 2424 E 21ST STE 320 TULSA OK 74114					<i>Patient Birth Year:</i> 1990

**ORTHOPEDIC & TRAUMA SERVICE OF OKLAHOMA**

*Office of State Finance VendorID:* 0000295367

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/26/2020	108464135	\$7,720.00	08/02/19	ACCT: 20571	
<i>Approx Mail Date:</i> 8/29/2020					<i>Patient Initials:</i> B.T.
<i>Mail To Address:</i> 5110 S YALE SUITE 525 TULSA OK 74135-7485					<i>Patient Birth Year:</i> 1988
8/17/2020	108459254	\$1,036.80	03/01/20	ACCT: 22946	
<i>Approx Mail Date:</i> 8/20/2020					<i>Patient Initials:</i> E.T.
<i>Mail To Address:</i> 5110 S YALE SUITE 525 TULSA OK 74135-7485					<i>Patient Birth Year:</i> 1983

6/15/2020 108432772 \$370.23 09/16/19 ACCT: 21014

Approx Mail Date: 6/18/2020

Mail To Address: 5110 S YALE SUITE 525  
TULSA OK 74135-7485

Payment amount based on \$9,683.00 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 4.779422% among all providers. Patient Initials: G.B.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1967

SIGNATURE CREMATION & FUNERAL CARE

Office of State Finance VendorID: 0000435518

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/10/2020 108389713 \$1,309.28 6/6/2019 ACCT: A.M.

Payment amount based on \$1,309.28 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/13/2020

Mail To Address: 447 SW 89TH  
OKLAHOMA CITY OK 73137

Patient Initials: A.M.

Patient Birth Year: 1988

DRUMRIGHT DENTAL CENTER, PLLC

Office of State Finance VendorID: 0000390374

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

7/8/2020 108441703 \$2,023.00 08/11/16 ACCT: C.D.S.

Payment amount based on \$2,528.75 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/11/2020

Mail To Address: 1226 W. BROADWAY  
DRUMRIGHT OK 74030-5826  
PO BOX 712

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Initials: C.S.

Patient Birth Year: 1979

MOBILE MEDICAL SOLUTIONS

Office of State Finance VendorID:

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$516.00 11/19/19 - 03/24/20 ACCT: 0000003652

Payment amount based on \$645.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 6/30/20 Expected to be mailed by 7/14/20

Mail To Address: 2760 WASHINGTON DR. STE 110  
NORMAN OK 73069

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Initials: K.M.

Patient Birth Year: 1969

CAH ACQUISITION COMPANY

Office of State Finance VendorID:

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$1,503.10 02/08/20 ACCT: 512435

Payment amount based on patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 9/15/20 Expected to be mailed by 9/29/20

Mail To Address: 1322 KLABZUBA AVE  
PRAGUE OK 74864-1090

Total Bills exceed maximum award. Payment is prorated at 94.78569% among all providers. Patient Initials: K.C.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1989

INTEGRITY FUNERAL SERVICE

Office of State Finance VendorID: 0000330975

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/3/2020 108427429 \$3,596.94 03/28/20 ACCT: D.G. Payment amount based on \$3,596.94 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 6/6/2020 *Patient Initials:* D.G.  
*Mail To Address:* 410 E. TRUDGEON *Patient Birth Year:* 1991  
 HENRYETTA OK 74437

4/14/2020 108406852 \$2,855.00 07/19/19 ACCT: E.D.R. Payment amount based on \$2,855.00 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 4/17/2020 *Patient Initials:* E.R.  
*Mail To Address:* 410 E. TRUDGEON *Patient Birth Year:* 1982  
 HENRYETTA OK 74437

**MELISSA D RATTERREE, MS LPC**

*Office of State Finance VendorID:* 0000483924

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
6/18/2020	108434697	\$260.00	10/7/19 - 12/11/2019	ACCT: J.G.	
<i>Approx Mail Date:</i> 6/21/2020					<i>Patient Initials:</i> J.G.
<i>Mail To Address:</i> 1133 N MAIN STREET					<i>Patient Birth Year:</i> 1979
MUSKOGEE OK 74401-4441					

**MERCY CLINIC OKLAHOMA COMMUNITIES INC**

*Office of State Finance VendorID:* 0000334305

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/9/2020	108353612	\$387.20	09/21/18	ACCT: OK1232676220	
<i>Approx Mail Date:</i> 1/12/2020					<i>Patient Initials:</i> J.A.
<i>Mail To Address:</i> PO BOX 776066					<i>Patient Birth Year:</i> 1972
CHICAGO IL 60677-6066					

**MERCY OKLAHOMA**

*Office of State Finance VendorID:* 0000334305

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
4/22/2020	108410363	\$6.40	5/10/2019	ACCT: 55000017577	
<i>Approx Mail Date:</i> 4/25/2020					<i>Patient Initials:</i> B.C.
<i>Mail To Address:</i> PO BOX 776066					<i>Patient Birth Year:</i> 1995
CHICAGO IL 60677-6066					
1/9/2020	108353613	\$1,354.80	09/21/18	ACCT: 5300115803101	
<i>Approx Mail Date:</i> 1/12/2020					<i>Patient Initials:</i> J.A.
<i>Mail To Address:</i> PO BOX 776066					<i>Patient Birth Year:</i> 1972
CHICAGO IL 60677-6066					

**SUMMIT MEDICAL CENTER**

*Office of State Finance VendorID:* 0000411039

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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8/17/2020 108459282 \$2,300.39 12/02/19 - 12/03/19 ACCT: V000071040 - \$38.50;  
V000070945 - \$2,261.89

Payment amount based on \$2,875.50 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/20/2020

Patient Initials: R.J.

Mail To Address: PO BOX 269083  
OKLAHOMA CITY OK 73126

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2000

**BISHOP FUNERAL SERVICE AND CREMATORY**

Office of State Finance VendorID: 0000320939

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

7/8/2020 108441718 \$2,076.89 02/11/20 ACCT: C.P.

Payment amount based on \$2,076.89 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/11/2020

Patient Initials: C.P.

Mail To Address: CHANEY HARKINS FUNERAL HOME 528 S 3RD  
MCALESTER OK 74501

Patient Birth Year: 1982

6/3/2020 108427423 \$4,529.75 6/29/19 ACCT: J.N.

Payment amount based on \$4,529.75 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/6/2020

Patient Initials: J.N.

Mail To Address: CHANEY HARKINS FUNERAL HOME 528 S 3RD  
MCALESTER OK 74501

Patient Birth Year: 2002

**FOCUS INSTITUTE**

Office of State Finance VendorID: 0000318959

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/3/2020 108427413 \$380.00 02/28/20 - 03/24/20 ACCT: C.L.

Payment amount based on \$475.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/6/2020

Patient Initials: C.L.

Mail To Address: 920 S. MAIN  
STILLWATER OK 74074

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1990

**EMERGENCY SERVICES OF OKLAHOMA**

Office of State Finance VendorID: 0000325378

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$755.20 10/03/18 ACCT: 601410980

Payment amount based on \$944.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/8/20 Expected to be mailed by 10/22/20

Patient Initials: E.P.

Mail To Address: PO BOX 636758  
CINCINNATI OH 45263

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1974

10/1/2020 108482935 \$71.52 04/27/19 ACCT: 0238175760-71579479

Payment amount based on \$89.40 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/4/2020

Patient Initials: J.N.

Mail To Address: PO BOX 636758  
CINCINNATI OH 45263

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1972

8/26/2020 108464028 \$640.80 03/01/20 ACCT: 82000670-51-1869

Payment amount based on \$801.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2020

Patient Initials: T.E.

Mail To Address: PO BOX 636758  
CINCINNATI OH 45263

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1985

\$39.02 11/24/16 ACCT: 178356876/51

Approx Mail Date: Requested from OSF 1/9/18 Expected to be mailed by 1/23/18

Mail To Address: PO BOX 636758  
CINCINNATI OH 45263

Payment amount based on \$1,086.00 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 4.49173% among all providers. Patient Initials: R.L.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1963

7/28/2020 108449454 \$1,388.80 04/27/19 ACCT: 69510764-51-1869

Approx Mail Date: 7/31/2020

Mail To Address: PO BOX 636758  
CINCINNATI OH 45263

Payment amount based on \$1,736.00 patient balance after insurance and insurance adjustments.

Patient Initials: A.N.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1992

7/28/2020 108449453 \$883.42 10/07/17 ACCT: 45764882-51-1869

Approx Mail Date: 7/31/2020

Mail To Address: PO BOX 636758  
CINCINNATI OH 45263

Payment amount based on \$3,371.00 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 32.75809% among all providers. Patient Initials: M.S.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1958

6/3/2020 108427407 \$1,570.40 04/27/19 05/20/19 ACCT: 71579479511869

Approx Mail Date: 6/6/2020

Mail To Address: PO BOX 636758  
CINCINNATI OH 45263

Payment amount based on \$1,963.00 patient balance after insurance and insurance adjustments.

Patient Initials: J.N.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1972

NORMAN EMERGENCY PHYSICIANS

Office of State Finance VendorID: 0000325378

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

7/27/2020 108448956 \$96.35 9/23/2018 ACCT:0222180265-43958126

Payment amount based on \$120.44 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/30/2020

Mail To Address: PO BOX 740022  
CINCINNATI OH 45274-0022

Patient Initials: H.H.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1989

INTEGRIS SOUTHWEST EMERGENCY PHYSICIANS

Office of State Finance VendorID: 0000332815

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

10/16/2020 108490831 \$150.76 9/28/2019 ACCT: 72367813-51-5102

Payment amount based on \$188.45 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/19/2020

Mail To Address: PO BOX 740022  
CINCINNATI OH 45274-0022

Patient Initials: C.F.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1983

7/27/2020 108449014 \$15.92 12/31/2018 ACCT:75045196-51-1862

Payment amount based on \$19.90 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/30/2020

Mail To Address: PO BOX 740022  
CINCINNATI OH 45274-0022

Patient Initials: C.M.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1991

EMERGENCY SERVICES OF OKLAHOMA

Office of State Finance VendorID: 0000325378

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

5/19/2020	108421285	\$845.60	10/18/18	ACCT: 65820414-51-3014	Payment amount based on \$1,057.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> O.P.
	<i>Approx Mail Date:</i> 5/22/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1995
	<i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274-0022					
3/18/2020	108394494	\$1,228.80	11/14/18	ACCT: 44669014-51-51000	Payment amount based on \$1,536.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.G.
	<i>Approx Mail Date:</i> 3/21/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1978
	<i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274-0022					
3/10/2020	108389594	\$18.73	9/26/2018	ACCT: 45257988-51-1864	Payment amount based on \$23.41 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> P.S.
	<i>Approx Mail Date:</i> 3/13/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1953
	<i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274-0022					

**MERCY HOSPITAL ADA EMERGENCY PHYSICIANS**

*Office of State Finance VendorID:* 0000325378

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		\$559.20	09/28/19	ACCT: 5000009523997	Payment amount based on \$699.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> B.S.
	<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 2002
	<i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274-0022					

**RADIOLOGY ASSOCIATES OF EASTERN OKLAHOMA**

*Office of State Finance VendorID:* 0000334138

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
10/16/2020	108490824	\$204.80	10/25/2018	ACCT: 62833	Payment amount based on \$256.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.G.
	<i>Approx Mail Date:</i> 10/19/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1993
	<i>Mail To Address:</i> 3433 NW 56TH ST #C40 OKLAHOMA CITY OK 73112-4455					
5/19/2020	108421365	\$8.58	01/14/19	ACCT: 56586	Payment amount based on \$22.95 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.E.
	<i>Approx Mail Date:</i> 5/22/2020				Total Bills exceed maximum award. Payment is prorated at 46.74856% among all providers.	<i>Patient Birth Year:</i> 1997
	<i>Mail To Address:</i> 3330 NW 56TH ST SUITE 206 OKLAHOMA CITY OK 73112					

**ANGELA CASE**

*Office of State Finance VendorID:* 0000506880

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
5/20/2020	108421968	\$172.00	01/09/20 - 02/26/20	ACCT: M.C.	Payment amount based on \$215.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.C.
	<i>Approx Mail Date:</i> 5/23/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 2000
	<i>Mail To Address:</i> 8104 NW 32ND ST BETHANY OK 73008					



5/19/2020	108421382	\$624.50	05/27/19 - 07/01/19	ACCT: 59378904-47-1835	Payment amount based on \$6,886.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 11.33645% among all providers. <b>Patient Initials:</b> R.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1995
	<i>Approx Mail Date:</i> 5/22/2020				
	<i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274				
3/9/2020	108388795	\$779.20	09/23/19	ACCT: 79461540-47-8011	Payment amount based on \$974.00 patient balance after insurance and insurance adjustments. <b>Patient Initials:</b> S.J. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1964
	<i>Approx Mail Date:</i> 3/12/2020				
	<i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274				
1/29/2020	108366109	\$644.80	11/04/17	ACCT: 68996418/47	Payment amount based on \$806.00 patient balance after insurance and insurance adjustments. <b>Patient Initials:</b> A.B. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1989
	<i>Approx Mail Date:</i> 2/1/2020				
	<i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274				
1/14/2020	108356576	\$55.25	5/23/2019	ACCT: 77600828-47-8011	Payment amount based on \$69.06 patient balance after insurance and insurance adjustments. <b>Patient Initials:</b> J.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1974
	<i>Approx Mail Date:</i> 1/17/2020				
	<i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274				

**LITTLE RIVER EMERGENCY PHYSICIANS**

*Office of State Finance VendorID:* 0000340903

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/18/2020	108394534	\$1,611.20	03/31/19	ACCT: 274014584	Payment amount based on \$2,014.00 patient balance after insurance and insurance adjustments. <b>Patient Initials:</b> P.J. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1993
	<i>Approx Mail Date:</i> 3/21/2020				
	<i>Mail To Address:</i> PO BOX 98543 LAS VEGAS NV 89193-8543				
3/10/2020	108389661	\$18.81	12/21/2018	ACCT: MIO11588431	Payment amount based on \$23.51 patient balance after insurance and insurance adjustments. <b>Patient Initials:</b> L.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1969
	<i>Approx Mail Date:</i> 3/13/2020				
	<i>Mail To Address:</i> PO BOX 98543 LAS VEGAS NV 89193-8543				

**MILLER CHIROPRACTIC CLINIC PLLC**

*Office of State Finance VendorID:* 0000500928

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/21/2020	108360163	\$319.09	08/29/18 - 04/18/18	ACCT: 2168	Payment amount based on \$1,098.14 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 36.32196% among all providers. <b>Patient Initials:</b> R.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1968
	<i>Approx Mail Date:</i> 1/24/2020				
	<i>Mail To Address:</i> JESSE G. MILLER MUSKOGEE OK 74401			300 W SHAWNEE, SUITE B	

**MISSION ON WHEELS**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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\$100.00 09/21/19 FUNERAL REIMBURSEMENT

Payment amount based on \$100.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 6/30/20 Expected to be mailed by 7/14/20

Patient Initials: T.M.

Mail To Address: 118 1/2 S. MAIN  
ALTUS OK 73521

Patient Birth Year: 1989

**SPECTRUM IMAGING PLLC**

Office of State Finance VendorID: 0000333221

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/21/2020 108360131 \$27.90 04/13/18 - 04/14/18 ACCT: 181047

Payment amount based on \$96.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/24/2020

Total Bills exceed maximum award. Payment is prorated at 36.32196% among all providers. Patient Initials: R.H.

Mail To Address: PO BOX 21228 DEPT 130  
TULSA OK 74121-1228

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1968

**NORTHSTAR ANESTHESIA OF OKLAHOMA, PLLC**

Office of State Finance VendorID: 0000367028

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

5/19/2020 108421334 \$105.60 11/05/18 ACCT: 0001112574

Payment amount based on \$132.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/22/2020

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: O.P.

Mail To Address: PO BOX 224747  
DALLAS TX 75222-4747

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1995

**CRONUS PLLC**

Office of State Finance VendorID: 0000376256

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/18/2020 108394480 \$281.12 07/18/19 - 08/15/19 ACCT: 148290001 - \$64.64;  
148290002 - \$38.13; 148290003 - \$28.60; 148290004 - \$44.90;  
148290005 - \$104.85

Payment amount based on \$3,775.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/21/2020

Total Bills exceed maximum award. Payment is prorated at 9.308603% among all providers. Patient Initials: S.S.

Mail To Address: PO BOX 4769  
TULSA OK 74159-0769

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1984

**CHARLES P. BOGIE III MD PHD INC PC**

Office of State Finance VendorID: 0000361812

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/15/2020 108432675 \$63.60 1/22/20 ACCT: 10338775

Payment amount based on \$79.50 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/18/2020

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: J.N.

Mail To Address: 5622 N PORTLAND, SUITE 200  
OKLAHOMA CITY OK 73112

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1979

**INTEGRITY PATHWAYS**

Office of State Finance VendorID: 0000327604

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

4/14/2020 108406853 \$380.00 12/2/18, 2/12/19, AND 2/19/19 ACCT: D.C.

Payment amount based on \$475.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 4/17/2020

Patient Initials: D.F.

Mail To Address: 814 WEST OKMULGEE MUSKOGEE OK 74403

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1979

NELSON MONUMENT COMPANY, LLC

Office of State Finance VendorID: 0000345306

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/15/2020 108432756 \$4,524.51 3/22/20 ACCT: J.M.

Payment amount based on \$4,524.51 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/18/2020

Patient Initials: J.M.

Mail To Address: 5305 N DIVISION ST. GUTHRIE OK 73044

Patient Birth Year: 1989

GARY DANIELS

Office of State Finance VendorID: 0000510464

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/12/2020 108456716 \$200.00 12-30-2019 FUNERAL REIMBURSEMENT

Payment amount based on \$200.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/15/2020

Patient Initials: M.D.

Mail To Address: 542 BETHANY FORD RD NORTH WILKESBOR NC 28659

Patient Birth Year: 1957

ANGELA L. ZAYAS, LCSW

Office of State Finance VendorID: 0000405223

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

4/22/2020 108410270 \$623.97 07/3/19 - 12/30/19 ACCT: BIZHAR

Payment amount based on \$1,124.85 patient balance after insurance and insurance adjustments.

Approx Mail Date: 4/25/2020

Patient Initials: D.G.

Mail To Address: 3908 N. PENIEL BETHANY OK 73008 SUITE 420

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1972

TRUEPARTNERS COMANCHE EMERGENCY

Office of State Finance VendorID: 0000481420

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/18/2020 108394628 \$723.86 06/18/19 AND 07/06/19 ACCT: TCE60163 - \$361.93; TCE62785 - \$361.93

Payment amount based on \$2,578.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/21/2020

Total Bills exceed maximum award. Payment is prorated at 35.09816% among all providers.

Patient Initials: M.B.

Mail To Address: PO BOX 24802 FORT WORTH TX 76124-1802

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1979

1/14/2020 108356587 \$1,031.20 10/28/2018 ACCT: TCE26129

Payment amount based on \$1,289.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/17/2020

Patient Initials: B.H.

Mail To Address: PO BOX 24802 FORT WORTH TX 76124-1802

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1996

**THERAWEST**

*Office of State Finance VendorID:* 0000380277

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
10/1/2020	108482984	\$1,127.30	01/21/20 - 04/10/20	ACCT: 5814	Payment amount based on \$1,409.13 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 10/4/2020			<i>Patient Initials:</i> K.T.
		<i>Mail To Address:</i> PO BOX 86 CLINTON OK 73601			<i>Patient Birth Year:</i> 1998

**HAYES FUNERAL HOME**

*Office of State Finance VendorID:* 0000477265

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
4/7/2020	108403257	\$871.60	12/20/19	ACCT: J.M.	Payment amount based on \$871.60 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 4/10/2020			<i>Patient Initials:</i> J.M.
		<i>Mail To Address:</i> 117 E NOBLE GUTHRIE OK 73044			<i>Patient Birth Year:</i> 1989

**PARIS REGIONAL MEDICAL CENTER**

*Office of State Finance VendorID:* 0000243703

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
9/18/2020	108476170	\$11,496.80	08/07/18	ACCT: PR0001221504	Payment amount based on \$14,371.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 9/21/2020			<i>Patient Initials:</i> J.A.
		<i>Mail To Address:</i> 865 DESHONG DR. PARIS TX 75460			<i>Patient Birth Year:</i> 1998
3/18/2020	108394562	\$5,642.99	05/21/18	ACCT: PR0001204947	Payment amount based on \$7,950.40 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 3/21/2020			Total Bills exceed maximum award. Payment is prorated at 88.72186% among all providers. <i>Patient Initials:</i> C.S.
		<i>Mail To Address:</i> 865 DESHONG DR. PARIS TX 75460			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1994

**SAMARITAN EMS**

*Office of State Finance VendorID:* 0000391090

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
5/19/2020	108421379	\$199.07	07/24/18	ACCT: 6229	Payment amount based on \$1,532.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 5/22/2020			Total Bills exceed maximum award. Payment is prorated at 16.24235% among all providers. <i>Patient Initials:</i> J.W.
		<i>Mail To Address:</i> PO BOX 15764 DEL CITY OK 73155			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1988
2/21/2020	108379778	\$729.82	01/01/18	ACCT: 6849 - \$529.82; 6850 - \$200.00	Payment amount based on \$912.28 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 2/24/2020			<i>Patient Initials:</i> C.M.
		<i>Mail To Address:</i> PO BOX 15764 DEL CITY OK 73155			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1980

**INTEGRITY PATHWAYS**

*Office of State Finance VendorID:* 0000327604

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
6/18/2020	108434677	\$860.00	6/3/19 - 7/24/19	ACCT: E.A.	Payment amount based on \$1,075.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 6/21/2020					<i>Patient Initials:</i> E.M.
<i>Mail To Address:</i> 814 WEST OKMULGEE MUSKOGEE OK 74401					<i>Patient Birth Year:</i> 1996
		\$860.00	6/3/18 - 7/24/18	Counseling \$860.00	Payment amount based on \$1,075.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 1/23/20 Expected to be mailed by 2/6/20					<i>Patient Initials:</i> E.M.
<i>Mail To Address:</i> 814 WEST OKMULGEE MUSKOGEE OK 74401					<i>Patient Birth Year:</i> 1996
4/22/2020	108410349	\$360.00	8/30/2019-12/23/2019	ACCT: A.M.	Payment amount based on \$450.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/25/2020					<i>Patient Initials:</i> A.M.
<i>Mail To Address:</i> 814 WEST OKMULGEE MUSKOGEE OK 74401					<i>Patient Birth Year:</i> 1970

**WAGONER COMMUNITY HOSPITAL**

*Office of State Finance VendorID:* 0000272747

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
4/14/2020	108406915	\$644.80	07/19/19	ACCT: 4433525A14254	Payment amount based on \$806.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/17/2020					<i>Patient Initials:</i> A.K.
<i>Mail To Address:</i> PO BOX 18159 BELFAST ME 04915-4076					<i>Patient Birth Year:</i> 1980

**WAGONER HOSPITAL AUTHORITY**

*Office of State Finance VendorID:* 0000272747

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
7/27/2020	108449028	\$120.00	5/10/2019	ACCT: 501230A14254	Payment amount based on \$150.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 7/30/2020					<i>Patient Initials:</i> H.K.
<i>Mail To Address:</i> 1200 W. CHEROKEE ST. WAGONER OK 74467					<i>Patient Birth Year:</i> 2008

**INTEGRIS COMMUNITY HOSPITAL DEL CITY**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$1,515.90	9/28/2019	ACCT: 602308885	Payment amount based on \$1,894.88 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 10/9/20 Expected to be mailed by 10/23/20					<i>Patient Initials:</i> C.F.
<i>Mail To Address:</i> PO BOX 734476 DALLAS TX 75373-4476					<i>Patient Birth Year:</i> 1983

**MCALESTER MEDICAL SERVICES LLC**

*Office of State Finance VendorID:* 0000399886

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/18/2020	108394538	\$2,304.06		ACCT: 00230307784 - \$1,867.30; 00230304295 - \$402.96; 00230316718 - \$33.80	Payment amount based on \$5,060.23 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/21/2020					Total Bills exceed maximum award. Payment is prorated at 56.91587% among all providers. <i>Patient Initials:</i> T.W.
<i>Mail To Address:</i> PO BOX 25885 OKLAHOMA CITY OK 73125-0885					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1976

**ALLIANCE HEALTH CLINTON**

*Office of State Finance VendorID:* 0000406751

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
9/18/2020	108476101	\$3,045.05	05/18/17	ACCT: 2118614	Payment amount based on \$3,806.31 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 9/21/2020					<i>Patient Initials:</i> A.S.
<i>Mail To Address:</i> 100 N. 30TH ST. CLINTON OK 73601-1569					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1960
4/29/2020	108413342	\$6,539.50	04/24/17	ACCT: 2117191	Payment amount based on \$8,174.38 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 5/2/2020					<i>Patient Initials:</i> P.W.
<i>Mail To Address:</i> 100 N. 30TH ST. CLINTON OK 73601-1569					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1991

**MCALESTER MEDICAL SERVICES**

*Office of State Finance VendorID:* 0000289661

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/9/2020	108388738	\$461.60	08/29/19	ACCT: 0023000000036061	Payment amount based on \$577.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/12/2020					<i>Patient Initials:</i> R.H.
<i>Mail To Address:</i> P O BOX 25885 OKLAHOMA CITY OK 73125-0885					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1972

**MID-MICHIGAN FAMILY, LTD**

*Office of State Finance VendorID:* 0000504909

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
4/14/2020	108406870	\$240.00	12/3/2019-1/28/2020	ACCT: G.S.	Payment amount based on \$300.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/17/2020					<i>Patient Initials:</i> G.S.
<i>Mail To Address:</i> 615 E WISCONSIN STREET MT PLEASANT MI 48858					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 2006

**ST JOHN BROKEN ARROW**

*Office of State Finance VendorID:* 0000344580

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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3/10/2020 108389716 \$1,154.60 8/6/2019 ACCT: B0036311410

Payment amount based on \$1,443.25 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/13/2020

Patient Initials: L.C.

Mail To Address: DEPT 2752  
TULSA OK 74182-4900

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2000

**RIETTA MILLER, LCSW LLC**

Office of State Finance VendorID: 0000465023

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

9/4/2020 108469006 \$672.00 12/5/2018-11/20/2019 ACCT: G.G

Payment amount based on \$840.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/7/2020

Patient Initials: K.B.

Mail To Address: 1818 WEST LINDSEY ST.  
NORMAN OK 73069-4162

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1962

**ALLIANCEHEALTH MADILL**

Office of State Finance VendorID: 0000406752

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/29/2020 108365571 \$2,490.06 08/21/19 ACCT: 5100302

Payment amount based on \$3,112.58 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/1/2020

Patient Initials: K.J.

Mail To Address: PO BOX 742011  
ATLANTA GA 30384-2011

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1974

**BIGFORK VALLEY HOSPITAL**

Office of State Finance VendorID: 0000513447

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/27/2020 108464838 \$7,388.54 03/04/20 - 04/28/20 ACCT: V0315245 - \$862.02; V0315366 - \$2,433.84; V0315453 - \$1,070.96; V0315453 - \$294.72; V0315978 - \$1,169.88; V0315909 - \$1,169.88; V0315909 - \$988.96; V0315982 - \$146.32; V0316318 - \$294.72; V0316610 - \$127.12

Payment amount based on \$9,235.68 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/30/2020

Patient Initials: T.E.

Mail To Address: PO BOX 258  
BIGFORK MN 56628-0258

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1985

**SCENIC RIVERS HEALTH SERVICES**

Office of State Finance VendorID: 0000513448

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/27/2020 108464791 \$230.40 03/04/20 ACCT: 655921

Payment amount based on \$288.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/30/2020

Patient Initials: T.E.

Mail To Address: 20 5TH ST SE  
COOK MN 55723

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1985

**MEDICAL IMAGING NORTH**

*Office of State Finance VendorID:* 0000515030

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
9/23/2020	108478723	\$444.31	03/04/20 - 03/11/20	ACCT: 42986	Payment amount based on \$555.39 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 9/26/2020					<i>Patient Initials:</i> T.E.
<i>Mail To Address:</i> 1200 E 25TH STREET HIBBERING MN 55746-3897					<i>Patient Birth Year:</i> 1985

**LINDA MORGAN**

*Office of State Finance VendorID:* 0000510465

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/12/2020	108456733	\$300.00	12/30/2019	FUNERAL REIMBURSEMENT	Payment amount based on \$300.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Initials:</i> M.D.
<i>Mail To Address:</i> PO BOX 14554 KNOXVILLE TN 37914					<i>Patient Birth Year:</i> 1957

**VIRTUAL RADIOLOGIC PROF INC**

*Office of State Finance VendorID:* 0000384420

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/26/2020	108464224	\$814.40	04/11/18	ACCTI 4447417	Payment amount based on \$1,018.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 8/29/2020					<i>Patient Initials:</i> T.P.
<i>Mail To Address:</i> PO BOX 4246 CAROL STREAM IL 60197-4246					<i>Patient Birth Year:</i> 1987
8/12/2020	108456781	\$112.08	2/12/20	ACCT:16363980	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Initials:</i> M.S.
<i>Mail To Address:</i> PO BOX 4246 CAROL STREAM IL 60197-4246					<i>Patient Birth Year:</i> 1999
3/31/2020	108400259	\$140.00	05/24/19	ACCT: 14659455	Payment amount based on \$175.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/3/2020					<i>Patient Initials:</i> M.F.
<i>Mail To Address:</i> PO BOX 4246 CAROL STREAM IL 60197-4246					<i>Patient Birth Year:</i> 1992
3/18/2020	108394644	\$656.54	05/21/18	ACCT: 22641755	Payment amount based on \$925.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/21/2020					Total Bills exceed maximum award. Payment is prorated at 88.72186% among all providers. <i>Patient Initials:</i> C.S.
<i>Mail To Address:</i> PO BOX 4246 CAROL STREAM IL 60197-4246					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1994
3/10/2020	108389746	\$28.00	5/26/2018	ACCT: VRD5013235	Payment amount based on \$35.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/13/2020					<i>Patient Initials:</i> B.F.
<i>Mail To Address:</i> PO BOX 4246 CAROL STREAM IL 60197-4246					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1977

**OKLAHOMA INTERVENTIONAL SPINE & PAIN**

*Office of State Finance VendorID:* 0000311351

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/21/2020	108360179	\$17.26	01/27/18 - 01/28/18	ACCT: 7151	Payment amount based on \$254.86 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 8.465149% among all providers. <i>Patient Initials:</i> J.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1970
<i>Approx Mail Date:</i> 1/24/2020					
<i>Mail To Address:</i> 9308 S TOLEDO AVE TULSA OK 74137-2739					

**PAFFORD MEDICAL SERVICES INC**

*Office of State Finance VendorID:* 0000257242

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
9/18/2020	108476169	\$1,523.20	06/22/20	ACCT: 9182012738	Payment amount based on \$1,904.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> M.I. <i>Patient Birth Year:</i> 1971
<i>Approx Mail Date:</i> 9/21/2020					
<i>Mail To Address:</i> P O BOX 1120 HOPE AR 71802					
6/15/2020	108432779	\$1,235.20	01/28/20	ACCT: 114215	Payment amount based on patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> A.L. <i>Patient Birth Year:</i> 1978
<i>Approx Mail Date:</i> 6/18/2020					
<i>Mail To Address:</i> P O BOX 1120 HOPE AR 71802					
4/29/2020	108413395	\$1,235.20	12/30/2019	ACCT: 9182001087	Payment amount based on \$1,544.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> A.L. <i>Patient Birth Year:</i> 1978
<i>Approx Mail Date:</i> 5/2/2020					
<i>Mail To Address:</i> P O BOX 1120 HOPE AR 71802					
1/21/2020	108360188	\$66.03	12/15/17	ACCT: 73125	Payment amount based on \$975.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 8.465149% among all providers. <i>Patient Initials:</i> J.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1970
<i>Approx Mail Date:</i> 1/24/2020					
<i>Mail To Address:</i> P O BOX 1120 HOPE AR 71802					

**STATE UNIVERSITY OF IOWA**

*Office of State Finance VendorID:* 0000103681

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
10/1/2020	108482994	\$160.00	07/15/20	ACCT: M.O.6483815	Payment amount based on \$200.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> M.O. <i>Patient Birth Year:</i> N/A
<i>Approx Mail Date:</i> 10/4/2020					
<i>Mail To Address:</i> HOSPITAL DENTISTRY INSTITUTE IOWA CITY IA 52242					
105 JESSUP HALL					

**AIR EVAC LIFETEAM**

*Office of State Finance VendorID:* 0000020236

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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		<b>\$16,085.11</b>	09/08/19	ACCT: 0119028707A	Payment amount based on \$49,300.60 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20			Total Bills exceed maximum award. Payment is prorated at 40.78328% among all providers. <i>Patient Initials:</i> R.F.	
		<i>Mail To Address:</i> PO BOX 106 WEST PLAINS MO 65775			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1968	
<b>6/15/2020</b>	<b>108432632</b>	<b>\$1,803.26</b>	09/16/19	ACCT: 0119032194A	Payment amount based on \$47,162.18 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 6/18/2020			Total Bills exceed maximum award. Payment is prorated at 4.779422% among all providers. <i>Patient Initials:</i> G.B.	
		<i>Mail To Address:</i> PO BOX 106 WEST PLAINS MO 65775			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1967	
<b>5/19/2020</b>	<b>108421212</b>	<b>\$4,670.89</b>	05/27/19	ACCT: 300199190A	Payment amount based on \$51,502.99 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 5/22/2020			Total Bills exceed maximum award. Payment is prorated at 11.33645% among all providers. <i>Patient Initials:</i> R.W.	
		<i>Mail To Address:</i> PO BOX 106 WEST PLAINS MO 65775			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1995	
<b>4/22/2020</b>	<b>108410267</b>	<b>\$3,140.00</b>	12/16/17	ACCT: 30017796764A	Payment amount based on \$3,925.00 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 4/25/2020			Total Bills exceed maximum award. Payment is prorated at 11.33645% among all providers. <i>Patient Initials:</i> K.B.	
		<i>Mail To Address:</i> PO BOX 106 WEST PLAINS MO 65775			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 2001	
<b>3/18/2020</b>	<b>108394408</b>	<b>\$4,362.65</b>	05/21/18	ACCT: 30018849484A	Payment amount based on \$6,146.53 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 3/21/2020			Total Bills exceed maximum award. Payment is prorated at 88.72186% among all providers. <i>Patient Initials:</i> C.S.	
		<i>Mail To Address:</i> PO BOX 106 WEST PLAINS MO 65775			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1994	
<b>3/18/2020</b>	<b>108394409</b>	<b>\$9,048.86</b>	07/19/19	ACCT: 0119009068AA	Payment amount based on \$61,577.48 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 3/21/2020			Total Bills exceed maximum award. Payment is prorated at 18.36885% among all providers. <i>Patient Initials:</i> T.S.	
		<i>Mail To Address:</i> PO BOX 106 WEST PLAINS MO 65775			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1968	
<b>2/18/2020</b>	<b>108376556</b>	<b>\$20,000.00</b>	07/18/18	ACCT: 30018871770AA	Payment amount based on \$50,281.93 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 2/21/2020			Total Bills exceed maximum award. Payment is prorated at 49.71966% among all providers. <i>Patient Initials:</i> J.R.	
		<i>Mail To Address:</i> PO BOX 106 WEST PLAINS MO 65775			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1992	
<b>1/21/2020</b>	<b>108360017</b>	<b>\$2,849.54</b>	12/15/17	ACCT: 30017796692A	Payment amount based on \$42,077.46 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 1/24/2020			Total Bills exceed maximum award. Payment is prorated at 8.465149% among all providers. <i>Patient Initials:</i> J.S.	
		<i>Mail To Address:</i> PO BOX 106 WEST PLAINS MO 65775			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1970	
<b>1/21/2020</b>	<b>108360015</b>	<b>\$20,000.00</b>	05/20/16	ACCT: 30016600010A	Payment amount based on \$41,627.30 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 1/24/2020			Total Bills exceed maximum award. Payment is prorated at 60.05674% among all providers. <i>Patient Initials:</i> S.T.	
		<i>Mail To Address:</i> PO BOX 106 WEST PLAINS MO 65775			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1976	

1/21/2020 108360016 \$17,306.10 03/10/18 ACCT: 300188124650A  
*Approx Mail Date:* 1/24/2020  
*Mail To Address:* PO BOX 106  
WEST PLAINS MO 65775

Payment amount based on \$59,483.95 patient balance after insurance and insurance adjustments.  
Total Bills exceed maximum award. Payment is prorated at 36.36716% among all providers. *Patient Initials:* J.R.  
Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1975

TRUMAN MEDICAL CENTER DENTAL

*Office of State Finance VendorID:* 0000109680

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

8/27/2020 108464879 \$852.00 01/30/20 ACCT: 94733 Payment amount based on \$852.00 patient balance after insurance and insurance adjustments. *Patient Initials:* R.M.  
*Approx Mail Date:* 8/30/2020 *Patient Birth Year:* 1984  
*Mail To Address:* PO BOX 958396  
ST LOUIS MO 63195-8396

BRENDA DANIELS

*Office of State Finance VendorID:* 0000510466

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

8/12/2020 108456666 \$300.00 12/30/2019 FUNERAL REIMBURSEMENT Payment amount based on \$300.00 patient balance after insurance and insurance adjustments. *Patient Initials:* M.D.  
*Approx Mail Date:* 8/15/2020 *Patient Birth Year:* 1957  
*Mail To Address:* 14662 W BIG LAKE BLV  
MT. VERNON WA 98274

RAYMOND MC CAFFREY JR PHD

*Office of State Finance VendorID:* 0000027291

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

3/19/2020 108395098 \$72.00 10/4/2019-10/28/2019 ACCT: 4629R1521 Payment amount based on \$90.00 patient balance after insurance and insurance adjustments. *Patient Initials:* R.G.  
*Approx Mail Date:* 3/22/2020 *Patient Birth Year:* 2010  
*Mail To Address:* 510 24TH AVE SW  
NORMAN OK 73069-5106

MARY ROBBINS VAN METER LPC, LADC

*Office of State Finance VendorID:* 0000504029

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

3/10/2020 108389622 \$1,040.00 12/19/2018-5/1/2019 ACCT: 27702-10043 Payment amount based on \$1,300.00 patient balance after insurance and insurance adjustments. *Patient Initials:* P.S.  
*Approx Mail Date:* 3/13/2020 *Patient Birth Year:* 1953  
*Mail To Address:* 6900 NORTH CLASSEN  
OKLAHOMA CITY OK 73116-7210

STACEY SLIMP

*Office of State Finance VendorID:* 0000507957

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

6/25/2020 108438948 \$180.00 1/07/20 - 2/24/20 ACCT: S.S.

Payment amount based on \$225.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/28/2020

Patient Initials: R.C.

Mail To Address: 899 MAYFIELD RD  
SAND SPRINGS OK 74063

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1981

COUNSELING SOLUTIONS OF NORMAN, LLC

Office of State Finance VendorID: 0000279347

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

2/12/2020 108373719 \$256.00 11/21/2019-1/23/2020 ACCT: G.M.

Payment amount based on \$320.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/15/2020

Patient Initials: G.M.

Mail To Address: MICHELLE BEALL, M.ED, PLC 913 CARACARA DRIVE  
NORMAN OK 73072

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2004

JANIE SWEETEN, LPC

Office of State Finance VendorID: 0000257348

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/29/2020 108365797 \$400.00 10/08/19 - 11/25/19 ACCT: B.P.

Payment amount based on \$500.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/1/2020

Patient Initials: B.P.

Mail To Address: PO BOX 450067 GROVE OK 74345-0067

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1986

AMY HAMPTON

Office of State Finance VendorID: 0000475852

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

2/12/2020 108373658 \$560.00 11/5/2019-1/21/2020 ACCT: K.N.

Payment amount based on \$700.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/15/2020

Patient Initials: K.N.

Mail To Address: 1627 OAKWOOD DR NORMAN OK 73069

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1993

KEN HANEY, LPC

Office of State Finance VendorID: 0000467129

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$80.00 2/29/2020 ACCT: A.E.

Payment amount based on \$100.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/16/20 Expected to be mailed by 10/30/20

Patient Initials: A.E.

Mail To Address: 4037 SW 50TH, SUITE 115 AMARILLO TX 79110

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1995

3/10/2020 108389644 \$240.00 12/9/2019-1/24/2020 ACCT: A.E.

Payment amount based on \$300.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/13/2020

Patient Initials: A.E.

Mail To Address: 4037 SW 50TH, SUITE 115 AMARILLO TX 79110

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1995

**KIAMICHI FAMILY MEDICAL CENTER**

*Office of State Finance VendorID:* 0000217173

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/10/2020	108389646	\$55.20	12/10/18, 12/18/18 & 2/11/19	ACCT: 270408 - \$18.40; 271282 - \$18.40; 276952 - \$18.40	Payment amount based on \$69.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/13/2020					<i>Patient Initials:</i> L.T.
<i>Mail To Address:</i> 500 MAIN STREET BATTIEST OK 74722-0180					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1969

**MIRAMAR GARCIA COHN, PHD**

*Office of State Finance VendorID:* 0000318634

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
4/22/2020	108410366	\$677.81	05/28/19 - 2/5/20	ACCT: R.H.	Payment amount based on \$847.26 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/25/2020					<i>Patient Initials:</i> D.L.
<i>Mail To Address:</i> 8908 S. YALE AVE, STE 403 TULSA OK 74137					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1998

**INTEGRIS HEALTH-EDMOND**

*Office of State Finance VendorID:* 0000332506

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/9/2020	108388712	\$1,809.53	09/23/19 - 09/24/19	ACCT: 2597766	Payment amount based on \$2,261.91 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/12/2020					<i>Patient Initials:</i> S.J.
<i>Mail To Address:</i> PO BOX 960423 OKLAHOMA CITY OK 73196					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1964

**RED CANYON COUNSELING PLLC**

*Office of State Finance VendorID:* 0000495706

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/9/2020	108353645	\$128.00	11/12/19 AND 11/18/19	ACCT: D.L.	Payment amount based on \$160.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 1/12/2020					<i>Patient Initials:</i> J.L.
<i>Mail To Address:</i> PO BOX 64 FREEDOM OK 73842					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1995

**HILLCREST HOSPITAL CLAREMORE**

*Office of State Finance VendorID:* 0000332101

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/12/2020	108456719	\$2,993.68	03/05/20	ACCT: 957930	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Initials:</i> H.R.
<i>Mail To Address:</i> DEPT 2805 TULSA OK 74182					<i>Patient Birth Year:</i> 1992

5/19/2020 108421305 \$1,411.02 03/03/18 - 01/06/20 ACCT: 1079612

Payment amount based on \$2,920.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/22/2020

Patient Initials: B.P.

Mail To Address: DEPT 2805  
TULSA OK 74182

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1943

HILLCREST HOSPITAL CLAREMORE

Office of State Finance VendorID: 0000332101

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

10/1/2020 108482945 \$4,392.98 03/10/20 ACCT: 2189089

Payment amount based on patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/4/2020

Patient Initials: D.E.

Mail To Address: 1202 N MUSKOGEE PL  
CLAREMORE OK 74017-3058

Patient Birth Year: 1980

9/18/2020 108476132 \$7,763.59 06/22/20 ACCT: 2266127

Payment amount based on \$9,704.49 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/21/2020

Patient Initials: M.I.

Mail To Address: 1202 N MUSKOGEE PL  
CLAREMORE OK 74017-3058

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1971

6/15/2020 108432728 \$9,089.32 01/28/20 AND 01/30/20 ACCT: 956064

Payment amount based on patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/18/2020

Patient Initials: A.L.

Mail To Address: 1202 N MUSKOGEE PL  
CLAREMORE OK 74017-3058

Patient Birth Year: 1978

4/29/2020 108413368 \$4,094.67 12/30/2019 ACCT: 956064

Payment amount based on \$5,118.34 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/2/2020

Patient Initials: A.L.

Mail To Address: 1202 N MUSKOGEE PL  
CLAREMORE OK 74017-3058

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1978

HILLCREST HOSPITAL SOUTH

Office of State Finance VendorID: 0000332100

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/12/2020 108456648 \$489.72 6/12/19 ACCT: 1827744

Payment amount based on \$612.15 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/15/2020

Patient Initials: J.A.

Mail To Address: DEPT 1241  
TULSA OK 74182-0001

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1996

3/31/2020 108400141 \$7,034.78 04/20/19 ACCT: 20002645935

Payment amount based on \$8,793.48 patient balance after insurance and insurance adjustments.

Approx Mail Date: 4/3/2020

Patient Initials: J.B.

Mail To Address: DEPT 1241  
TULSA OK 74182-0001

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1989

ST. ANTHONY SHAWNEE HOSPITAL

Office of State Finance VendorID: 0000342737

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

4/22/2020 108410393 \$396.46 06/14/17 ACCT: 24171651706

Payment amount based on \$495.58 patient balance after insurance and insurance adjustments.

Approx Mail Date: 4/25/2020

Patient Initials: J.W.

Mail To Address: 1102 W. MACARTHUR SHAWNEE OK 74804

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1975

HEARTSWORTH SENIOR LIVING, LLC

Office of State Finance VendorID:

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$3.41 05/11/18 - 07/13/18 ACCT: 37039

Payment amount based on \$50.43 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 1/14/20 Expected to be mailed by 1/28/20

Total Bills exceed maximum award. Payment is prorated at 8.465149% among all providers. Patient Initials: J.S.

Mail To Address: 1200 W CANADIAN AVE VINITA OK 74301-2702

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1970

OSH AAI PLLC

Office of State Finance VendorID: 0000370285

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/19/2020 108395089 \$397.40 8/22/2018 ACCT: 180265

Payment amount based on \$2,125.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/22/2020

Total Bills exceed maximum award. Payment is prorated at 23.37621% among all providers. Patient Initials: Y.T.

Mail To Address: 6839 S. CANTON AVE. TULSA OK 74136-3402

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1979

OKLAHOMA EM PHYS PART PLLC

Office of State Finance VendorID: 0000365680

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$2,152.00 05/05/20 ACCT: 14X67478091

Payment amount based on patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/15/20 Expected to be mailed by 10/29/20

Patient Initials: R.W.

Mail To Address: PO BOX 975213 DALLAS TX 75397-5213

Patient Birth Year: 2001

10/16/2020 108490808 \$1,487.84 5-24-18 ACCT: 14X49706323

Payment amount based on \$1,859.80 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/19/2020

Patient Initials: N.F.

Mail To Address: PO BOX 975213 DALLAS TX 75397-5213

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1990

ALLIANCE HEALTH DURANT

Office of State Finance VendorID: 0000054038

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/12/2020 108456749 \$5,533.74 01/25/20 ACCT: 6547956

Payment amount based on patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/15/2020

Patient Initials: G.G.

Mail To Address: PO BOX 281463 ATLANTA GA 30384-1463

Patient Birth Year: 1969

**COLONIAL MORTUARY**

*Office of State Finance VendorID:* 0000507348

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

6/18/2020 108434728 \$7,500.00 03/07/20 ACCT: J.H.

Payment amount based on \$8,698.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 6/21/2020

*Patient Initials:* J.H.

*Mail To Address:* 1600 SAYERS ST  
LUFKIN TX 75904

*Patient Birth Year:* 1991

**CELERITY PROSTHETICS LLC**

*Office of State Finance VendorID:*

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

\$4,183.96 04/30/20 ACCT: 157

Payment amount based on \$13,247.31 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 8/11/20 Expected to be mailed by 8/25/20

Total Bills exceed maximum award. Payment is prorated at 39.47931% among all providers. *Patient Initials:* E.R.

*Mail To Address:* 8625 S. WALKER AVE  
OKLAHOMA CITY OK 73139

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1974

**MERCY HOSPITAL ADA INC**

*Office of State Finance VendorID:* 0000365877

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

\$266.89 09/08/19 ACCT: 507000317465

Payment amount based on \$818.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

Total Bills exceed maximum award. Payment is prorated at 40.78328% among all providers. *Patient Initials:* R.F.

*Mail To Address:* PO BOX 776066  
CHICAGO IL 60677-6066

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1968

**MERCY HOSPITAL ADA**

*Office of State Finance VendorID:* 0000365877

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

\$8,676.22 09/28/19 ACCT: 507000322408

Payment amount based on \$10,845.28 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

*Patient Initials:* B.S.

*Mail To Address:* PO BOX 504292  
ST LOUIS MO 63150-4292

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 2002

**R. JAY CHRISTENSEN, MD**

*Office of State Finance VendorID:* 0000517090

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

\$97.34 12/20/19 TGP18542

Payment amount based on \$121.68 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 8/6/20 Expected to be mailed by 8/20/20

*Patient Initials:* D.J.

*Mail To Address:* 5415 MYSTIC PLACE  
OKLAHOMA CITY OK 73150

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1974

**MERCY HOSPITAL KINGFISHER**

*Office of State Finance VendorID:* 0000372693

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
7/28/2020	108449500	\$482.82	10/10/15 AND 10/18/15	ACCT: 511151990015 - \$146.08; 511151210048 - \$336.74	Payment amount based on \$603.53 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 7/31/2020					<i>Patient Initials:</i> R.C.
<i>Mail To Address:</i> 1000 HOSPITAL DRIVE KINGFISHER OK 73750					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 2000

**ADAMS CREST FUNERAL HOME**

*Office of State Finance VendorID:* 0000399896

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/31/2020	108400139	\$4,118.00	12/30/19	ACCT: J.L	Payment amount based on \$4,118.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/3/2020					<i>Patient Initials:</i> J.L.
<i>Mail To Address:</i> 1916 S SHERIDAN TULSA OK 74112					<i>Patient Birth Year:</i> 1996
3/9/2020	108388612	\$3,490.00		ACCT: J.W.F.	Payment amount based on \$3,490.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/12/2020					<i>Patient Initials:</i> J.F.
<i>Mail To Address:</i> 1916 S SHERIDAN TULSA OK 74112					<i>Patient Birth Year:</i> 1992

**FUNERAL CONSULTING UR EXCELLENCY**

*Office of State Finance VendorID:* 0000503448

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
2/26/2020	108382287	\$1,461.00	12/18/2019	ACCT: R.S.	Payment amount based on \$1,461.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 2/29/2020					<i>Patient Initials:</i> R.S.
<i>Mail To Address:</i> 8191 BRIGHTON AVE EDMOND OK 73034					<i>Patient Birth Year:</i> 2003
2/24/2020	108380617	\$1,461.00	12/18/19	ACCT: C.P.P.	Payment amount based on \$1,461.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 2/27/2020					<i>Patient Initials:</i> C.P.
<i>Mail To Address:</i> 8191 BRIGHTON AVE EDMOND OK 73034					<i>Patient Birth Year:</i> 1983

**MICHELINE CHRISMAN**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$1,938.75	7/22/2019-7/29/2020	ACCT: K.W.	Payment amount based on \$2,423.44 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 10/16/20 Expected to be mailed by 10/30/20					<i>Patient Initials:</i> K.W.
<i>Mail To Address:</i> 1225 W MAIN STREET, SUITE 102 NORMAN OK 73069					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1990

**CAVANAL HILL EMERG PHYS, LLC**

*Office of State Finance VendorID:* 0000410665

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
10/1/2020	108482912	\$635.20	03/10/20	ACCT: 1000185043075LAR	Payment amount based on patient balance after insurance and insurance adjustments.  <i>Patient Initials:</i> D.E. <i>Patient Birth Year:</i> 1980
	<i>Approx Mail Date:</i> 10/4/2020				
	<i>Mail To Address:</i> PO BOX 99009 LAS VEGAS NV 89193				
6/15/2020	108432670	\$1,558.40	01/28/20 AND 01/30/20	ACCT: LAR1000182616609 - \$598.40; LAR1000182791630 - \$960.00	Payment amount based on patient balance after insurance and insurance adjustments.  <i>Patient Initials:</i> A.L. <i>Patient Birth Year:</i> 1978
	<i>Approx Mail Date:</i> 6/18/2020				
	<i>Mail To Address:</i> PO BOX 99009 LAS VEGAS NV 89193				
5/28/2020	-108413339	(\$6,660.27)	12/30/2019	ACCT: LAKR1000181131070 **VOID OF ORIGINAL CHECK ISSUED IN WRONG AMOUNT**	Payment amount based on (\$8,325.34) patient balance after insurance and insurance adjustments.  <i>Patient Initials:</i> A.L. <i>Patient Birth Year:</i> 1978
	<i>Approx Mail Date:</i> 5/31/2020				
	<i>Mail To Address:</i> PO BOX 99009 LAS VEGAS NV 89193			Acceptance of payment may require a provider write-off. EOB will accompany payment.	
5/28/2020	108425732	\$1,330.40	12/30/2019	ACCT: LAKR1000181131070	Payment amount based on \$1,663.00 patient balance after insurance and insurance adjustments.  <i>Patient Initials:</i> A.L. <i>Patient Birth Year:</i> 1978
	<i>Approx Mail Date:</i> 5/31/2020				
	<i>Mail To Address:</i> PO BOX 99009 LAS VEGAS NV 89193			Acceptance of payment may require a provider write-off. EOB will accompany payment.	
4/29/2020	108413339	\$6,660.27	12/30/2019	ACCT: LAKR1000181131070 **VOIDED. WRONG AMOUNT IN ERROR**	Payment amount based on \$8,325.34 patient balance after insurance and insurance adjustments.  <i>Patient Initials:</i> A.L. <i>Patient Birth Year:</i> 1978
	<i>Approx Mail Date:</i> 5/2/2020				
	<i>Mail To Address:</i> PO BOX 99009 LAS VEGAS NV 89193			Acceptance of payment may require a provider write-off. EOB will accompany payment.	

**LILES VISION CLINIC**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$63.20	10/12/17	ACCT: 45781	Payment amount based on \$79.00 patient balance after insurance and insurance adjustments.  <i>Patient Initials:</i> B.D. <i>Patient Birth Year:</i> 1982
	<i>Approx Mail Date:</i> Requested from OSF 3/4/20 Expected to be mailed by 3/18/20				
	<i>Mail To Address:</i> 208 MORROW STREET SOUTH MENA AR 71953-4395			Acceptance of payment may require a provider write-off. EOB will accompany payment.	

**CROSSWAY MEDICAL CLINIC W MEMORIAL PLLC**

*Office of State Finance VendorID:* 0000404573

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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9/18/2020 108476109 \$317.59 09/30/19 - 10/14/19 ACCT: 264692552

Approx Mail Date: 9/21/2020

Mail To Address: 609 W MEMORIAL RD  
OKLAHOMA CITY OK 73114

Payment amount based on \$1,766.61 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers. Patient Initials: S.G.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1983

GILLISPIE COUNSELING

Office of State Finance VendorID: 0000379921

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/25/2020 108438875 \$144.00 02/12/20 - 03/23/20 ACCT:1045

Payment amount based on \$180.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/28/2020

Patient Initials: R.N.

Mail To Address: 23 N 8TH  
DUNCAN OK 73533

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1958

3/10/2020 108389604 \$96.00 12/5/2019 & 1/16/2020 ACCT: R.N.

Payment amount based on \$120.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/13/2020

Patient Initials: R.N.

Mail To Address: 23 N 8TH  
DUNCAN OK 73533

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1958

LIFEGUARD AMBULANCE SERVICE

Office of State Finance VendorID:

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$807.53 2/17/17 ACCT: 465007345

Payment amount based on \$1,009.41 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 6/12/20 Expected to be mailed by 6/26/20

Patient Initials: M.P.

Mail To Address: P.O. BOX 277  
BIRMINGHAM AL 35201-0277

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1984

EMPOWERED BY CHOICE

Office of State Finance VendorID: 0000511170

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$660.00 5/18/20-8/18/20 ACCT:90837

Payment amount based on \$825.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/16/20 Expected to be mailed by 10/30/20

Patient Initials: M.W.

Mail To Address: 212 N. MAIN STREET SUITE 207  
SAND SPRINGS OK 74063

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1990

8/26/2020 108464030 \$840.00 ACCT: I.F.

Payment amount based on patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2020

Patient Initials: I.F.

Mail To Address: 212 N. MAIN STREET SUITE 207  
SAND SPRINGS OK 74063

Patient Birth Year: 1974

PANHANDLE COUNSELING & HEALTH CENTER

Office of State Finance VendorID: 0000382018

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/21/2020 108462145 \$144.00 11/07/2019 ACCT: 18394

Payment amount based on \$180.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/24/2020

Patient Initials: L.C.

Mail To Address: 3247 HIGHWAY 54  
GUYMON OK 73942

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1998

NUNLEY'S FUNERAL HOME

Office of State Finance VendorID: 0000088120

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

9/25/2020 108480205 \$7,500.00 6/24/20 ACCOUNT: M.L.

Payment amount based on \$7,500.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/28/2020

Patient Initials: M.L.

Mail To Address: 3 NW BOIS D'ARC  
IDABEL OK 74745

Patient Birth Year: 1991

EMERGENCY PHYSICIANS

Office of State Finance VendorID: 0000401844

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/12/2020 108456708 \$180.99 2/15/2019 ACCT:55442324-56-5602

Payment amount based on \$226.24 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/15/2020

Patient Initials: K.B.

Mail To Address: PO BOX 638568  
CINCINNATI OH 45263

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1968

EMERGENCY PHYS OF MID- AMERICA

Office of State Finance VendorID: 0000401844

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

9/18/2020 108476121 \$228.49 01/23/20 ACCT: 57280124-56-56002

Payment amount based on \$1,271.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/21/2020

Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers.

Patient Initials: S.G.

Mail To Address: PO BOX 638568  
CINCINNATI OH 46263-8568

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1983

9/18/2020 108476120 \$102.66 06/20/19 ACCT: 66751230-56-56002

Payment amount based on \$128.33 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/21/2020

Patient Initials: B.L.

Mail To Address: PO BOX 638568  
CINCINNATI OH 46263-8568

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1994

6/15/2020 108432715 \$1,384.00 12/12/19 ACCT: 76970329-56-5616

Payment amount based on \$1,730.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/18/2020

Patient Initials: J.N.

Mail To Address: PO BOX 638568  
CINCINNATI OH 46263-8568

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1979

3/9/2020 108388684 \$648.00 09/22/19 ACCT: 79440918-56-56002

Payment amount based on \$810.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/12/2020

Patient Initials: A.B.

Mail To Address: PO BOX 638568  
CINCINNATI OH 46263-8568

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1990

**INNOVATIONS DENTISTRY**

*Office of State Finance VendorID:*

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

**\$763.20** 1/30/20-3/5/20 ACCT: 5675

Payment amount based on \$954.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 10/9/20 Expected to be mailed by 10/23/20

*Patient Initials:* V.B.

*Mail To Address:* 14617 S MEMORIAL DR  
BIXBY OK 74008

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1998

**WHINERY HUDDLESTON FUNERAL SERVICE**

*Office of State Finance VendorID:* 0000427567

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

3/10/2020 108389750 \$2,028.00 3/13/2019 ACCT: I.M.

Payment amount based on \$2,028.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 3/13/2020

*Patient Initials:* I.M.

*Mail To Address:* 6210 NW CACHE RD  
LAWTON OK 73505

*Patient Birth Year:* 1930

2/21/2020 108379809 \$7,500.00 10/06/19 ACCT: T.W.

Payment amount based on \$7,500.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 2/24/2020

*Patient Initials:* T.W.

*Mail To Address:* 6210 NW CACHE RD  
LAWTON OK 73505

*Patient Birth Year:* 1993

2/21/2020 108379810 \$7,500.00 11/19/19 ACCT: T.Z.J.

Payment amount based on \$7,681.30 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 2/24/2020

*Patient Initials:* T.J.

*Mail To Address:* 6210 NW CACHE RD  
LAWTON OK 73505

*Patient Birth Year:* 2000

**CHAMPION MINDS COUNSELING**

*Office of State Finance VendorID:* 0000505907

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

4/22/2020 108410291 \$1,360.00 12/19/19 - 01/31/20 ACCT: CB09261986

Payment amount based on \$1,700.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 4/25/2020

*Patient Initials:* C.B.

*Mail To Address:* 1622 SOUTH BOSTON  
TULSA OK 74119

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1986

**NATUS PELOTON**

*Office of State Finance VendorID:*

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

**\$72.21** 09/29/16 ACCT: 552397

Payment amount based on \$90.26 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 7/14/20 Expected to be mailed by 7/28/20

*Patient Initials:* L.C.

*Mail To Address:* PO BOX 3606  
CAROL STREAM IL 60132-3606

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* N/A

**SOUTHWEST MEDICAL CENTER***Office of State Finance VendorID:* 0000047783**Check Date: Check #: Amount: Service Date(s): Provider Reference:****Patient Identifiers**

2/18/2020 108376754 \$9,899.45 08/23/19 ACCT: V00011764594

Payment amount based on \$12,374.31 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 2/21/2020*Patient Initials:* E.O.*Mail To Address:* PO BOX 1340

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1971

LIBERAL KS 67905-1340

**DERFELT FUNERAL HOME***Office of State Finance VendorID:***Check Date: Check #: Amount: Service Date(s): Provider Reference:****Patient Identifiers**

\$7,500.00

10/28/19

ACCT: K.B.

Payment amount based on \$11,400.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 3/10/20 Expected to be mailed by 3/24/20*Patient Initials:* K.B.*Mail To Address:* P O BOX 367*Patient Birth Year:* 2008

GALENA KS 66739

**THOMAS M. ROGERS, D.D.S.***Office of State Finance VendorID:* 0000160867**Check Date: Check #: Amount: Service Date(s): Provider Reference:****Patient Identifiers**

6/3/2020 108427432 \$1,516.80 08/19/18 ACCT: 413014

Payment amount based on \$1,896.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 6/6/2020*Patient Initials:* A.G.*Mail To Address:* 2105 E. 21ST ST.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1998

TULSA OK 74114

**DJ ORTHOPEDICS, LLC***Office of State Finance VendorID:* 0000051064**Check Date: Check #: Amount: Service Date(s): Provider Reference:****Patient Identifiers**

6/15/2020 108432707 \$58.30 12/16/19 ACCT: D3266451

Payment amount based on \$198.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 6/18/2020

Total Bills exceed maximum award. Payment is prorated at 36.80409% among all providers.

*Patient Initials:* W.E.*Mail To Address:* PO BOX 515471

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1998

LOS ANGELES CA 90051-6771

**DJO, LLC***Office of State Finance VendorID:* 0000363264**Check Date: Check #: Amount: Service Date(s): Provider Reference:****Patient Identifiers**

10/16/2020 108490756 \$78.43 12/15/19 ACCT:D3344729

Payment amount based on \$98.04 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 10/19/2020*Patient Initials:* G.M.*Mail To Address:* 1430 DECISION ST.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1965

VISTA CA 92081-8553

**DONNIE SMITH**

*Office of State Finance VendorID:* 0000510265

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/11/2020	108455891	\$3,935.89	1/21/20	FUNERAL REIMBURSEMENT	Payment amount based on \$3,935.89 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 8/14/2020					<i>Patient Initials:</i> K.P.
<i>Mail To Address:</i> 10766e. 14TH PL TULSA OK 74128					<i>Patient Birth Year:</i> 2002

**VEOLA IVAN WADE**

*Office of State Finance VendorID:* 0000508694

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
7/27/2020	108449027	\$2,318.00	23/30/2016	FUNERAL REIMBURSEMENT	Payment amount based on \$2,318.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 7/30/2020					<i>Patient Initials:</i> S.M.
<i>Mail To Address:</i> 114516 PORTSIDE DR EUFALA OK 74432					<i>Patient Birth Year:</i> 1980

**DURANT HMA LLC**

*Office of State Finance VendorID:* 0000054038

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$2,754.43	05/05/20	ACCT: 6553870	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20					<i>Patient Initials:</i> R.W.
<i>Mail To Address:</i> ALLIANCEHEALTH DURANT ATLANTA GA 30384					<i>Patient Birth Year:</i> 2001

**ALLIANCE HEALTH WOODWARD**

*Office of State Finance VendorID:* 0000196936

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
7/27/2020	108449032	\$461.60	1/09/2020	ACCT: 254463801	Payment amount based on \$577.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 7/30/2020					<i>Patient Initials:</i> S.W.
<i>Mail To Address:</i> 900 17TH ST. WOODWARD OK 73801					<i>Patient Birth Year:</i> 1988
5/19/2020	108421407	\$7,465.50	10/18/18,11/2/18,11/5/18 , 11/19/18, 1/3/19- 1/18/19	ACCT: 247924601 - \$185.93; 247930601 - \$4,856.64; 248154101 - \$46.48; 2481541 - \$569.45; 247682601 - \$1,807.00	Payment amount based on \$9,331.88 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 5/22/2020					<i>Patient Initials:</i> O.P.
<i>Mail To Address:</i> 900 17TH ST. WOODWARD OK 73801					<i>Patient Birth Year:</i> 1995

**OU MEDICAL CENTER OF EDMOND**

*Office of State Finance VendorID:* 0000071817

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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8/12/2020 108456760 \$1,296.71 2/12/20 ACCT:100511808C

Payment amount based on patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/15/2020

Patient Initials: M.S.

Mail To Address: PO BOX 740782  
CINCINNATI OH 45274-0782

Patient Birth Year: 1999

OU MEDICAL CENTER

Office of State Finance VendorID: 0000071817

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		<b>\$18,731.67</b>	05/10/19 - 05/17/19	ACCT: 99900502555	
<p>Payment amount based on \$295,360.95 patient balance after insurance and insurance adjustments.            Total Bills exceed maximum award. Payment is prorated at 7.92745% among all providers. <b>Patient Initials:</b> A.M.            Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1977</p>					
<p><b>Approx Mail Date:</b> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20  <b>Mail To Address:</b> PO BOX 277362            ATLANTA GA 30384-7362</p>					
		<b>\$16,901.84</b>	05/28/20 - 07/27/20	ACCT: 99900704717 - \$15,946.58; 669896472 - \$312.15; 669978402 - \$312.15; 670389343 - \$330.95	
<p>Payment amount based on \$21,198.08 patient balance after insurance and insurance adjustments.            Total Bills exceed maximum award. Payment is prorated at 99.66612% among all providers. <b>Patient Initials:</b> J.B.            Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 2007</p>					
<p><b>Approx Mail Date:</b> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20  <b>Mail To Address:</b> PO BOX 277362            ATLANTA GA 30384-7362</p>					
		<b>\$17,987.97</b>	07/23/20 - 07/25/20 AND 08/06/20	ACCT: 99900561155 - \$2,462.21; 670548149 - \$15,525.76	
<p>Payment amount based on \$43,391.26 patient balance after insurance and insurance adjustments.            Total Bills exceed maximum award. Payment is prorated at 51.81909% among all providers. <b>Patient Initials:</b> M.V.            Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1975</p>					
<p><b>Approx Mail Date:</b> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20  <b>Mail To Address:</b> PO BOX 277362            ATLANTA GA 30384-7362</p>					
		<b>\$13,804.52</b>	02/22/20 - 02/23/20	ACCT: 99900540909	
<p>Payment amount based on \$47,769.75 patient balance after insurance and insurance adjustments.            Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> K.P.  <b>Patient Birth Year:</b> 1971</p>					
<p><b>Approx Mail Date:</b> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20  <b>Mail To Address:</b> PO BOX 277362            ATLANTA GA 30384-7362</p>					
		<b>\$3,883.28</b>	01/25/20	ACCT: 99900537368 - \$396.54; 668722335 - \$3,486.74	
<p>Payment amount based on patient balance after insurance and insurance adjustments.            Total Bills exceed maximum award. Payment is prorated at 99.66612% among all providers. <b>Patient Initials:</b> J.F.            Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1978</p>					
<p><b>Approx Mail Date:</b> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20  <b>Mail To Address:</b> PO BOX 277362            ATLANTA GA 30384-7362</p>					
		<b>\$2,134.13</b>	05/25/19	ACCT: 99900504371	
<p>Payment amount based on \$2,667.66 patient balance after insurance and insurance adjustments.            Total Bills exceed maximum award. Payment is prorated at 51.81909% among all providers. <b>Patient Initials:</b> T.J.            Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1973</p>					
<p><b>Approx Mail Date:</b> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20  <b>Mail To Address:</b> PO BOX 277362            ATLANTA GA 30384-7362</p>					
		<b>\$1,688.18</b>	06/30/19 - 07/03/19	ACCT: 99900509357	
<p>Payment amount based on \$2,110.23 patient balance after insurance and insurance adjustments.            Total Bills exceed maximum award. Payment is prorated at 99.66612% among all providers. <b>Patient Initials:</b> A.A.            Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 2004</p>					
<p><b>Approx Mail Date:</b> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20  <b>Mail To Address:</b> PO BOX 277362            ATLANTA GA 30384-7362</p>					

9/18/2020	108476168	\$15,165.71	02/08/20 - 02/10/20	ACCT: 99900539235	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 94.78569% among all providers. <b>Patient Initials:</b> K.C. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1989
	<b>Approx Mail Date:</b> 9/21/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
9/18/2020	108476162	\$8,484.86	03/22/20 - 04/22/20	ACCT: 99900544565	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 53.03037% among all providers. <b>Patient Initials:</b> C.C. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1987
	<b>Approx Mail Date:</b> 9/21/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
9/18/2020	108476163	\$16,000.00	06/17/18 - 06/20/18	ACCT: 66247070322	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> C.J. <b>Patient Birth Year:</b> 1963
	<b>Approx Mail Date:</b> 9/21/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
9/18/2020	108476165	\$11,751.19	07/13/19 - 08/20/19	ACCT: 99900511112	Payment amount based on \$715,180.28 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 2.053886% among all providers. <b>Patient Initials:</b> P.C. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1987
	<b>Approx Mail Date:</b> 9/21/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
9/18/2020	108476166	\$6,365.39	09/19/19 - 02/14/20	ACCT: 99900520628 - \$3,595.40; 667780588 - \$82.20; 667944409 - \$2,530.10; 668399833 - \$157.69	Payment amount based on \$35,408.54 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers. <b>Patient Initials:</b> S.G. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1983
	<b>Approx Mail Date:</b> 9/21/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
9/18/2020	108476164	\$20,000.00	11/01/18 - 11/03/18	ACCT: 99900480608	Payment amount based on \$58,897.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 42.44698% among all providers. <b>Patient Initials:</b> C.F. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1983
	<b>Approx Mail Date:</b> 9/21/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
9/18/2020	108476167	\$16,000.00	12/21/19 - 12/22/19	ACCT: 99900532584	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> D.M. <b>Patient Birth Year:</b> 1992
	<b>Approx Mail Date:</b> 9/21/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
9/18/2020	108476161	\$1,321.96	10/19/18	ACCT: 99900478956	Payment amount based on \$3,304.91 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> J.C. <b>Patient Birth Year:</b> 1989
	<b>Approx Mail Date:</b> 9/21/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
8/26/2020	108464145	\$12,879.24	03/02/20 - 03/13/20	ACCT: 99900542131	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 80.49522% among all providers. <b>Patient Initials:</b> S.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1975
	<b>Approx Mail Date:</b> 8/29/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				

8/26/2020	108464146	\$10,247.53	02/09/20 - 02/25/20	ACCT: 99900539273	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 64.04706% among all providers. <b>Patient Initials:</b> J.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1987
	<b>Approx Mail Date:</b> 8/29/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
8/26/2020	108464148	\$18,778.84	05/27/20 - 05/29/20	ACCT: 99900552473	Payment amount based on \$172,088.53 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 13.64039% among all providers. <b>Patient Initials:</b> S.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1996
	<b>Approx Mail Date:</b> 8/29/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
8/26/2020	108464144	\$17,627.21	02/08/20 AND 02/28/20	ACCT: 668890506 - \$362.08; 669023548 - \$17,265.13	Payment amount based on \$73,097.68 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 30.14325% among all providers. <b>Patient Initials:</b> J.N. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1962
	<b>Approx Mail Date:</b> 8/29/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
8/26/2020	108464143	\$17,563.58	02/05/20 - 04/28/20	ACCT: 99900538815 - \$17,545.79; 669055545 - \$5.67; 668996029 - \$6.02; 669302867 - \$6.10	Payment amount based on \$346,864.61 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 6.329409% among all providers. <b>Patient Initials:</b> A.K. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1997
	<b>Approx Mail Date:</b> 8/29/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
8/26/2020	108464141	\$16,000.00	03/10/19 - 03/12/19	ACCT: 99900495647	Payment amount based on \$16,000.00 patient balance after insurance and insurance adjustments. <b>Patient Initials:</b> S.W. <b>Patient Birth Year:</b> 1996
	<b>Approx Mail Date:</b> 8/29/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
8/26/2020	108464142	\$10,461.07	03/27/19 - 04/08/19	ACCT: 99900497540	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 65.3817% among all providers. <b>Patient Initials:</b> D.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1984
	<b>Approx Mail Date:</b> 8/29/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
8/26/2020	108464139	\$19,756.96	12/17/16 - 12/26/16	ACCT: 99900401424 - \$19,558.59; 657143295 - \$198.38	Payment amount based on \$39,913.40 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 61.87445% among all providers. <b>Patient Initials:</b> F.R. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1976
	<b>Approx Mail Date:</b> 8/29/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
8/26/2020	108464138	\$12,221.67	04/22/16 -05/05/16	ACCT: 99900378358	Payment amount based on \$38,696.44 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 39.47931% among all providers. <b>Patient Initials:</b> E.R. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1974
	<b>Approx Mail Date:</b> 8/29/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				
8/26/2020	108464140	\$10,537.75	08/19/18 - 08/20/18	ACCT: 99900472182	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 65.86092% among all providers. <b>Patient Initials:</b> R.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1964
	<b>Approx Mail Date:</b> 8/29/2020				
	<b>Mail To Address:</b> PO BOX 277362 ATLANTA GA 30384-7362				

\$19,098.90

11/06/16 - 02/26/19

ACCT: 99900397839 - \$11,700.78; 656860321 - \$90.87; 662708947 - \$5,147.89; 662765163 - \$273.58; 662778374 - \$5.29; 662783363 - \$1,077.51; 662867905 - \$6.05; 663876929 - \$508.40; 664983509 - \$6.41; 665081130 - \$276.51; 665081243 - \$5.60

Payment amount based on \$531,501.83 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 1/9/18 Expected to be mailed by 1/23/18

*Mail To Address:* PO BOX 277362  
ATLANTA GA 30384-7362

Total Bills exceed maximum award. Payment is prorated at 4.49173% among all providers.

*Patient Initials:* R.L.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1963

7/28/2020 108449525 \$18,259.23 02/22/20 ACCT: 99900540911

*Approx Mail Date:* 7/31/2020

*Mail To Address:* PO BOX 277362  
ATLANTA GA 30384-7362

Payment amount based on patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 45.40086% among all providers.

*Patient Initials:* T.J.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1968

7/28/2020 108449524 \$539.52 04/27/19 ACCT: 665788342

*Approx Mail Date:* 7/31/2020

*Mail To Address:* PO BOX 277362  
ATLANTA GA 30384-7362

Payment amount based on \$674.40 patient balance after insurance and insurance adjustments.

*Patient Initials:* A.N.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1992

7/28/2020 108449523 \$12,456.60 09/14/18 - 09/18/18 ACCT: 99900475102

*Approx Mail Date:* 7/31/2020

*Mail To Address:* PO BOX 277362  
ATLANTA GA 30384-7362

Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 77.85373% among all providers.

*Patient Initials:* D.R.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1977

7/28/2020 108449522 \$8,885.35 05/19/18 AND 07/12/18 ACCT: 662133164 - \$512.61; 662378578 - \$913.18; 1004842734 - \$7,459.56

*Approx Mail Date:* 7/31/2020

*Mail To Address:* PO BOX 277362  
ATLANTA GA 30384-7362

Payment amount based on \$23,822.74 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 46.62222% among all providers.

*Patient Initials:* C.J.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1986

7/28/2020 108449521 \$16,822.97 10/12/17 - 04/27/18 ACCT: 660027802 - \$344.94; 660041612 - \$13,409.64; 660073885 - \$89.89; 660096201 - \$68.27; 660183686 - \$1,571.60; 660157958 - \$170.74; 660485650 - \$774.86; 660528412 - \$170.74; 661037309 - \$190.26; 661037157 - \$32.04

*Approx Mail Date:* 7/31/2020

*Mail To Address:* PO BOX 277362  
ATLANTA GA 30384-7362

Payment amount based on \$64,194.00 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 32.75809% among all providers.

*Patient Initials:* M.S.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1958

7/28/2020 108449519 \$16,000.00 01/27/20 - 01/28/20 ACCT: 99900537712

*Approx Mail Date:* 7/31/2020

*Mail To Address:* PO BOX 277362  
ATLANTA GA 30384-7362

Payment amount based on patient balance after insurance and insurance adjustments.

*Patient Initials:* S.H.

*Patient Birth Year:* 2000

7/28/2020	108449520	\$7,789.60	07/30/17 AND 01/20/20	ACCT: 659256929 - \$7,661.55; 668426375 - \$128.05	Payment amount based on \$9,737.00 patient balance after insurance and insurance adjustments.		
							<i>Patient Initials:</i> L.N.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1991
<hr/>							
7/8/2020	108441747	\$4,397.71	01/04/19	ACCT: 9990489466	Payment amount based on \$5,497.14 patient balance after insurance and insurance adjustments.		
							<i>Patient Initials:</i> K.M.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1969
<hr/>							
6/15/2020	108432775	\$399.52	01/09/19 - 01/27/20	ACCT: 99900489494 - \$2.41; 666986204 - \$64.25; 667015575 - \$184.92; 668716700 - \$147.93	Payment amount based on \$1,654.48 patient balance after insurance and insurance adjustments.		
					Total Bills exceed maximum award. Payment is prorated at 30.18452% among all providers.		<i>Patient Initials:</i> B.D.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1999
<hr/>							
6/15/2020	108432776	\$19,370.11	03/01/20	ACCT: 99900541836	Payment amount based on patient balance after insurance and insurance adjustments.		
					Total Bills exceed maximum award. Payment is prorated at 44.03599% among all providers.		<i>Patient Initials:</i> C.A.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1998
<hr/>							
6/15/2020	108432774	\$8,687.02	11/14/18 - 01/04/19	ACCT: 99900481989	Payment amount based on \$25,959.71 patient balance after insurance and insurance adjustments.		
					Total Bills exceed maximum award. Payment is prorated at 41.82931% among all providers.		<i>Patient Initials:</i> D.R.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1989
<hr/>							
6/3/2020	108427472	\$1,759.60	09/10/19 and 09/17/19	ACCT: 667321891 - \$1,194.00; 667247374 - \$565.60	Payment amount based on \$2,199.50 patient balance after insurance and insurance adjustments.		
							<i>Patient Initials:</i> R.B.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1996
<hr/>							
5/19/2020	108421351	\$4,427.51	08/18/19 - 08/28/19	ACCT: 99900516073	Payment amount based on \$5,970.00 patient balance after insurance and insurance adjustments.		
					Total Bills exceed maximum award. Payment is prorated at 92.70327% among all providers.		<i>Patient Initials:</i> D.F.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1991
<hr/>							
5/19/2020	108421352	\$41.09	06/04/19	ACCT: 66156914	Payment amount based on \$168.54 patient balance after insurance and insurance adjustments.		
					Total Bills exceed maximum award. Payment is prorated at 30.47813% among all providers.		<i>Patient Initials:</i> J.W.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1988

5/19/2020	108421348	\$11,934.33	05/27/19 - 06/17/19	ACCT: 99900504775 - \$11,913.13; 666635871 - \$17.57; 666202418 - \$3.63	Payment amount based on \$131,592.44 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 11.33645% among all providers. <i>Patient Initials:</i> R.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1995
	<i>Approx Mail Date:</i> 5/22/2020				
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362				
5/19/2020	108421349	\$2,231.08	06/10/19 - 10/03/19	ACCT: 99900506743	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 13.94428% among all providers. <i>Patient Initials:</i> B.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1995
	<i>Approx Mail Date:</i> 5/22/2020				
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362				
5/19/2020	108421350	\$1,718.49	04/17/19 - 04/18/19	ACCT: 665703976 - \$51.26; 99900500044 - \$1,667.23	Payment amount based on \$2,148.11 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> T.W. <i>Patient Birth Year:</i> 1961
	<i>Approx Mail Date:</i> 5/22/2020				
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362				
5/19/2020	108421347	\$12,271.07	02/23/19 - 02/28/19	ACCT: 99900493895	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 76.69417% among all providers. <i>Patient Initials:</i> K.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1988
	<i>Approx Mail Date:</i> 5/22/2020				
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362				
5/19/2020	108421346	\$18,031.11	07/24/18 - 07/27/18	ACCT: 662853336	Payment amount based on \$138,766.25 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 16.24235% among all providers. <i>Patient Initials:</i> J.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1988
	<i>Approx Mail Date:</i> 5/22/2020				
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362				
5/19/2020	108421345	\$10,283.57	09/27/18 - 10/31/18	ACCT: 99900476560	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 64.27231% among all providers. <i>Patient Initials:</i> B.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1988
	<i>Approx Mail Date:</i> 5/22/2020				
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362				
3/31/2020	108400212	\$2,106.26	12/01/18 - 12/02/18	ACT: 99900483680	Payment amount based on \$2,632.83 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> A.A. <i>Patient Birth Year:</i> 1989
	<i>Approx Mail Date:</i> 4/3/2020				
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362				
3/31/2020	108400213	\$1,173.02	08/07/19 - 08/29/19	ACCT: 99900514649 - \$997.22; 666949220 - \$108.90; 666969765 - \$66.90	Payment amount based on \$1,466.26 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> N.S. <i>Patient Birth Year:</i> 1994
	<i>Approx Mail Date:</i> 4/3/2020				
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362				
3/31/2020	108400211	\$4,431.09	04/30/19 - 05/02/19	ACCT: 99900501503	Payment amount based on \$5,538.86 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> R.J. <i>Patient Birth Year:</i> 2003
	<i>Approx Mail Date:</i> 4/3/2020				
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362				

3/31/2020	108400210	\$1,706.09	10/27/19	ACCT: 99900525680	Payment amount based on \$2,132.61 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.S.
						<i>Patient Birth Year:</i> 1993
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
3/18/2020	108394560	\$6,702.14	08/04/19	ACCT: 99900514132	Payment amount based on \$8,377.68 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> T.M.
						<i>Patient Birth Year:</i> 1966
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
3/9/2020	108388760	\$2,081.72	09/24/19	ACCT: 667381948	Payment amount based on \$2,602.15 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> S.J.
						<i>Patient Birth Year:</i> 1964
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
3/9/2020	108388759	\$705.95	09/16/17	ACCT: 99900425412	Payment amount based on \$882.44 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.W.
						<i>Patient Birth Year:</i> 1996
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
3/9/2020	108388758	\$3,207.20	08/20/19, 09/24/19, AND 10/08/19	ACCT: 667017264 - \$2,932.40; 667373357 - \$142.60; 667389259 - \$132.20	Payment amount based on \$4,009.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> E.L.
						<i>Patient Birth Year:</i> 1981
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
2/18/2020	108376727	\$12,260.16	11/06/18 - 11/10/18	ACCT: 99900481167	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.A.
					Total Bills exceed maximum award. Payment is prorated at 76.626% among all providers.	<i>Patient Birth Year:</i> 1988
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
2/18/2020	108376726	\$18,465.02	09/16/17 - 10/09/17	ACCT: 99900425400 - \$18,405.91; 659847819 - \$6.31; 659958597 - \$52.79	Payment amount based on \$357,642.39 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> N.S.
					Total Bills exceed maximum award. Payment is prorated at 6.453729% among all providers.	<i>Patient Birth Year:</i> 1995
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
1/29/2020	108365994	\$10,825.95	02/21/18 - 04/10/18	ACCT: 99900444789	Payment amount based on \$234,957.53 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.V.
					Total Bills exceed maximum award. Payment is prorated at 5.75953% among all providers.	<i>Patient Birth Year:</i> 1988
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
1/29/2020	108365995	\$465.04	11/15/18	ACCT: 664043507	Payment amount based on \$581.30 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.C.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 2003

1/21/2020	108360185	\$7,994.70	10/05/19	ACCT: 99900522925	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 49.96687% among all providers. <b>Patient Initials:</b> S.K. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1988
<i>Approx Mail Date:</i> 1/24/2020					
<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					
1/21/2020	108360184	\$16,000.00	03/10/19	ACCT: 99900495623	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> L.P. <b>Patient Birth Year:</b> 1966
<i>Approx Mail Date:</i> 1/24/2020					
<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					
1/21/2020	108360183	\$1,070.36	03/10/18	ACCT: 661494028	Payment amount based on \$3,679.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 36.36716% among all providers. <b>Patient Initials:</b> J.R. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1975
<i>Approx Mail Date:</i> 1/24/2020					
<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					

**OKLAHOMA UNIVERSITY PATHOLOGY**

*Office of State Finance VendorID:* 0000185546

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/26/2020	108464147	\$16,000.00	04/13/20 - 04/15/20	ACCT: 99900546711	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> C.A. <b>Patient Birth Year:</b> 1989
<i>Approx Mail Date:</i> 8/29/2020					
<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048					

**HEALTHQUEST**

*Office of State Finance VendorID:* 0000409477

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/29/2020	108365764	\$956.00	11/15/14 - 05/04/19	ACCT: 65972 DOS: 11/15/14; 1/19/18, 4/28/18, 9/12/18, 10/27/18, 6/6/18, 1/26/19, 4/20/19, 5/4/19	Payment amount based on \$1,402.39 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 85.21182% among all providers. <b>Patient Initials:</b> C.P. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1984
<i>Approx Mail Date:</i> 2/1/2020					
<i>Mail To Address:</i> 58 TIMBER CREEK DRIVE CORDOVA TN 38018-4233					

**MCGEE EYE SURGERY CENTER**

*Office of State Finance VendorID:* 0000055044

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/12/2020	108456746	\$253.92	12/20/2019	ACCT:335433	Payment amount based on \$317.40 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> D.J. <b>Patient Birth Year:</b> 1974
<i>Approx Mail Date:</i> 8/15/2020					
<i>Mail To Address:</i> 1000 N LINCOLN BLVD STE 150 OKLAHOMA CITY OK 73104					

**LITTLE ROCK EYE CLINIC LLP**

*Office of State Finance VendorID:* 0000510319

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/12/2020	108456735	\$48.00	6/16/2017-8/07/2017	ACCT:84125803	Payment amount based on \$60.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Initials:</i> K.C.
<i>Mail To Address:</i> 201 EXECUTIVE COURT LITTLE ROCK AR 72205					<i>Patient Birth Year:</i> 1996

**MEDICAL CENTER OF PLANO**

*Office of State Finance VendorID:* 0000055069

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$1,217.29	05/16/20	ACCT: 995226101	Payment amount based on \$1,521.61 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20					<i>Patient Initials:</i> J.B.
<i>Mail To Address:</i> PO BOX 740782 CINCINNATI OH 45274-0782					<i>Patient Birth Year:</i> 1994

**SW MEDICAL CENTER**

*Office of State Finance VendorID:* 0000055101

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/10/2020	108389715	\$696.80	12/15/2016	ACCT: 200010171	Payment amount based on \$871.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/13/2020					<i>Patient Initials:</i> R.C.
<i>Mail To Address:</i> PO BOX 409179 ATLANTA GA 30384-9179					<i>Patient Birth Year:</i> 1985
1/14/2020	108356577	\$1,814.59	10/15/2018	ACCT: 201105616	Payment amount based on \$2,268.24 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 1/17/2020					<i>Patient Initials:</i> C.F.
<i>Mail To Address:</i> PO BOX 409179 ATLANTA GA 30384-9179					<i>Patient Birth Year:</i> 1982

**SOUTHWESTERN MEDICAL CENTER**

*Office of State Finance VendorID:* 0000055101

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/9/2020	108388798	\$729.92	01/12/18	ACCT: 200651859	Payment amount based on \$912.40 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/12/2020					<i>Patient Initials:</i> M.B.
<i>Mail To Address:</i> PO BOX 740757 CINCINNATI OH 45274					<i>Patient Birth Year:</i> 1985

**ALLIANCE HEALTH WOODWARD**

*Office of State Finance VendorID:* 0000196936

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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6/3/2020 108427351 \$4,315.40 02/16/20 ACCT: 255034901 Payment amount based on patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 6/6/2020 *Patient Initials:* B.E.  
*Mail To Address:* PO BOX 849110 *Patient Birth Year:* 1973  
DALLAS TX 75284

5/20/2020 108421934 \$587.60 03/26/20 ACCT:255599401 Payment amount based on patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 5/23/2020 *Patient Initials:* J.O.  
*Mail To Address:* PO BOX 849110 *Patient Birth Year:* 1996  
DALLAS TX 75284

**THREE RIVERS SURGERY CENTER**

*Office of State Finance VendorID:* 0000393057

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/18/2020	108394625	\$3,637.25	06/25/19	ACCT: 101158-3	
<i>Approx Mail Date:</i> 3/21/2020					<i>Patient Initials:</i> J.S.
<i>Mail To Address:</i> 3800 W OKMULGEE ST					<i>Patient Birth Year:</i> 1957
MUSKOGEE OK 74401-4933					

Payment amount based on \$4,546.56 patient balance after insurance and insurance adjustments.  
Acceptance of payment may require a provider write-off. EOB will accompany payment.

**TAHLEQUAH ORTHOPEDIC SURGERY**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$3,196.14	12/26/19 AND 02/19/20	ACCT: 5645-010004 - \$2,975.50; 5645-010002 - \$220.65	
<i>Approx Mail Date:</i> Requested from OSF 6/30/20 Expected to be mailed by 7/14/20					<i>Patient Initials:</i> T.F.
<i>Mail To Address:</i> 1373 E. BOONE ST. #3401					<i>Patient Birth Year:</i> 1974
TAHLEQUAH OK 74464					

Payment amount based on \$3,995.18 patient balance after insurance and insurance adjustments.  
Acceptance of payment may require a provider write-off. EOB will accompany payment.

**HOLT MEMORIAL CHAPEL**

*Office of State Finance VendorID:* 0000507208

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
6/15/2020	108432730	\$7,500.00	10/10/19	ACCT: V.D.M.	
<i>Approx Mail Date:</i> 6/18/2020					<i>Patient Initials:</i> V.M.
<i>Mail To Address:</i> 1904 CAPPS ROAD					<i>Patient Birth Year:</i> 1960
HARRISON AR 72601					

Payment amount based on \$11,888.45 patient balance after insurance and insurance adjustments.

**COOPER CLINIC, P.A.**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$96.00	5/12/2017-5/16/2017	ACCT:343066	
<i>Approx Mail Date:</i> Requested from OSF 8/6/20 Expected to be mailed by 8/20/20					<i>Patient Initials:</i> K.C.
<i>Mail To Address:</i> PO BOX 17025					<i>Patient Birth Year:</i> 1996
FORT SMITH AR 72917					

Payment amount based on \$120.00 patient balance after insurance and insurance adjustments.  
Acceptance of payment may require a provider write-off. EOB will accompany payment.

**WATKINS MONUMENTS, INC**

*Office of State Finance VendorID:* 0000335282

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
2/21/2020	108379807	\$1,173.85	12/19/19	ACCT: 58892	Payment amount based on \$1,173.85 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 2/24/2020					<i>Patient Initials:</i> B.W.
<i>Mail To Address:</i> 5505 ALMA HYW VAN BUREN AR 72956					<i>Patient Birth Year:</i> 1963

**LIFENET**

*Office of State Finance VendorID:* 0000055753

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$1,282.30	08/08/20	ACCT: 20-55565	Payment amount based on \$1,602.88 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20					<i>Patient Initials:</i> E.Q.
<i>Mail To Address:</i> 6225 ST. MICHAEL DR. TEXARKANA TX 75503					<i>Patient Birth Year:</i> 1989
		\$850.80	01/25/20	ACCT: 20-6358	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20					<i>Patient Initials:</i> J.F.
<i>Mail To Address:</i> 6225 ST. MICHAEL DR. TEXARKANA TX 75503					<i>Patient Birth Year:</i> 1978

**PAFFORD MEDICAL SVS**

*Office of State Finance VendorID:* 0000257242

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
6/15/2020	108432778	\$764.98	10/03/19	ACCT: 9181921497A	Payment amount based on \$1,594.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 6/18/2020					Total Bills exceed maximum award. Payment is prorated at 59.98875% among all providers. <i>Patient Initials:</i> Z.V.
<i>Mail To Address:</i> PO BOX 1120 HOPE AR 71802-1120					<i>Patient Birth Year:</i> 1992

**OPEN ARMS BEHAVIORAL HEALTH**

*Office of State Finance VendorID:* 0000361851

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/29/2020	108365991	\$722.76	09/04/19 - 10/16/19	ACCT: A.D. - \$350.09; A.R. - \$372.67	Payment amount based on \$903.45 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 2/1/2020					<i>Patient Initials:</i> A.D.
<i>Mail To Address:</i> 2215 NW CACHE RD, SUITE 107 LAWTON OK 73505					<i>Patient Birth Year:</i> 2007
1/29/2020	108365992	\$608.00	08/13/19 - 10/22/19	ACCT: K.D.	Payment amount based on \$760.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 2/1/2020					<i>Patient Initials:</i> K.D.
<i>Mail To Address:</i> 2215 NW CACHE RD, SUITE 107 LAWTON OK 73505					<i>Patient Birth Year:</i> 2009

**FAIRVIEW PHARMACY SERVICES**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		<b>\$93.48</b>	04/22/20	ACCT: 00000212535	Payment amount based on \$116.85 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 8/11/20 Expected to be mailed by 8/25/20					<i>Patient Initials:</i> T.E.
<i>Mail To Address:</i> NW 6184 MINNEAPOLIS MN 55485-6184					<i>Patient Birth Year:</i> 1985

**HILLCREST MEDICAL CENTER**

*Office of State Finance VendorID:* 0000056219

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		<b>\$2,196.80</b>	04/09/20	ACCT: 200045748661	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20					<i>Patient Initials:</i> J.S.
<i>Mail To Address:</i> DEPT 572 TULSA OK 74182					<i>Patient Birth Year:</i> 1976
<b>10/16/2020</b>	<b>108490780</b>	<b>\$1,622.41</b>	6/22/20	ACCT: 20004962050	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 10/19/2020					<i>Patient Initials:</i> G.F.
<i>Mail To Address:</i> DEPT 572 TULSA OK 74182					<i>Patient Birth Year:</i> 1992
<b>6/15/2020</b>	<b>108432727</b>	<b>\$20,000.00</b>	12/18/19 - 02/13/20	ACCT: 20003933849	Payment amount based on \$483,228.91 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 5.17353% among all providers.
<i>Approx Mail Date:</i> 6/18/2020					<i>Patient Initials:</i> R.H.
<i>Mail To Address:</i> DEPT 572 TULSA OK 74182					<i>Patient Birth Year:</i> 1986
<b>3/9/2020</b>	<b>108388710</b>	<b>\$7,074.91</b>	03/12/19	ACCT: 20002443878	Payment amount based on \$8,843.64 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/12/2020					<i>Patient Initials:</i> M.W.
<i>Mail To Address:</i> DEPT 572 TULSA OK 74182					<i>Patient Birth Year:</i> 1989
<b>1/21/2020</b>	<b>108360123</b>	<b>\$17,129.77</b>	06/24/19	ACCT: 20002976794	Payment amount based on \$21,412.21 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 1/24/2020					<i>Patient Initials:</i> O.G.
<i>Mail To Address:</i> DEPT 572 TULSA OK 74182					<i>Patient Birth Year:</i> 1986
<b>1/21/2020</b>	<b>108360124</b>	<b>\$19,952.32</b>	09/22/19 - 12/09/19	ACCT: 20003452317 - \$15,528.38; 20003711947 - \$4,423.95	Payment amount based on \$842,446.36 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 1/24/2020					<i>Patient Initials:</i> E.D.
<i>Mail To Address:</i> DEPT 572 TULSA OK 74182					<i>Patient Birth Year:</i> 1991

**ARLINGTON MEMORY GARDENS**

*Office of State Finance VendorID:* 0000201690

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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4/14/2020 108406800 \$3,293.70 04/01/20 ACCT: M.Y. Payment amount based on \$3,293.70 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 4/17/2020 *Patient Initials:* M.Y.  
*Mail To Address:* 3400 N MIDWEST BLVD *Patient Birth Year:* 1988  
 OKLAHOMA CITY OK 73141

**REED-CULVER FUNERAL HOME**

*Office of State Finance VendorID:* 0000201690

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

3/9/2020 108388784 \$7,500.00 11/15/19 ACCT: R.M. Payment amount based on \$8,326.65 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 3/12/2020 *Patient Initials:* R.M.  
*Mail To Address:* ALDERWOODS GROUP, INC 117 WEST DELAWARE *Patient Birth Year:* 1979  
 TAHLEQUAH OK 74464

**MOORE'S SOUTHLAWN CHAPEL**

*Office of State Finance VendorID:* 0000056132

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

\$3,181.42 08/03/20 ACCT: D.M. Payment amount based on \$3,181.42 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* Requested from OSF 10/8/20 Expected to be mailed by 10/22/20 *Patient Initials:* D.M.  
*Mail To Address:* 9350 E 51ST ST *Patient Birth Year:* 1977  
 TULSA OK 74145-9031

**MOORE'S ROSEWOOD CHAPEL**

*Office of State Finance VendorID:* 0000056132

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

6/3/2020 108427453 \$5,144.33 03/13/20 ACCT: J.S. Payment amount based on \$5,144.33 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 6/6/2020 *Patient Initials:* J.S.  
*Mail To Address:* 2570 S HARVARD *Patient Birth Year:* 1954  
 TULSA OK 74114-4661

6/3/2020 108427452 \$4,053.14 03/13/20 ACCT: B.S. Payment amount based on \$4,053.14 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 6/6/2020 *Patient Initials:* B.S.  
*Mail To Address:* 2570 S HARVARD *Patient Birth Year:* 1954  
 TULSA OK 74114-4661

**PEOPLE'S CO-OPERATIVE FUNERAL HOME**

*Office of State Finance VendorID:* 0000209954

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

4/7/2020 108403269 \$4,463.20 08/15/19 ACCT: R.E.T. Payment amount based on \$4,463.20 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 4/10/2020 *Patient Initials:* R.T.  
*Mail To Address:* PO BOX 146 *Patient Birth Year:* 1986  
 LONE WOLF OK 73655

**SMITH & KERNKE FUNERAL DIR.**

*Office of State Finance VendorID:* 0000056165

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		<b>\$7,500.00</b>	07/24/20	ACCT: B.S.	Payment amount based on \$9,518.96 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 10/8/20 Expected to be mailed by 10/22/20					<i>Patient Initials:</i> B.S.
<i>Mail To Address:</i> 1401 NW 23RD ST OKLAHOMA CITY OK 73106-3619					<i>Patient Birth Year:</i> 1981

**JACKSON COUNTY MEMORIAL HOSPITAL**

*Office of State Finance VendorID:* 0000056211

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/31/2020	108400187	<b>\$2,983.39</b>	10/21/19 - 10/31/19	ACCT: J00011540295 - \$504.62; J00011561314 - \$2,282.96; F0058815 - \$106.22; AN023104 - \$89.60	Payment amount based on \$3,729.24 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/3/2020					<i>Patient Initials:</i> K.T.
<i>Mail To Address:</i> PO BOX 8190 ALTUS OK 73522-8190					<i>Patient Birth Year:</i> 1998
3/31/2020	108400186	<b>\$166.92</b>	06/15/19	ACCT: J0011144829	Payment amount based on \$208.65 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/3/2020					<i>Patient Initials:</i> L.M.
<i>Mail To Address:</i> PO BOX 8190 ALTUS OK 73522-8190					<i>Patient Birth Year:</i> 1987
3/10/2020	108389627	<b>\$960.30</b>	11/3/2018	ACCT: J00010450284	Payment amount based on \$1,200.38 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/13/2020					<i>Patient Initials:</i> B.W.
<i>Mail To Address:</i> PO BOX 8190 ALTUS OK 73522-8190					<i>Patient Birth Year:</i> 1963

**JACKSON CO MEMORIAL HOSPITAL**

*Office of State Finance VendorID:* 0000056211

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
7/8/2020	108441722	<b>\$45.26</b>	10/28/19	ACCT: 2193060000OR	Payment amount based on \$56.58 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 7/11/2020					<i>Patient Initials:</i> K.T.
<i>Mail To Address:</i> 1200 E PECAN ALTUS OK 73521					<i>Patient Birth Year:</i> 1998
1/29/2020	108365788	<b>\$394.64</b>	10/08/19	ACCT: 2192860067OR - \$226.40; 2192870195 FP - \$168.24	Payment amount based on \$493.30 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 2/1/2020					<i>Patient Initials:</i> T.K.
<i>Mail To Address:</i> 1200 E PECAN ALTUS OK 73521					<i>Patient Birth Year:</i> 1967

HILLCREST HEALTHCARE SYSTEM

Office of State Finance VendorID: 0000056219

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
5/19/2020	108421304	\$14,860.52	05/20/19 AND 05/27/19	ACCT: 20002801873 - \$12,607.02; 20002829636 - \$2,253.50	Payment amount based on \$18,575.65 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 5/22/2020 <i>Mail To Address:</i> DEPT 572 TULSA OK 74182					<i>Patient Initials:</i> J.C. <i>Patient Birth Year:</i> 1977
1/29/2020	108365777	\$2,376.02	12/26/18	ACCT: 20002037716	Payment amount based on \$2,970.03 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 2/1/2020 <i>Mail To Address:</i> DEPT 572 TULSA OK 74182					<i>Patient Initials:</i> J.B. <i>Patient Birth Year:</i> 1992

MERCY HEALTH CENTER

Office of State Finance VendorID: 0000056220

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
8/12/2020	108456751	\$918.38	4/30/2019-7/6/2019	ACCT: 500008374467 - 66.27, ACCT:5000008389033 - 24.67 ACCT:53001535321 - 677235 ACCT:53001585214 - 150.08	Payment amount based on \$1,147.98 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 8/15/2020 <i>Mail To Address:</i> P O BOX 504292 ST LOUIS MO 63150-4292					<i>Patient Initials:</i> L.T. <i>Patient Birth Year:</i> 1961

MERCY OKLAHOMA

Office of State Finance VendorID: 0000056220

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		\$324.66	09/08/19	ACCT: 112542144	Payment amount based on \$995.08 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20 <i>Mail To Address:</i> PO BOX 505393 ST LOUIS MO 63150					Total Bills exceed maximum award. Payment is prorated at 40.78328% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> R.F. <i>Patient Birth Year:</i> 1968
10/1/2020	108482957	\$197.60	03/01/20	ACCT: 59000230806	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 10/4/2020 <i>Mail To Address:</i> PO BOX 505393 ST LOUIS MO 63150					<i>Patient Initials:</i> K.R. <i>Patient Birth Year:</i> 1989
8/12/2020	108456750	\$186.30	3/11/2019-9/4/2019	ACCT:102993153	Payment amount based on \$232.88 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 8/15/2020 <i>Mail To Address:</i> PO BOX 505393 ST LOUIS MO 63150					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> K.B. <i>Patient Birth Year:</i> 1968

7/28/2020	108449502	\$6,413.40	04/16/19	ACCT: 54000406168 - \$6,013.20; 500000285290 - \$400.20	Payment amount based on \$8,016.75 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> J.H.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1979
<hr/>						
7/28/2020	108449503	\$1,809.23	03/17/19	ACCT: 106203556	Payment amount based on \$4,658.54 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 48.54606% among all providers.	<i>Patient Initials:</i> S.L.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1996
<hr/>						
7/28/2020	108449501	\$115.20	10/31/18	ACCT: 5000007068640	Payment amount based on \$144.00 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> A.Q.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1993

**ST JOHN MEDICAL CENTER**

*Office of State Finance VendorID:* 0000056221

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
10/16/2020	108490834	\$821.73	8/29/2019	ACCT: J0077044311	Payment amount based on \$1,027.16 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> R.B.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1964
<hr/>						
10/1/2020	108482979	\$1,809.03	09/01/18 - 03/04/20	ACCT: 0076100764 - \$1,321.09; 0077408240 - \$29.80; 0075527365 - \$52.84; 0076100853 - \$8.41; 0076107050 - \$2.36; 0076191212 - \$4.40; 0099833670 - \$13.73; 00996566620 - \$307.54; 007717632 - \$61.43; 007542063 - \$2.82; 00781224663 - \$4.62	Payment amount based on \$143,801.29 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 1.572509% among all providers.	<i>Patient Initials:</i> D.B.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1973
<hr/>						
9/18/2020	108476197	\$20,000.00	01/30/17	ACCT: J0014376164	Payment amount based on \$54,185.69 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 46.13764% among all providers.	<i>Patient Initials:</i> L.M.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1961
<hr/>						
9/18/2020	108476198	\$13,509.36	03/10/20 - 03/11/20	ACCT: J0078235667	Payment amount based on \$16,886.70 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> J.S.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1988

8/26/2020	108464201	\$367.26	08/02/19 - 10/17/19	ACCT: J0077301429 - \$102.42; J0077075950 - \$82.42; J0076886792 - \$00; J077234799 - \$102.42	Payment amount based on \$459.08 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> B.T.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1988
8/26/2020	108464200	\$19,585.64	09/25/16	ACCT: J0007246481	Payment amount based on \$66,551.73 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> D.B.
					Total Bills exceed maximum award. Payment is prorated at 36.78649% among all providers.	<i>Patient Birth Year:</i> 1974
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
8/17/2020	108459278	\$80.00	03/01/20	ACCT: J0078181010	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> E.T.
						<i>Patient Birth Year:</i> 1983
7/28/2020	108449566	\$7,612.82	08/07/17	ACCT: B0035310592	Payment amount based on \$12,838.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> T.A.
					Total Bills exceed maximum award. Payment is prorated at 74.12385% among all providers.	<i>Patient Birth Year:</i> 1969
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
7/28/2020	108449565	\$1,091.20	01/02/19 - 01/05/19	ACCT: J0075625359	Payment amount based on \$1,364.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> L.P.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1949
6/15/2020	108432810	\$11,353.37	09/16/19 - 09/24/19	ACCT: J0077148809	Payment amount based on \$296,933.66 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> G.B.
					Total Bills exceed maximum award. Payment is prorated at 4.779422% among all providers.	<i>Patient Birth Year:</i> 1967
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
3/31/2020	108400239	\$4,404.69	07/05/19 AND 07/23/19	ACCT: J0076719772 - \$4,101.49; S007251379 - \$303.20	Payment amount based on \$5,505.86 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.K.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1990
3/31/2020	108400238	\$738.33	03/06/18 - 06/22/18	ACCT: J0094922640	Payment amount based on \$922.91 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> G.M.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1943

3/18/2020	108394603	\$15,346.41	08/30/19 - 09/25/19	ACCT:J0077084169 - \$1,330.58; J0077160647 - \$697.95; J0077189025 - \$3,117.02; J0077048677 - \$10,092.32; J0077040617 - \$108.54	Payment amount based on \$19,183.01 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> T.H.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1979
3/18/2020	108394600	\$18,569.24	05/28/19	ACCT: J0076487332	Payment amount based on \$68,410.21 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> D.A.
					Total Bills exceed maximum award. Payment is prorated at 33.92995% among all providers.	<i>Patient Birth Year:</i> 1982
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
3/18/2020	108394601	\$17,670.78	06/17/19 - 06/20/19	ACCT: J0076613931	Payment amount based on \$87,401.90 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.H.
					Total Bills exceed maximum award. Payment is prorated at 25.27231% among all providers.	<i>Patient Birth Year:</i> 1971
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
3/18/2020	108394602	\$5,573.84	07/19/19 - 07/23/19	ACCT: J0076796301	Payment amount based on \$37,929.96 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> T.S.
					Total Bills exceed maximum award. Payment is prorated at 18.36885% among all providers.	<i>Patient Birth Year:</i> 1968
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
3/18/2020	108394599	\$9,771.34	06/24/18 - 06/27/18	ACCT: J0098066900	Payment amount based on \$12,214.18 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> S.G.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1984
3/19/2020	108395111	\$360.93	7/18/2018-8/20/2018	ACCT: J0098670700	Payment amount based on \$6,287.78 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> Y.T.
					Total Bills exceed maximum award. Payment is prorated at 23.37621% among all providers.	<i>Patient Birth Year:</i> 1979
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
3/10/2020	108389717	\$1,067.60	5/16/2019-5/17/2019	ACCT: J0076433810	Payment amount based on \$1,334.50 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.V.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1987
1/21/2020	108360229	\$14,083.04	06/29/16 - 07/03/16	ACCT: J0087042740	Payment amount based on \$17,603.80 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.O.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1981

ST JOHN OWASSO

Office of State Finance VendorID: 0000056221

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

4/22/2020	108410394	\$2,756.02	02/20/27 AND 04/12/12	ACCT: W0022984578 - \$889.82; W00223045753 - \$1,866.20	Payment amount based on \$3,445.03 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/25/2020					<i>Patient Initials:</i> A.D.
<i>Mail To Address:</i> DEPT 2334 TULSA OK 74182-0001					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1980

**GREAT PLAINS REGIONAL MEDICAL CENTER**

*Office of State Finance VendorID:* 0000056222

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
8/26/2020	108464044	\$1,113.77	12-17-17	ACCT: V001124828	Payment amount based on \$1,392.21 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 8/29/2020					<i>Patient Initials:</i> S.S.	
<i>Mail To Address:</i> PO BOX 2339 ELK CITY OK 73648-2339					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1997
3/9/2020	108388698	\$2,881.08	09/01/18	ACCT: V001164557	Payment amount based on \$3,601.35 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 3/12/2020					<i>Patient Initials:</i> K.B.	
<i>Mail To Address:</i> PO BOX 2339 ELK CITY OK 73648-2339					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1999

**BASS BAPTIST HEALTH CENTER**

*Office of State Finance VendorID:* 0000072365

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
7/28/2020	108449469	\$11,740.61	07/19/15, 05/13/15, AND 05/23/15	ACCT: 6051670003 - \$1,994.74; 605167002 - \$3,576.13; 605167001 - \$6,169.74	Payment amount based on \$14,675.76 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 7/31/2020					<i>Patient Initials:</i> R.C.	
<i>Mail To Address:</i> PO BOX 960239 OKLAHOMA CITY OK 73196-0239					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 2000

**ST. MARY'S REGIONAL MEDICAL CENTER**

*Office of State Finance VendorID:* 0000078683

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
7/27/2020	108449016	\$1,070.70	12/29/2019	ACCT:000314499542	Payment amount based on \$1,338.38 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 7/30/2020					<i>Patient Initials:</i> B.B.	
<i>Mail To Address:</i> PO BOX 31001-0827 PASADENA CA 91110-0827					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1956

**SSM HEALTH**

*Office of State Finance VendorID:* 0000072415

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
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		<b>\$564.50</b>	09/15/17, 09/23/17, AND 09/26/17	ACCT: 40172583220 - \$129.73; 40172660064 - \$337.18; 40172692745 - \$97.58	Payment amount based on \$705.63 patient balance after insurance and insurance adjustments.		
	<b>Approx Mail Date:</b>	Requested from OSF 10/8/20 Expected to be mailed by 10/22/20				<b>Patient Initials:</b>	R.P.
	<b>Mail To Address:</b>	ST ANTHONY HOSPITAL CHICAGO IL 60677-6323		PO BOX 776323	Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1975
		<b>\$1,474.14</b>	2/15/2019	ACCT: 40190462234	Payment amount based on \$1,842.68 patient balance after insurance and insurance adjustments.		
	<b>Approx Mail Date:</b>	Requested from OSF 10/16/20 Expected to be mailed by 10/30/20				<b>Patient Initials:</b>	K.B.
	<b>Mail To Address:</b>	ST ANTHONY HOSPITAL CHICAGO IL 60677-6323		PO BOX 776323	Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1968
<b>9/18/2020</b>	<b>108476196</b>	<b>\$2,162.02</b>	01/23/20	ACCT: 40200233540	Payment amount based on \$12,026.58 patient balance after insurance and insurance adjustments.		
	<b>Approx Mail Date:</b>	9/21/2020				<b>Patient Initials:</b>	S.G.
	<b>Mail To Address:</b>	ST ANTHONY HOSPITAL CHICAGO IL 60677-6323		PO BOX 776323	Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1983
<b>9/18/2020</b>	<b>108476195</b>	<b>\$4,973.21</b>	06/20/19	ACCT: 40191710267	Payment amount based on \$6,216.51 patient balance after insurance and insurance adjustments.		
	<b>Approx Mail Date:</b>	9/21/2020				<b>Patient Initials:</b>	B.L.
	<b>Mail To Address:</b>	ST ANTHONY HOSPITAL CHICAGO IL 60677-6323		PO BOX 776323	Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1994
<b>7/28/2020</b>	<b>108449564</b>	<b>\$160.00</b>	04/24/18	ACCT: 4018114093101	Payment amount based on \$200.00 patient balance after insurance and insurance adjustments.		
	<b>Approx Mail Date:</b>	7/31/2020				<b>Patient Initials:</b>	J.W.
	<b>Mail To Address:</b>	ST ANTHONY HOSPITAL CHICAGO IL 60677-6323		PO BOX 776323	Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1981
<b>6/15/2020</b>	<b>108432809</b>	<b>\$7,272.32</b>	12/12/19	ACCT:40193460134	Payment amount based on \$9,090.40 patient balance after insurance and insurance adjustments.		
	<b>Approx Mail Date:</b>	6/18/2020				<b>Patient Initials:</b>	J.N.
	<b>Mail To Address:</b>	ST ANTHONY HOSPITAL CHICAGO IL 60677-6323		PO BOX 776323	Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1979
<b>5/19/2020</b>	<b>108421386</b>	<b>\$717.20</b>	04/27/19	ACCT: 150459	Payment amount based on \$896.50 patient balance after insurance and insurance adjustments.		
	<b>Approx Mail Date:</b>	5/22/2020				<b>Patient Initials:</b>	T.W.
	<b>Mail To Address:</b>	ST ANTHONY HOSPITAL CHICAGO IL 60677-6323		PO BOX 776323	Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1961
<b>5/19/2020</b>	<b>108421384</b>	<b>\$16,061.49</b>	08/16/18 AND 10/02/18	ACCT: 40182282531 - \$6,350.51; 40182740521 - \$9,710.99	Payment amount based on \$27,175.24 patient balance after insurance and insurance adjustments.		
	<b>Approx Mail Date:</b>	5/22/2020				<b>Patient Initials:</b>	V.M.
	<b>Mail To Address:</b>	ST ANTHONY HOSPITAL CHICAGO IL 60677-6323		PO BOX 776323	Total Bills exceed maximum award. Payment is prorated at 73.87926% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1958
<b>3/9/2020</b>	<b>108388802</b>	<b>\$1,551.90</b>	09/22/19	ACCT: 40192650041	Payment amount based on \$1,939.88 patient balance after insurance and insurance adjustments.		
	<b>Approx Mail Date:</b>	3/12/2020				<b>Patient Initials:</b>	A.B.
	<b>Mail To Address:</b>	ST ANTHONY HOSPITAL CHICAGO IL 60677-6323		PO BOX 776323	Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1990

2/21/2020 108379784 \$1,173.49 10/21/18- 10/26/18 AND 08/01/19 ACCT: 40182940379 - \$1,133.49; 24192131215 - \$40.00 Payment amount based on \$1,466.86 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 2/24/2020 *Patient Initials:* C.M.

*Mail To Address:* ST ANTHONY HOSPITAL PO BOX 776323 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1980  
CHICAGO IL 60677-6323

1/21/2020 108360228 \$18,461.21 07/14/19 ACCT: 730657693 Payment amount based on \$23,076.51 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 1/24/2020 *Patient Initials:* C.W.

*Mail To Address:* ST ANTHONY HOSPITAL PO BOX 776323 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1979  
CHICAGO IL 60677-6323

**SAINTS PHYSICIANS**

*Office of State Finance VendorID:* 0000072415

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

5/19/2020 108421385 \$1,212.92 10/02/18 ACCT: 401000751123 Payment amount based on \$2,052.20 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 5/22/2020 Total Bills exceed maximum award. Payment is prorated at 73.87926% among all providers. *Patient Initials:* V.M.

*Mail To Address:* PO BOX 248849 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1958  
OKLAHOMA CITY OK 73124-8849

**ST. JOHN SAPULPA**

*Office of State Finance VendorID:* 0000056348

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

\$13,084.60 05/07/20 ACCT: S0072691474 Payment amount based on \$16,355.75 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 10/13/20 Expected to be mailed by 10/27/20 *Patient Initials:* C.B.

*Mail To Address:* DEPT 2594 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1978  
TULSA OK 74182

**ST. FRANCIS HOSPITAL**

*Office of State Finance VendorID:* 0000056512

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

7/28/2020 108449551 \$10,831.77 08/07/17 AND 08/21/17 ACCT: 3112536810 - \$15.42; 604091068 - \$3,547.48; 604141386 - \$7,268.87 Payment amount based on \$18,266.34 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 7/31/2020 Total Bills exceed maximum award. Payment is prorated at 74.12385% among all providers. *Patient Initials:* T.A.

*Mail To Address:* 6600 S YALE AVE SUITE 500 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1969  
TULSA OK 74136-3319

**ST FRANCIS HEALTH SYSTEM**

*Office of State Finance VendorID:* 0000056512

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

8/26/2020	108464184	\$594.51	5/7/2019	ACCT: 60574366401	Payment amount based on \$743.14 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.B.
						<i>Patient Birth Year:</i>	1977
8/26/2020	108464183	\$935.60	8/29/2015	ACCT: 3402233	Payment amount based on \$1,169.50 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	C.W.
						<i>Patient Birth Year:</i>	1994
8/11/2020	108455937	\$2,122.22	11/9/19	ACCT: 606201747	Payment amount based on \$2,652.78 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	C.C.
						<i>Patient Birth Year:</i>	1968
7/28/2020	108449554	\$10,283.73	09/03/19	ACCT: 3710708	Payment amount based on \$12,854.66 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	A.C.
						<i>Patient Birth Year:</i>	1974
7/28/2020	108449555	\$13,932.84	01/14/20 - 05/01/20	ACCT: 606414379 - \$11,690.66; 16108731200 - \$2,128.58; 483525326 - \$113.60	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	W.G.
						<i>Patient Birth Year:</i>	1963
6/25/2020	108438943	\$1,908.16	6/21/20 - 6/26/20	ACCT: 605855064	Payment amount based on \$2,385.20 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	T.S.
						<i>Patient Birth Year:</i>	1998
6/15/2020	108432802	\$17,319.43	03/19/20	ACCT: 3755198 - \$836.40; 606692564 - \$16,483.03	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	G.M.
						<i>Patient Birth Year:</i>	1999
4/22/2020	108410388	\$10,871.29	01/25/18 - 01/28/18	ACCT: 604592177	Payment amount based on \$13,589.11 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.M.
						<i>Patient Birth Year:</i>	1995

3/18/2020	108394590	\$19,050.93	06/14/19 - 07/07/19	ACCT: 60586982400 - \$101.65; 60588377700 - \$2,910.75; 60590551800 - \$12,406.45; 0583564403 - \$3,632.08	Payment amount based on \$255,824.25 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 3/21/2020					Total Bills exceed maximum award. Payment is prorated at 9.308603% among all providers.	<i>Patient Initials:</i> S.S.
<i>Mail To Address:</i> PO BOX 707001 TULSA OK 74170					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1984
3/10/2020	108389701	\$728.00	4/26/2019-4/27/2019	ACCT: 605720306	Payment amount based on \$910.00 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 3/13/2020						<i>Patient Initials:</i> K.B.
<i>Mail To Address:</i> PO BOX 707001 TULSA OK 74170					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1985
3/10/2020	108389699	\$1,724.47	7/8/2019	ACCT: 160964523	Payment amount based on \$2,155.59 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 3/13/2020						<i>Patient Initials:</i> K.B.
<i>Mail To Address:</i> PO BOX 707001 TULSA OK 74170					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1955
2/18/2020	108376750	\$17,578.92	02/04/19 - 02/15/19	ACCT: 3663033	Payment amount based on \$49,358.34 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 2/21/2020					Total Bills exceed maximum award. Payment is prorated at 44.51862% among all providers.	<i>Patient Initials:</i> J.L.
<i>Mail To Address:</i> PO BOX 707001 TULSA OK 74170					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1969

**ST FRANCIS HOSP. INC dba ST FRANCIS HLTH SYSTEMS**

*Office of State Finance VendorID:* 0000056512

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		\$12,399.27	02/08/20- 02/10/20	ACCT: 60652361801	Payment amount based on \$15,499.09 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20						<i>Patient Initials:</i> D.S.
<i>Mail To Address:</i> PO BOX 706161 TULSA OK 74170-6161					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1962
		\$110.08	02/11/20 AND 02/19/20	ACCT: 1658149	Payment amount based on \$137.60 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20						<i>Patient Initials:</i> D.S.
<i>Mail To Address:</i> PO BOX 706161 TULSA OK 74170-6161					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1962
		\$17,016.71	02/29/20	ACCT: 606613045	Payment amount based on \$29,561.76 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20					Total Bills exceed maximum award. Payment is prorated at 71.95409% among all providers.	<i>Patient Initials:</i> E.A.
<i>Mail To Address:</i> PO BOX 706161 TULSA OK 74170-6161					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1981

		<b>\$15,233.84</b>	09/20/18 - 03/20/20	ACCT: 3083528761 - \$6.90; 3083634241 - \$6.90; 60518172702 - \$13,257.28; 60528629100 - \$1,058.07; 60657878500 - \$518.46; 606695573 - \$386.22	Payment amount based on \$57,389.78 patient balance after insurance and insurance adjustments.		
					Total Bills exceed maximum award. Payment is prorated at 33.18064% among all providers.	<b>Patient Initials:</b>	M.M.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1988
<b>10/1/2020</b>	<b>108482975</b>	<b>\$711.69</b>	05/22/17 - 06/01/17	ACCT: 3526343	Payment amount based on \$889.61 patient balance after insurance and insurance adjustments.		
						<b>Patient Initials:</b>	O.L.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1974
<b>8/26/2020</b>	<b>108464182</b>	<b>\$6,563.35</b>	10/06/19	ACCT: 606114119	Payment amount based on \$8,204.19 patient balance after insurance and insurance adjustments.		
						<b>Patient Initials:</b>	B.G.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1965
<b>8/26/2020</b>	<b>108464181</b>	<b>\$13,256.06</b>	06/19/19 AND 09/09/19	ACCT: 60584942002 - \$12,928.06; 60603015300 - \$328.00	Payment amount based on \$16,570.08 patient balance after insurance and insurance adjustments.		
						<b>Patient Initials:</b>	J.B.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1987
<b>8/26/2020</b>	<b>108464179</b>	<b>\$12,577.39</b>	07/17/18 - 08/24/18	ACCT: 605149368900 - \$123.44; 60510480200 - \$3,914.39; 60502536500 - \$4,613.17; 60510480201 - \$3,914.39; 3090746040 - \$6.00; 3081322871 - \$6.00	Payment amount based on \$54,528.10 patient balance after insurance and insurance adjustments.		
					Total Bills exceed maximum award. Payment is prorated at 28.83237% among all providers.	<b>Patient Initials:</b>	I.M.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1996
<b>7/28/2020</b>	<b>108449550</b>	<b>\$1,627.39</b>	10/29/16 - 01/11/17	ACCT: 603086683 - \$621.41; 603093512 - \$729.06; 603339493 - \$276.92	Payment amount based on \$2,034.24 patient balance after insurance and insurance adjustments.		
						<b>Patient Initials:</b>	L.C.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	N/A
<b>7/28/2020</b>	<b>108449553</b>	<b>\$7,975.02</b>	11/14/19 AND 11/16/19	ACCT: 161027727 - \$2,224.40; 161027085 - \$5,750.61	Payment amount based on \$9,968.78 patient balance after insurance and insurance adjustments.		
						<b>Patient Initials:</b>	M.S.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b>	1964

7/28/2020	108449552	\$14,841.59	05/26/19	ACCT: 605790380 - \$14,459.19; 605790395 - \$382.40	Payment amount based on \$18,551.99 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.C.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1956
6/15/2020	108432801	\$14,882.00	10/03/19	ACCT: 0611043400	Payment amount based on \$31,009.99 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> Z.V.
					Total Bills exceed maximum award. Payment is prorated at 59.98875% among all providers.	<i>Patient Birth Year:</i> 1992
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
6/15/2020	108432800	\$691.51	04/01/17 - 10/10/19	ACCT: 3473564	Payment amount based on \$1,183.80 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> D.T.
					Total Bills exceed maximum award. Payment is prorated at 73.01783% among all providers.	<i>Patient Birth Year:</i> 1990
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
5/19/2020	108421375	\$17,840.29	07/05/19	ACCT: 60588482902	Payment amount based on \$56,114.39 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.H.
					Total Bills exceed maximum award. Payment is prorated at 39.7409% among all providers.	<i>Patient Birth Year:</i> 1970
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
5/19/2020	108421376	\$9,503.43	01/16/19 - 05/03/19	ACCT: 605462436 - \$8,438.39; 481989634 - \$80.78; 482276008 - \$16.08; 481936082 - \$80.78; 481906974 - \$21.32; 481900387 - \$135.76; 605476105 - \$730.32	Payment amount based on \$25,411.03 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.E.
					Total Bills exceed maximum award. Payment is prorated at 46.74856% among all providers.	<i>Patient Birth Year:</i> 1997
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
2/18/2020	108376748	\$15,065.18	02/03/19 - 02/18/19	ACCT: 605547207 - \$12.05; 60550842000 - \$12,685.90; 605547052 - \$2,367.23	Payment amount based on \$32,499.19 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.S.
					Total Bills exceed maximum award. Payment is prorated at 57.94448% among all providers.	<i>Patient Birth Year:</i> 1990
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
1/29/2020	108366073	\$1,322.40	11/14/18	ACCT: 160855975	Payment amount based on \$1,653.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.D.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1978
1/29/2020	108366072	\$19,394.32	07/30/18 - 08/01/18	ACCT: 605055949	Payment amount based on \$43,164.15 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.C.
					Total Bills exceed maximum award. Payment is prorated at 56.16444% among all providers.	<i>Patient Birth Year:</i> 1964
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	

1/21/2020 108360216 \$7,840.97 12/15/17 - 06/27/19 ACCT: 3568471  
*Approx Mail Date:* 1/24/2020  
*Mail To Address:* PO BOX 706161  
TULSA OK 74170-6161

Payment amount based on \$115,783.23 patient balance after insurance and insurance adjustments.  
Total Bills exceed maximum award. Payment is prorated at 8.465149% among all providers. *Patient Initials:* J.S.  
Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1970

**ASSOCIATED ANESTHESIOLOGIST**

*Office of State Finance VendorID:* 0000056444

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$1,559.49	09/25/18 - 03/20/20	ACCT: 72461	
		<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20			Payment amount based on \$5,875.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> 6839 S CANTON AVE TULSA OK 74136-3402			Total Bills exceed maximum award. Payment is prorated at 33.18064% among all providers. <i>Patient Initials:</i> M.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1988
10/11/2020	108482865	\$3,300.00	05/21/17 AND 05/31/17	ACCT: 19823 - \$2,300.00; 22972 - \$1,000.00	
					Payment amount based on \$4,125.00 patient balance after insurance and insurance adjustments.
					<i>Patient Initials:</i> O.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1974
9/18/2020	108476064	\$2,600.00	12/24/19	ACCT: 3760008	
					Payment amount based on \$3,250.00 patient balance after insurance and insurance adjustments.
					<i>Patient Initials:</i> B.P. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1966
8/26/2020	108463950	\$2,825.57	07/16/16 - 08/24/16	ACCT: 203893 - \$720.81; 203897 - \$86.50; 203896 - \$1,355.11; 170763 - \$317.16; 203898 - \$345.99	
					Payment amount based on \$12,250.00 patient balance after insurance and insurance adjustments.
					Total Bills exceed maximum award. Payment is prorated at 28.83237% among all providers. <i>Patient Initials:</i> I.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1996
7/28/2020	108449401	\$2,300.00	01/14/20	ACCT: AAI130177	
					Payment amount based on patient balance after insurance and insurance adjustments.
					<i>Patient Initials:</i> W.G. <i>Patient Birth Year:</i> 1963
6/15/2020	108432640	\$1,259.76	10/18/19	ACCT: AAI119464	
					Payment amount based on \$2,625.00 patient balance after insurance and insurance adjustments.
					Total Bills exceed maximum award. Payment is prorated at 59.98875% among all providers. <i>Patient Initials:</i> Z.V. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1992

5/19/2020	108421216	\$14,602.40	05/17/19 - 06/05/19	ACCT: 268703 - \$2,590.40; 268704 - \$1,910.40; 268705 - \$2,100.00; 268706 - \$300.00; 265903 - \$2,370.40; 265904 - \$1,530.40; 270892 - \$900.00; 270894 - \$630.40; 270893 - \$970.40; 274033 - \$760.00; 274034 - \$540.00	Payment amount based on \$18,253.00 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> T.P.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1964
<hr/>						
5/19/2020	108421217	\$323.97	07/05/19	ACCT: 284036	Payment amount based on \$1,019.00 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 39.7409% among all providers.	<i>Patient Initials:</i> M.H.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1970
<hr/>						
5/19/2020	108421218	\$981.72	01/22/19	ACCT: AA186407	Payment amount based on \$2,625.00 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 46.74856% among all providers.	<i>Patient Initials:</i> J.E.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1997
<hr/>						
3/18/2020	108394416	\$502.66	06/14/19 - 07/17/19	ACCT: 310540	Payment amount based on \$6,750.00 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 9.308603% among all providers.	<i>Patient Initials:</i> S.S.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1984
<hr/>						
2/18/2020	108376590	\$890.37	02/15/19	ACCT: AA190622	Payment amount based on \$2,500.00 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 44.51862% among all providers.	<i>Patient Initials:</i> J.L.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1969
<hr/>						
1/21/2020	108360027	\$296.28	12/16/17	ACCT: AAI37499	Payment amount based on \$4,375.00 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 8.465149% among all providers.	<i>Patient Initials:</i> J.S.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1970

**SOUTHERN OK AMBULANCE SERVICE**

*Office of State Finance VendorID:* 0000056450

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
7/28/2020	108449561	\$1,728.80	04/17/19	ACCT: 201913779	Payment amount based on \$2,161.00 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> J.H.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1979
<hr/>						
7/28/2020	108449562	\$781.59	03/17/19	ACCT: 201909711	Payment amount based on \$2,012.50 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 48.54606% among all providers.	<i>Patient Initials:</i> S.L.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1996

**CITY OF COWETA - AMBULANCE**

*Office of State Finance VendorID:* 0000056471

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/21/2020	108360072	\$29.06	04/13/18	ACCT 1247	
<i>Approx Mail Date:</i> 1/24/2020 <i>Mail To Address:</i> PO BOX 850 COWETA OK 74429-0850					Payment amount based on \$100.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 36.32196% among all providers. <i>Patient Initials:</i> R.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1968

**MEMORIAL HOSPITAL OF TEXAS COUNTY**

*Office of State Finance VendorID:* 0000056492

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/12/2020	108456749	\$362.37	09/13/2019	ACCT:741718	
<i>Approx Mail Date:</i> 8/15/2020 <i>Mail To Address:</i> 520 MEDICAL DR GUYMON OK 73942-4438					Payment amount based on \$452.96 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> L.C. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1998

**KIRK'S EMERGENCY SERVICE**

*Office of State Finance VendorID:* 0000056507

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/14/2020	108356533	\$210.42	10/28/2018	ACCT: KIRA29B61	
<i>Approx Mail Date:</i> 1/17/2020 <i>Mail To Address:</i> 1616 SW F AVE LAWTON OK 73501-4755					Payment amount based on \$263.03 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> B.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1996

**MIDWEST CITY REGIONAL HOSPITAL**

*Office of State Finance VendorID:* 0000061360

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
2/18/2020	108376708	\$12,631.86	10/23/19	ACCT: 8504372	
<i>Approx Mail Date:</i> 2/21/2020 <i>Mail To Address:</i> 2825 PARKLAWN DR MIDWEST CITY OK 73110-4201					Payment amount based on \$15,789.83 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> J.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1984

**OKLAHOMA RADIOLOGY GROUP**

*Office of State Finance VendorID:* 0000056502

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
6/15/2020	108432765	\$532.00	12/12/19	ACCT: 485375	
<i>Approx Mail Date:</i> 6/18/2020 <i>Mail To Address:</i> PO BOX 21228 TULSA OK 74121-1228					Payment amount based on \$665.00 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> J.N. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1979

2/18/2020 108376723 \$252.00 10/25/19 ACCT: 367243

Payment amount based on \$315.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/21/2020

Patient Initials: J.M.

Mail To Address: PO BOX 26064  
OKLAHOMA CITY OK 73157-0064

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1984

**OK RADIOLOGY GROUP**

Office of State Finance VendorID: 0000056502

**Check Date: Check #: Amount: Service Date(s): Provider Reference:**

**Patient Identifiers**

9/18/2020 108476155 \$73.71 01/23/20 ACCT: 408268

Payment amount based on \$410.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/21/2020

Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers. Patient Initials: S.G.

Mail To Address: PO BOX 21228 DEPT 146  
TULSA OK 74121-1228

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1983

9/18/2020 108476154 \$83.84 06/20/19 ACCT: 363683

Payment amount based on \$104.80 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/21/2020

Patient Initials: B.L.

Mail To Address: PO BOX 21228 DEPT 146  
TULSA OK 74121-1228

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1994

8/12/2020 108456759 \$808.00 2/15/2019 ACCT:431394

Payment amount based on \$1,010.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/15/2020

Patient Initials: K.B.

Mail To Address: PO BOX 21228 DEPT 146  
TULSA OK 74121-1228

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1968

5/19/2020 108421338 \$218.69 08/16/18 ACCT: 403118

Payment amount based on \$370.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/22/2020

Total Bills exceed maximum award. Payment is prorated at 73.87926% among all providers. Patient Initials: V.M.

Mail To Address: PO BOX 21228 DEPT 146  
TULSA OK 74121-1228

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1958

3/9/2020 108388754 \$80.00 09/22/19 ACCT: 473974

Payment amount based on \$100.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/12/2020

Patient Initials: A.B.

Mail To Address: PO BOX 21228 DEPT 146  
TULSA OK 74121-1228

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1990

**GIFFORD MONUMENT**

Office of State Finance VendorID: 0000056537

**Check Date: Check #: Amount: Service Date(s): Provider Reference:**

**Patient Identifiers**

7/28/2020 108449462 \$690.46 06/02/20 ACCT: L.D.

Payment amount based on \$690.46 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/31/2020

Patient Initials: L.D.

Mail To Address: 900 N BROADWAY AVE  
ADA OK 74820-2035

Patient Birth Year: 1982

**JACK'S MEMORIAL CHAPEL**

Office of State Finance VendorID: 0000062704

**Check Date: Check #: Amount: Service Date(s): Provider Reference:**

**Patient Identifiers**

3/9/2020 108388716 \$5,309.04 07/12/19 ACCT: K.W. Payment amount based on \$5,309.04 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 3/12/2020 *Patient Initials:* K.W.  
*Mail To Address:* 801 E 36TH ST N *Patient Birth Year:* 1992  
TULSA OK 74106-1926

**LOWELL-TIMS FUNERAL HOME**

*Office of State Finance VendorID:* 0000060844

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

3/31/2020 108400196 \$4,698.64 09/25/19 ACCT: J.M. Payment amount based on \$4,698.64 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 4/3/2020 *Patient Initials:* J.M.  
*Mail To Address:* 1100 E TAMARACK RD *Patient Birth Year:* 1987  
ALTUS OK 73521-1232

**SURGERY, INC**

*Office of State Finance VendorID:* 0000192709

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

\$573.66 4/26/2019 ACCT: 2004560 Payment amount based on \$717.08 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* Requested from OSF 10/16/20 Expected to be mailed by 10/30/20 *Patient Initials:* K.B.  
*Mail To Address:* P.O. BOX 35307 *Patient Birth Year:* 1985  
TULSA OK 74153-0307

8/17/2020 108459283 \$3,664.03 03/01/20 ACCT: 204927 Payment amount based on patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 8/20/2020 *Patient Initials:* E.T.  
*Mail To Address:* P.O. BOX 35307 *Patient Birth Year:* 1983  
TULSA OK 74153-0307

3/18/2020 108394613 \$264.20 05/28/19 ACCT: 201887 Payment amount based on \$973.33 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 3/21/2020 Total Bills exceed maximum award. Payment is prorated at 33.92995% among all providers. *Patient Initials:* D.A.  
*Mail To Address:* P.O. BOX 35307 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1982  
TULSA OK 74153-0307

3/18/2020 108394614 \$59.66 07/19/19 ACCT: 201589CFB Payment amount based on \$406.00 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 3/21/2020 Total Bills exceed maximum award. Payment is prorated at 18.36885% among all providers. *Patient Initials:* T.S.  
*Mail To Address:* P.O. BOX 35307 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1968  
TULSA OK 74153-0307

**TULSA RADIOLOGY ASSOCIATES**

*Office of State Finance VendorID:* 0000056693

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

\$1,103.20

05/07/20

ACCT: 3455300C - \$113.60; 3455301C - \$96.80; 3455302C - \$18.40; 3455303C - \$50.40; 3455304C - \$625.60; 3455305C - \$198.40

Payment amount based on \$1,379.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

*Patient Initials:* C.B.

*Mail To Address:* PO BOX 4939  
TULSA OK 74159-0939

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1978

10/16/2020 108490843 \$89.63 8/29/2019 ACCT: 1106557

Payment amount based on \$112.04 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 10/19/2020

*Patient Initials:* R.B.

*Mail To Address:* PO BOX 4939  
TULSA OK 74159-0939

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1964

10/1/2020 108482989 \$8.19 05/10/19 - 11/07/19 ACCT: TRA38315

Payment amount based on \$651.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 10/4/2020

Total Bills exceed maximum award. Payment is prorated at 1.572509% among all providers.

*Patient Initials:* D.B.

*Mail To Address:* PO BOX 4939  
TULSA OK 74159-0939

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1973

9/18/2020 108476205 \$20.00 03/10/20 ACCT: TRA447499

Payment amount based on \$25.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 9/21/2020

*Patient Initials:* J.S.

*Mail To Address:* PO BOX 4939  
TULSA OK 74159-0939

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1988

8/26/2020 108464220 \$902.40 12/29/19 - 01/04/20 ACCT: 1127459

Payment amount based on \$1,128.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 8/29/2020

*Patient Initials:* B.P.

*Mail To Address:* PO BOX 4939  
TULSA OK 74159-0939

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1998

8/26/2020 108464219 \$55.21 09/04/19 - 10/17/19 ACCT: 1101867

Payment amount based on \$69.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 8/29/2020

*Patient Initials:* B.T.

*Mail To Address:* PO BOX 4939  
TULSA OK 74159-0939

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1988

8/12/2020 108456726 \$277.60 03/01/20 ACCT: 1139113

Payment amount based on patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 8/15/2020

*Patient Initials:* E.T.

*Mail To Address:* PO BOX 4939  
TULSA OK 74159-0939

*Patient Birth Year:* 1983

7/28/2020 108449580 \$43.69 01/02/19 - 01/04/19 ACCT: 1066388

Payment amount based on \$54.61 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 7/31/2020

*Patient Initials:* L.P.

*Mail To Address:* PO BOX 4939  
TULSA OK 74159-0939

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1949

6/15/2020 108432819 \$34.45 09/16/19 - 09/18/19 ACCT: 109872

Payment amount based on \$901.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 6/18/2020

Total Bills exceed maximum award. Payment is prorated at 4.779422% among all providers.

*Patient Initials:* G.B.

*Mail To Address:* PO BOX 4939  
TULSA OK 74159-0939

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1967

3/31/2020	108400253	\$19.20	07/05/19	ACCT: 235749	Payment amount based on \$24.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	A.K.
	<i>Approx Mail Date:</i>	4/3/2020				<i>Patient Birth Year:</i>	1990
	<i>Mail To Address:</i>	PO BOX 4939 TULSA	OK	74159-0939	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
3/18/2020	108394632	\$714.40	08/25/19 - 09/19/19	ACCT: 1105666	Payment amount based on \$893.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	T.H.
	<i>Approx Mail Date:</i>	3/21/2020				<i>Patient Birth Year:</i>	1979
	<i>Mail To Address:</i>	PO BOX 4939 TULSA	OK	74159-0939	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
3/18/2020	108394630	\$276.87	05/19/19	ACCT: 1090972	Payment amount based on \$1,020.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	D.A.
	<i>Approx Mail Date:</i>	3/21/2020			Total Bills exceed maximum award. Payment is prorated at 33.92995% among all providers.	<i>Patient Birth Year:</i>	1982
	<i>Mail To Address:</i>	PO BOX 4939 TULSA	OK	74159-0939	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
3/18/2020	108394631	\$269.91	06/17/19 - 06/18/19	ACCT: 1094144	Payment amount based on \$1,335.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.H.
	<i>Approx Mail Date:</i>	3/21/2020			Total Bills exceed maximum award. Payment is prorated at 25.27231% among all providers.	<i>Patient Birth Year:</i>	1971
	<i>Mail To Address:</i>	PO BOX 4939 TULSA	OK	74159-0939	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
3/10/2020	108389735	\$36.00	8/6/2019	ACCT: 1102481	Payment amount based on \$45.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	L.C.
	<i>Approx Mail Date:</i>	3/13/2020				<i>Patient Birth Year:</i>	2000
	<i>Mail To Address:</i>	PO BOX 4939 TULSA	OK	74159-0939	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
1/27/2020	108363807	\$125.66	7/3/2019	ACCT: 220228	Payment amount based on \$157.08 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	C.R.
	<i>Approx Mail Date:</i>	1/30/2020				<i>Patient Birth Year:</i>	1985
	<i>Mail To Address:</i>	PO BOX 4939 TULSA	OK	74159-0939	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
1/21/2020	108360252	\$720.80	03/08/19, 08/03/19 - 08/04/19	ACCT: 1077762	Payment amount based on \$901.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.J.
	<i>Approx Mail Date:</i>	1/24/2020				<i>Patient Birth Year:</i>	1966
	<i>Mail To Address:</i>	PO BOX 4939 TULSA	OK	74159-0939	Acceptance of payment may require a provider write-off. EOB will accompany payment.		

**TULSA X-RAY LABORATORY, INC.**

*Office of State Finance VendorID:* 0000056723

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
10/16/2020	108490844	\$58.40	6/22/20	ACCT: Z6VB9KG	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> G.F.
	<i>Approx Mail Date:</i>	10/19/2020				<i>Patient Birth Year:</i> 1992
	<i>Mail To Address:</i>	P.O. BOX 54760 TULSA	OK	74155-0760		

7/28/2020	108449581	\$10.00	09/20/16	ACCT: 322415-QTXRL	Payment amount based on \$12.50 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> L.C.
	<i>Approx Mail Date:</i> 7/31/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> N/A
	<i>Mail To Address:</i> P.O. BOX 54760 TULSA OK 74155-0760					
6/15/2020	108432820	\$188.00	01/28/20 AND 01/30/20	ACCT: Z6AJ5VO - \$26.40; Z6B3PHU - \$161.60	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.L.
	<i>Approx Mail Date:</i> 6/18/2020					<i>Patient Birth Year:</i> 1978
	<i>Mail To Address:</i> P.O. BOX 54760 TULSA OK 74155-0760					
6/18/2020	108434753	\$265.60	7/12/2018	ACCT: 524951-QTXRL	Payment amount based on \$332.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.S.
	<i>Approx Mail Date:</i> 6/21/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1985
	<i>Mail To Address:</i> P.O. BOX 54760 TULSA OK 74155-0760					
1/29/2020	108366175	\$17.00	12/26/18	ACCT: 582582-QTXRL	Payment amount based on \$21.25 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.B.
	<i>Approx Mail Date:</i> 2/1/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1992
	<i>Mail To Address:</i> P.O. BOX 54760 TULSA OK 74155-0760					
1/21/2020	108360253	\$7.42	09/28/19 - 10/13/19	ACCT: Z66CI84 - \$0.78; Z63TPY5 - \$0.78; Z63TPX6 - \$0.78; Z63XUEF - \$0.78; Z64V684 - \$0.78; Z64YJTV - \$3.52	Payment amount based on \$313.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> E.D.
	<i>Approx Mail Date:</i> 1/24/2020				Total Bills exceed maximum award. Payment is prorated at 2.960474% among all providers.	<i>Patient Birth Year:</i> 1991
	<i>Mail To Address:</i> P.O. BOX 54760 TULSA OK 74155-0760					

**PURCELL MUNICIPAL**

*Office of State Finance VendorID:* 0000056820

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
6/18/2020	108434721	\$100.00	5/28/18	ACCT:907181480003	Payment amount based on \$125.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.A.
	<i>Approx Mail Date:</i> 6/21/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1999
	<i>Mail To Address:</i> 1500 N. GREEN AVENUE PURCELL OK 73080					

**DIAGNOSTIC IMAGING ASSOC INC**

*Office of State Finance VendorID:* 0000072917

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
8/12/2020	108456703	\$16.49	2/14/2019	ACCT: 927512QDIA-1	Payment amount based on \$20.61 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.B.
	<i>Approx Mail Date:</i> 8/15/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1968
	<i>Mail To Address:</i> PO BOX 973038 DALLAS TX 75397					

**DIAGNOSTIC IMAGING ASSOCIATES**

*Office of State Finance VendorID: 0000072917*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		<b>\$56.00</b>	01/03/19	ACCT: Z4Z3VPV	Payment amount based on \$70.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20			<i>Patient Initials:</i> L.J.
		<i>Mail To Address:</i> P.O. BOX 973038 DALLAS TX 75397-3038			<i>Patient Birth Year:</i> 1988
<b>10/1/2020</b>	<b>108482932</b>	<b>\$276.00</b>	07/23/20	ACCT: Z6XPI99	Payment amount based on patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 10/4/2020			<i>Patient Initials:</i> K.R.
		<i>Mail To Address:</i> P.O. BOX 973038 DALLAS TX 75397-3038			<i>Patient Birth Year:</i> 1989
<b>8/26/2020</b>	<b>108464013</b>	<b>\$411.40</b>	04/10/19	ACCT: 1871863712	Payment amount based on \$523.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 8/29/2020			<i>Patient Initials:</i> J.S.
		<i>Mail To Address:</i> P.O. BOX 973038 DALLAS TX 75397-3038			<i>Patient Birth Year:</i> 1979
<b>8/26/2020</b>	<b>108464014</b>	<b>\$399.36</b>	08/22/19	ACCT: 1688005	Payment amount based on \$544.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 8/29/2020			<i>Patient Initials:</i> J.S.
		<i>Mail To Address:</i> P.O. BOX 973038 DALLAS TX 75397-3038			<i>Patient Birth Year:</i> 1979
<b>7/28/2020</b>	<b>108449448</b>	<b>\$464.80</b>	11/09/19	ACCT: Z61A3QD - \$277.60; Z61A3JR - \$48.00; Z61A3HD - \$99.20; Z62NY2R - \$40.00	Payment amount based on \$581.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 7/31/2020			<i>Patient Initials:</i> H.M.
		<i>Mail To Address:</i> P.O. BOX 973038 DALLAS TX 75397-3038			<i>Patient Birth Year:</i> 1988
<b>2/18/2020</b>	<b>108376645</b>	<b>\$262.40</b>	10/23/19	ACCT: 1980853	Payment amount based on \$328.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 2/21/2020			<i>Patient Initials:</i> J.M.
		<i>Mail To Address:</i> P.O. BOX 973038 DALLAS TX 75397-3038			<i>Patient Birth Year:</i> 1984

**DIAGNOSTIC IMAGING ASSOCIATES**

*Office of State Finance VendorID: 0000072917*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
<b>8/12/2020</b>	<b>108456704</b>	<b>\$51.16</b>	5/11/20	ACCT:2704741-QDIA1	Payment amount based on patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 8/15/2020			<i>Patient Initials:</i> J.T.
		<i>Mail To Address:</i> PO BOX 3205 INDIANAPOLIS IN 46206-3205			<i>Patient Birth Year:</i> 1968

<b>3/18/2020</b>	<b>108394487</b>	<b>\$235.71</b>	07/19/19 AND 09/06/19	ACCT: 2437617-QDIA1	Payment amount based on \$1,604.00 patient balance after insurance and insurance adjustments.
	<i>Approx Mail Date:</i>	3/21/2020			Total Bills exceed maximum award. Payment is prorated at 18.36885% among all providers. <i>Patient Initials:</i> T.S.
	<i>Mail To Address:</i>	PO BOX 3205			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1968
		INDIANAPOLIS	IN	46206-3205	

<b>2/21/2020</b>	<b>108379695</b>	<b>\$389.60</b>	10/22/19	ACCT: 887092-QDIA1	Payment amount based on \$487.00 patient balance after insurance and insurance adjustments.
	<i>Approx Mail Date:</i>	2/24/2020			<i>Patient Initials:</i> C.H.
	<i>Mail To Address:</i>	PO BOX 3205			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1991
		INDIANAPOLIS	IN	46206-3205	

**DIAGNOSTIC IMAGING ASSOCIATES**

*Office of State Finance VendorID:* 0000072917

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
<b>9/18/2020</b>	<b>108476113</b>	<b>\$23.51</b>	02/08/20	ACCT: 2006987-QDIA1	Payment amount based on \$31.00 patient balance after insurance and insurance adjustments.
	<i>Approx Mail Date:</i>	9/21/2020			Total Bills exceed maximum award. Payment is prorated at 94.78569% among all providers. <i>Patient Initials:</i> K.C.
	<i>Mail To Address:</i>	PO BOX 973038			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1989
		DALLAS	TX	75397-3038	

<b>2/21/2020</b>	<b>108379696</b>	<b>\$43.48</b>	12/16/18	ACCT: Z5Q3ZPY	Payment amount based on \$54.35 patient balance after insurance and insurance adjustments.
	<i>Approx Mail Date:</i>	2/24/2020			<i>Patient Initials:</i> A.H.
	<i>Mail To Address:</i>	PO BOX 973038			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1999
		DALLAS	TX	75397-3038	

**MMS - PAYNE FUNERAL HOME & CREMATION SERVICE**

*Office of State Finance VendorID:* 0000435261

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
<b>7/8/2020</b>	<b>108441742</b>	<b>\$7,500.00</b>	03/30/17	ACCT: S.M.	Payment amount based on \$7,500.00 patient balance after insurance and insurance adjustments.
	<i>Approx Mail Date:</i>	7/11/2020			<i>Patient Initials:</i> S.M.
	<i>Mail To Address:</i>	102 W 5TH ST			<i>Patient Birth Year:</i> 1964
		CLAREMORE	OK	74017-7079	

**RADIOLOGY CONSULTANTS**

*Office of State Finance VendorID:* 0000056853

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
<b>10/1/2020</b>	<b>108482971</b>	<b>\$40.80</b>	03/01/20	ACCT: 429068	Payment amount based on patient balance after insurance and insurance adjustments.
	<i>Approx Mail Date:</i>	10/4/2020			<i>Patient Initials:</i> K.R.
	<i>Mail To Address:</i>	PO BOX 95818			<i>Patient Birth Year:</i> 1989
		OKLAHOMA CITY	OK	73143-5818	

**NORMAN RADIOLOGY DBA SOUTHWEST RADIOLOGY ASSOCIATES**

*Office of State Finance VendorID:* 0000056863

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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8/26/2020	108464109	\$203.20	03/01/20	ACCT: 513375	Payment amount based on \$254.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> T.E.
	<i>Approx Mail Date:</i> 8/29/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1985
	<i>Mail To Address:</i> PO BOX 269083 OKLAHOMA CITY OK 73126-9083					
7/28/2020	108449508	\$37.48	10/07/17	ACCT: 462667	Payment amount based on \$143.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> M.S.
	<i>Approx Mail Date:</i> 7/31/2020				Total Bills exceed maximum award. Payment is prorated at 32.75809% among all providers.	<b>Patient Birth Year:</b> 1958
	<i>Mail To Address:</i> PO BOX 269083 OKLAHOMA CITY OK 73126-9083				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

**STILLWATER MEDICAL CENTER**

*Office of State Finance VendorID:* 0000175255

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		\$8,558.40	08/08/20	ACCT: V00003177191	Payment amount based on \$10,698.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> E.Q.
	<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1989
	<i>Mail To Address:</i> 1323 W 6TH AVE STILLWATER OK 74074-4306					
		\$1,198.87	01/25/20	ACCT: V00003086776	Payment amount based on patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> J.F.
	<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20					<b>Patient Birth Year:</b> 1978
	<i>Mail To Address:</i> 1323 W 6TH AVE STILLWATER OK 74074-4306					
8/17/2020	108459280	\$4,233.60	08/25/19	ACCT: V00003011066	Payment amount based on \$5,292.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> A.B.
	<i>Approx Mail Date:</i> 8/20/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1999
	<i>Mail To Address:</i> 1323 W 6TH AVE STILLWATER OK 74074-4306					
6/3/2020	108427505	\$4,244.00	12/30/19	ACCT: V00003073235	Payment amount based on \$5,305.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> C.L.
	<i>Approx Mail Date:</i> 6/6/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1990
	<i>Mail To Address:</i> 1323 W 6TH AVE STILLWATER OK 74074-4306					
		(\$10,916.22)		RESCIND DUE TO PROVIDER'S RETURNED PORTION OF PAYMENT. PRIMARY INSURANCE PD.	Payment amount based on (\$13,645.28) patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> A.C.
	<i>Approx Mail Date:</i> Requested from OSF 2/8/19 Expected to be mailed by 2/22/19				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 2003
	<i>Mail To Address:</i> 1323 W 6TH AVE STILLWATER OK 74074-4306					
1/21/2020	108360234	\$20,000.00	06/06/17 - 06/29/17 and 02/18/19	ACCT: 00002659112 - 19,795.78; 000102814679 - \$204.22	Payment amount based on \$30,555.60 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> G.M.
	<i>Approx Mail Date:</i> 1/24/2020				Total Bills exceed maximum award. Payment is prorated at 81.81806% among all providers.	<b>Patient Birth Year:</b> 1988
	<i>Mail To Address:</i> 1323 W 6TH AVE STILLWATER OK 74074-4306				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

**RADIOLOGY SERVICES OF ARDMORE**

*Office of State Finance VendorID:* 0000056950

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/26/2020	108464171	\$3.20	6/18/2019	ACCT: ARD28429	Payment amount based on \$4.00 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> J.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> N/A
<i>Approx Mail Date:</i> 8/29/2020					
<i>Mail To Address:</i> PO BOX 518 ARDMORE OK 73402					
7/28/2020	108449540	\$152.00	04/16/19	ACCT: ARD15080	Payment amount based on \$190.00 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> J.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1979
<i>Approx Mail Date:</i> 7/31/2020					
<i>Mail To Address:</i> PO BOX 518 ARDMORE OK 73402					
7/28/2020	108449541	\$67.58	03/17/19	ACCT: ARD20332	Payment amount based on \$174.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 48.54606% among all providers. <i>Patient Initials:</i> S.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1996
<i>Approx Mail Date:</i> 7/31/2020					
<i>Mail To Address:</i> PO BOX 518 ARDMORE OK 73402					

**MARANATHA BAPTIST CHURCH**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$400.00	09/21/19	FUNERAL REIMBURSEMENT	Payment amount based on \$400.00 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> T.M. <i>Patient Birth Year:</i> 1989
<i>Approx Mail Date:</i> Requested from OSF 6/30/20 Expected to be mailed by 7/14/20					
<i>Mail To Address:</i> 2800 N DIVIS BETHANY OK 73008					

**ORTHOPEDIC SPORTS MEDICAL CENTER**

*Office of State Finance VendorID:* 0000057045

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
7/28/2020	108449516	\$654.25	03/17/19	ACCT: 254436	Payment amount based on \$1,684.60 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 48.54606% among all providers. <i>Patient Initials:</i> S.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1996
<i>Approx Mail Date:</i> 7/31/2020					
<i>Mail To Address:</i> PO BOX 550 NORMAN OK 73070-0550					
6/3/2020	108427467	\$154.85	04/25/19 - 05/09/19	ACCT: 255475	Payment amount based on \$193.56 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> S.D. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1959
<i>Approx Mail Date:</i> 6/6/2020					
<i>Mail To Address:</i> PO BOX 550 NORMAN OK 73070-0550					

**RADIOLOGY CONSULTANTS OF TULSA, INC.**

*Office of State Finance VendorID:* 0000057079

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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		<b>\$338.80</b>	02/11/20	ACCT: 535832	Payment amount based on \$423.50 patient balance after insurance and insurance adjustments.		
		<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20					<i>Patient Initials:</i> D.S.
		<i>Mail To Address:</i> PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1962
<hr/>							
		<b>\$756.09</b>	03/01/20	ACCT: RCT781061	Payment amount based on \$1,313.50 patient balance after insurance and insurance adjustments.		
		<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20			Total Bills exceed maximum award. Payment is prorated at 71.95409% among all providers.		<i>Patient Initials:</i> E.A.
		<i>Mail To Address:</i> PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1981
<hr/>							
<b>9/18/2020</b>	<b>108476181</b>	<b>\$357.60</b>		ACCT: 4356113C - \$19.80; 4356147C - \$20.60; 4356356C - \$42.80; 4356357C - \$21.40; 4356358C - \$21.40; 4356359C - \$21.40; 4356398C - \$210.20	Payment amount based on \$447.00 patient balance after insurance and insurance adjustments.		
		<i>Approx Mail Date:</i> 9/21/2020					<i>Patient Initials:</i> B.P.
		<i>Mail To Address:</i> PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1966
<hr/>							
<b>8/26/2020</b>	<b>108464169</b>	<b>\$251.40</b>	10/06/19	ACCT: RCT759562	Payment amount based on \$314.25 patient balance after insurance and insurance adjustments.		
		<i>Approx Mail Date:</i> 8/29/2020					<i>Patient Initials:</i> B.G.
		<i>Mail To Address:</i> PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1965
<hr/>							
<b>8/26/2020</b>	<b>108464170</b>	<b>\$89.80</b>	8/25/15-8/29/15	ACCT: 2312023 42.80 2312024 21.40 ACCT: 2312025 25.60	Payment amount based on \$112.25 patient balance after insurance and insurance adjustments.		
		<i>Approx Mail Date:</i> 8/29/2020			ACCT:		<i>Patient Initials:</i> C.W.
		<i>Mail To Address:</i> PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1994
<hr/>							
<b>8/12/2020</b>	<b>108456736</b>	<b>\$854.40</b>	08/31/15 - 09/02/15	ACCT: 363127	Payment amount based on \$1,068.00 patient balance after insurance and insurance adjustments.		
		<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Initials:</i> T.C.
		<i>Mail To Address:</i> PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1980
<hr/>							
<b>7/28/2020</b>	<b>108449539</b>	<b>\$1,289.00</b>	01/14/20 - 02/10/20	ACCT: 774329	Payment amount based on patient balance after insurance and insurance adjustments.		
		<i>Approx Mail Date:</i> 7/31/2020					<i>Patient Initials:</i> W.G.
		<i>Mail To Address:</i> PO BOX 4975 TULSA OK 74159-0975					<i>Patient Birth Year:</i> 1963
<hr/>							
<b>7/28/2020</b>	<b>108449538</b>	<b>\$3.65</b>	11/14/19 - 12/06/19	ACCT: RCT400721	Payment amount based on \$4.56 patient balance after insurance and insurance adjustments.		
		<i>Approx Mail Date:</i> 7/31/2020					<i>Patient Initials:</i> M.S.
		<i>Mail To Address:</i> PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1964

7/28/2020	108449537	\$871.80	05/27/19	ACCT: RCT533709	Payment amount based on \$1,089.75 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.C.
	<i>Approx Mail Date:</i>	7/31/2020				<i>Patient Birth Year:</i>	1956
	<i>Mail To Address:</i>	PO BOX 4975 TULSA	OK	74159-0975	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
6/15/2020	108432795	\$407.46	03/19/20	ACCT: RCA783744	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	G.M.
	<i>Approx Mail Date:</i>	6/18/2020			Total Bills exceed maximum award. Payment is prorated at 99.47671% among all providers.	<i>Patient Birth Year:</i>	1999
	<i>Mail To Address:</i>	PO BOX 4975 TULSA	OK	74159-0975	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
6/15/2020	108432794	\$635.17	10/03/19 - 10/04/19	ACCT: 4147171C - \$233.84; 4147632C - \$388.01; 4146557C - \$13.32;	Payment amount based on \$1,323.50 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	Z.V.
	<i>Approx Mail Date:</i>	6/18/2020			Total Bills exceed maximum award. Payment is prorated at 59.98875% among all providers.	<i>Patient Birth Year:</i>	1992
	<i>Mail To Address:</i>	PO BOX 4975 TULSA	OK	74159-0975	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
3/18/2020	108394578	\$115.76	06/14/19 - 02/26/20	ACCT: 742317	Payment amount based on \$1,554.50 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	S.S.
	<i>Approx Mail Date:</i>	3/21/2020			Total Bills exceed maximum award. Payment is prorated at 9.308603% among all providers.	<i>Patient Birth Year:</i>	1984
	<i>Mail To Address:</i>	PO BOX 4975 TULSA	OK	74159-0975	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
3/10/2020	108389695	\$6.46	7/8/2019	ACCT: RCT113628	Payment amount based on \$8.08 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	K.B.
	<i>Approx Mail Date:</i>	3/13/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i>	1955
	<i>Mail To Address:</i>	PO BOX 4975 TULSA	OK	74159-0975			
2/18/2020	108376736	\$633.86	02/04/19 - 12/27/19	ACCT: 613372	Payment amount based on \$1,779.75 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.L.
	<i>Approx Mail Date:</i>	2/21/2020			Total Bills exceed maximum award. Payment is prorated at 44.51862% among all providers.	<i>Patient Birth Year:</i>	1969
	<i>Mail To Address:</i>	PO BOX 4975 TULSA	OK	74159-0975	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
2/18/2020	108376735	\$215.44	02/03/19 - 02/18/19	ACCT: 661481	Payment amount based on \$464.75 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.S.
	<i>Approx Mail Date:</i>	2/21/2020			Total Bills exceed maximum award. Payment is prorated at 57.94448% among all providers.	<i>Patient Birth Year:</i>	1990
	<i>Mail To Address:</i>	PO BOX 4975 TULSA	OK	74159-0975	Acceptance of payment may require a provider write-off. EOB will accompany payment.		
2/12/2020	108373833	\$736.00	8/13/2019	ACCT: 497594	Payment amount based on \$920.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	A.F.
	<i>Approx Mail Date:</i>	2/15/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i>	1983
	<i>Mail To Address:</i>	PO BOX 4975 TULSA	OK	74159-0975			
1/29/2020	108366030	\$1,389.40	6/21/19, 6/22/19, 6/26/19, AND 6/30/19	ACCT: 4067574C - \$144.20; 4067573C - \$871.80; 4067571C - \$99.80; 4067572C - \$173.80; 4067570C - \$99.80	Payment amount based on \$1,736.75 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	T.S.
	<i>Approx Mail Date:</i>	2/1/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i>	1998
	<i>Mail To Address:</i>	PO BOX 4975 TULSA	OK	74159-0975			

1/29/2020 108366029 \$41.20 11/14/18 ACCT: 4134098

Approx Mail Date: 2/1/2020

Mail To Address: PO BOX 4975  
TULSA OK 74159-0975

Payment amount based on \$51.50 patient balance after insurance and insurance adjustments.

Patient Initials: C.D.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1978

1/21/2020 108360202 \$18.32 12/15/17 - 06/28/19 ACCT: 651631

Approx Mail Date: 1/24/2020

Mail To Address: PO BOX 4975  
TULSA OK 74159-0975

Payment amount based on \$270.50 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 8.465149% among all providers. Patient Initials: J.S.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1970

NEUROLOGICAL SURGERY INC.

Office of State Finance VendorID: 0000057111

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/21/2020 108360169 \$117.05 12/16/17 ACCT: 75311

Approx Mail Date: 1/24/2020

Mail To Address: PO BOX 21228, DEPT. 1  
TULSA OK 74121-1228

Payment amount based on \$1,728.36 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 8.465149% among all providers. Patient Initials: J.S.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1970

EMERGENCY MEDICAL SERVICES

Office of State Finance VendorID: 0000057115

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/15/2020 108432710 \$36.90 09/16/19 ACCT: 2584

Approx Mail Date: 6/18/2020

Mail To Address: PO BOX 1056  
OKMULGEE OK 74447-1056

Payment amount based on \$965.00 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 4.779422% among all providers. Patient Initials: G.B.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1967

CRISWELL FUNERAL HOME, INC.

Office of State Finance VendorID: 0000057122

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

9/18/2020 108476108 \$7,499.26 10/31/19 ACCT: C.J.

Approx Mail Date: 9/21/2020

Mail To Address: PO BOX 1300  
ADA OK 74821-1300

Payment amount based on \$7,499.26 patient balance after insurance and insurance adjustments.

Patient Initials: C.J.

Patient Birth Year: 1998

8/11/2020 108455887 \$6,954.85 1/24/20 ACCT: B.P.

Approx Mail Date: 8/14/2020

Mail To Address: PO BOX 1300  
ADA OK 74821-1300

Payment amount based on \$6,954.85 patient balance after insurance and insurance adjustments.

Patient Initials: B.P.

Patient Birth Year: 1988

BARTLESVILLE AMBULANCE

Office of State Finance VendorID: 0000057150

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/17/2020 108459152 \$1,764.00 03/01/20 ACCT: 39094 Payment amount based on patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 8/20/2020 *Patient Initials:* E.T.  
*Mail To Address:* PO BOX 468 *Patient Birth Year:* 1983  
 TONKAWA OK 74653-0468

6/3/2020 108427373 \$604.34 08/19/18 ACCT: 36524 Payment amount based on \$755.43 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 6/6/2020 *Patient Initials:* A.G.  
*Mail To Address:* PO BOX 468 *Patient Birth Year:* 1998  
 TONKAWA OK 74653-0468  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**BESIDE STILLWATERS**

*Office of State Finance VendorID:* 0000492608

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

9/18/2020 108476082 \$7,500.00 03/10/20 ACCT: G.J. Payment amount based on \$7,940.00 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 9/21/2020 *Patient Initials:* G.J.  
*Mail To Address:* 1616 NE 36TH ST. *Patient Birth Year:* 1993  
 OKLAHOMA CITY OK 73117

**MEMORIAL HOSPITAL**

*Office of State Finance VendorID:* 0000057172

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

3/19/2020 108394989 \$1,163.94 8/11/2019-8/17/2019 ACCT: 4166573 - \$1,091.20; 4165741 - \$72.74 Payment amount based on \$1,454.93 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 3/22/2020 *Patient Initials:* T.N.  
*Mail To Address:* PO BOX 272 *Patient Birth Year:* 1958  
 STILWELL OK 74960-0272  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**PHYSICIANS' CLINIC**

*Office of State Finance VendorID:* 0000057172

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

3/19/2020 108394988 \$93.87 8/15/2019-9/3/2019 ACCT: 4168048 - \$6.37; 4166492 - \$75.10; 4173048 - \$6.20; 4173047 - \$6.20 Payment amount based on \$117.34 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 3/22/2020 *Patient Initials:* T.N.  
*Mail To Address:* 1401 W LOCUST ST STE 102 *Patient Birth Year:* 1958  
 STILWELL OK 74960-3217  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**EASTERN OKLAHOMA EAR, NOSE & THROAT INC**

*Office of State Finance VendorID:* 0000073220

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

4/22/2020 108410332 \$60.58 09/26/19 AND 10/31/19 ACCT: 5821500 - \$30.29; 5890110-\$30.29 Payment amount based on \$75.73 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 4/25/2020 *Patient Initials:* D.S.  
*Mail To Address:* PO BOX 2244 *Patient Birth Year:* 1988  
 OKLAHOMA CITY OK 73101  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**MCALESTER REGIONAL HEALTH CENTER**

*Office of State Finance VendorID:* 0000057252

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

5/19/2020 108421324 \$3,626.58 01/18/19 AND 03/04/19 ACCT: V00017127168 - \$305.71; V00017244047 - \$1,978.31; V00017244047 - \$1,342.56 Payment amount based on \$9,697.03 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 5/22/2020 *Total Bills exceed maximum award. Payment is prorated at 46.74856% among all providers. Patient Initials:* J.E.  
*Mail To Address:* 1 E CLARK BASS BLVD *Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year:* 1997  
 MCALESTER OK 74501

4/29/2020 108413382 \$4,399.70 6/28/19 ACCT:V00017521659 Payment amount based on \$5,499.63 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 5/2/2020 *Patient Initials:* B.M.  
*Mail To Address:* 1 E CLARK BASS BLVD *Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year:* 1981  
 MCALESTER OK 74501

4/29/2020 108413381 \$1,006.28 6/10/2019 ACCT: C00017477373 Payment amount based on \$1,257.85 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 5/2/2020 *Patient Initials:* D.S.  
*Mail To Address:* 1 E CLARK BASS BLVD *Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year:* 1956  
 MCALESTER OK 74501

3/18/2020 108394539 \$17,695.94 ACCT: V00017562489 - \$4,146.84; V00017591512 - \$13,380.17; V00017706870 - \$168.93 Payment amount based on \$38,864.26 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 3/21/2020 *Total Bills exceed maximum award. Payment is prorated at 56.91587% among all providers. Patient Initials:* T.W.  
*Mail To Address:* 1 E CLARK BASS BLVD *Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year:* 1976  
 MCALESTER OK 74501

2/12/2020 108373790 \$1,046.22 6/17/2019 ACCT: V00017493644 Payment amount based on \$1,307.78 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 2/15/2020 *Patient Initials:* J.L.  
*Mail To Address:* 1 E CLARK BASS BLVD *Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year:* 1996  
 MCALESTER OK 74501

**McALESTER REGIONAL HEALTH CENTER**

*Office of State Finance VendorID:* 0000057252

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

10/16/2020 108490802 \$875.01 10/25/2018 ACCT: V00016947939 Payment amount based on \$1,093.76 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 10/19/2020 *Patient Initials:* M.G.  
*Mail To Address:* PAYMENT PROCESSING CENTER - AVADYN PO BOX 219714 *Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year:* 1993  
 KANSAS CITY MO 64121

3/9/2020 108388739 \$1,350.96 08/25/19 ACCT: V00017656042

Payment amount based on \$1,688.70 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/12/2020

Patient Initials: R.H.

Mail To Address: PAYMENT PROCESSING CENTER - AVADYN PO BOX 219714  
KANSAS CITY MO 64121

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1972

TEMPLE & SON FUNERAL HOME, INC.

Office of State Finance VendorID: 0000057298

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$5,127.59 04/18/20 ACCT: S.M.

Payment amount based on \$5,127.59 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/8/20 Expected to be mailed by 10/22/20

Patient Initials: S.M.

Mail To Address: PO BOX 11301  
OKLAHOMA CITY OK 73136-0301

Patient Birth Year: 1987

\$5,117.67 040/10/20 ACCT: L.F.

Payment amount based on \$5,117.67 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/8/20 Expected to be mailed by 10/22/20

Patient Initials: L.F.

Mail To Address: PO BOX 11301  
OKLAHOMA CITY OK 73136-0301

Patient Birth Year: 1971

10/1/2020 108482983 \$5,020.88 11/22/19 ACCT: A.P.

Payment amount based on \$5,020.88 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/4/2020

Patient Initials: A.P.

Mail To Address: PO BOX 11301  
OKLAHOMA CITY OK 73136-0301

Patient Birth Year: 1992

2/21/2020 108379792 \$3,358.00 10/25/19 ACCT: D.D.S.

Payment amount based on \$3,358.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/24/2020

Patient Initials: D.S.

Mail To Address: PO BOX 11301  
OKLAHOMA CITY OK 73136-0301

Patient Birth Year: 1978

DUNCAN REGIONAL HOSPITAL

Office of State Finance VendorID: 0000057308

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$560.00 04/18/20 ACCT: D00040225492

Payment amount based on patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/8/20 Expected to be mailed by 10/22/20

Patient Initials: T.C.

Mail To Address: PO BOX 100  
DUNCAN OK 73534

Patient Birth Year: 2000

8/26/2020 108464015 \$19,429.05 10/26/19 - 11/06/19 ACCT: D00039683412 - \$816.87;  
D00039633045 - \$18,612.18

Payment amount based on \$72,925.06 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2020

Total Bills exceed maximum award. Payment is prorated at 33.30311% among all providers.

Patient Initials: S.H.

Mail To Address: PO BOX 100  
DUNCAN OK 73534

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1967

2/21/2020	108379699	\$5,743.90	08/25/19	ACCT: D00039394408	Payment amount based on \$7,179.88 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.C.
	<i>Approx Mail Date:</i> 2/24/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1977
	<i>Mail To Address:</i> PO BOX 100 DUNCAN OK 73534					
2/12/2020	108373735	\$1,450.24	9/21/2019	ACCT: D00039499371	Payment amount based on \$1,812.80 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.B.
	<i>Approx Mail Date:</i> 2/15/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1966
	<i>Mail To Address:</i> PO BOX 100 DUNCAN OK 73534					
1/29/2020	108365725	\$2,828.80	03/14/18 - 3/22/18	ACCT: 64618	Payment amount based on \$3,536.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> S.H.
	<i>Approx Mail Date:</i> 2/1/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1966
	<i>Mail To Address:</i> PO BOX 100 DUNCAN OK 73534					

**DUNCAN REGIONAL HOSPITAL**

*Office of State Finance VendorID:* 0000057308

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
5/19/2020	108421273	\$1,793.44	05/27/19 - 07/01/19	ACCT: D00039057948 - \$1,163.77; D00039113592 - \$63.12; D00039134507 - \$61.14; D00039194113 - 505.42	Payment amount based on \$19,775.19 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> 5/22/2020				Total Bills exceed maximum award. Payment is prorated at 11.33645% among all providers.	<i>Patient Initials:</i> R.W.
	<i>Mail To Address:</i> P.O. BOX 248821 OKLAHOMA CITY OK 73124-8821				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1995

**INTEGRIS BAPTIST MEDICAL CENTER**

*Office of State Finance VendorID:* 0000057438

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
5/19/2020	108421307	\$579.84	07/24/18	ACCT: 601245497 - \$548.91; 107263257 - \$30.93	Payment amount based on \$4,462.40 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> 5/22/2020				Total Bills exceed maximum award. Payment is prorated at 16.24235% among all providers.	<i>Patient Initials:</i> J.W.
	<i>Mail To Address:</i> PO BOX 268907 OKLAHOMA CITY OK 73126				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1988

**INTEGRIS**

*Office of State Finance VendorID:* 0000245453

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
7/28/2020	108449470	\$655.03	10/07/17	ACCT: 600601647	Payment amount based on \$2,499.51 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> 7/31/2020				Total Bills exceed maximum award. Payment is prorated at 32.75809% among all providers.	<i>Patient Initials:</i> M.S.
	<i>Mail To Address:</i> PAYMENT PROCESSING CENTER KANSAS CITY MO 64121-9714				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1958

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		<b>\$846.76</b>	02/29/20	ACCT: 20-20038463	
		<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20			Payment amount based on \$1,471.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505			Total Bills exceed maximum award. Payment is prorated at 71.95409% among all providers. <i>Patient Initials:</i> E.A. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1981
		<b>\$40.00</b>	06/15/19	ACCT: 19-19101985	
		<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20			Payment amount based on \$50.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> M.E. <i>Patient Birth Year:</i> 1985
10/16/2020	108490762	<b>\$702.99</b>	8/29/2019	ACCT:19-19151301	
		<i>Approx Mail Date:</i> 10/19/2020			Payment amount based on \$878.74 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> R.B. <i>Patient Birth Year:</i> 1964
8/26/2020	108464018	<b>\$414.36</b>	09/24/16	ACCT: 16-16156879	
		<i>Approx Mail Date:</i> 8/29/2020			Payment amount based on \$1,408.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505			Total Bills exceed maximum award. Payment is prorated at 36.78649% among all providers. <i>Patient Initials:</i> D.B. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1974
8/12/2020	108456741	<b>\$1,232.00</b>	08/31/15	ACCT:15-15139520	
		<i>Approx Mail Date:</i> 8/15/2020			Payment amount based on \$1,540.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> T.C. <i>Patient Birth Year:</i> 1980
8/11/2020	108455893	<b>\$1,176.80</b>	11/9/19	ACCT: 19-19197853	
		<i>Approx Mail Date:</i> 8/14/2020			Payment amount based on \$1,471.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> C.C. <i>Patient Birth Year:</i> 1968
6/15/2020	108432712	<b>\$471.36</b>	03/01/20	ACCT: 20038595	
		<i>Approx Mail Date:</i> 6/18/2020			Payment amount based on patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505			Total Bills exceed maximum award. Payment is prorated at 44.03599% among all providers. <i>Patient Initials:</i> C.A. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1998
5/19/2020	108421280	<b>\$1,078.40</b>	05/17/19	ACCT: 1919084359	
		<i>Approx Mail Date:</i> 5/22/2020			Payment amount based on \$1,348.00 patient balance after insurance and insurance adjustments.
		<i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> T.P. <i>Patient Birth Year:</i> 1964

5/19/2020	108421281	\$428.57	07/05/19	ACCT: 1919115141	Payment amount based on \$1,348.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 39.7409% among all providers. <b>Patient Initials:</b> M.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1970
	<b>Approx Mail Date:</b> 5/22/2020				
	<b>Mail To Address:</b> PO BOX 392505 PITTSBURG PA 15251-9505				
5/19/2020	108421282	\$2,214.40	05/20/19 AND 05/27/19	ACCT: 1919085961 - \$1,107.20; 1919090100 - \$1,107.20	Payment amount based on \$2,768.00 patient balance after insurance and insurance adjustments.  Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> J.C. <b>Patient Birth Year:</b> 1977
	<b>Approx Mail Date:</b> 5/22/2020				
	<b>Mail To Address:</b> PO BOX 392505 PITTSBURG PA 15251-9505				
3/18/2020	108394493	\$1,192.00	09/06/19	ACCT: 19-19156177	Payment amount based on \$1,490.00 patient balance after insurance and insurance adjustments.  Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> T.H. <b>Patient Birth Year:</b> 1979
	<b>Approx Mail Date:</b> 3/21/2020				
	<b>Mail To Address:</b> PO BOX 392505 PITTSBURG PA 15251-9505				
3/18/2020	108394492	\$185.61	05/28/19	ACCT: 19-19090584	Payment amount based on \$683.81 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 33.92995% among all providers. <b>Patient Initials:</b> D.A. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1982
	<b>Approx Mail Date:</b> 3/21/2020				
	<b>Mail To Address:</b> PO BOX 392505 PITTSBURG PA 15251-9505				
3/18/2020	108394491	\$1,126.40	06/24/18	ACCT: 18-18104104	Payment amount based on \$1,408.00 patient balance after insurance and insurance adjustments.  Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> S.G. <b>Patient Birth Year:</b> 1984
	<b>Approx Mail Date:</b> 3/21/2020				
	<b>Mail To Address:</b> PO BOX 392505 PITTSBURG PA 15251-9505				
1/29/2020	108365737	\$1,078.40	06/21/19	ACCT: 19-19106209	Payment amount based on \$1,348.00 patient balance after insurance and insurance adjustments.  Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> T.S. <b>Patient Birth Year:</b> 1998
	<b>Approx Mail Date:</b> 2/1/2020				
	<b>Mail To Address:</b> PO BOX 392505 PITTSBURG PA 15251-9505				
1/29/2020	108365736	\$605.68	07/30/18	ACCT: 18-18125844	Payment amount based on \$1,348.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 56.16444% among all providers. <b>Patient Initials:</b> A.C. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1964
	<b>Approx Mail Date:</b> 2/1/2020				
	<b>Mail To Address:</b> PO BOX 392505 PITTSBURG PA 15251-9505				

**EMSA - WESTERN DIVISION - OKC**

**Office of State Finance VendorID:** 0000057454

<b>Check Date:</b>	<b>Check #:</b>	<b>Amount:</b>	<b>Service Date(s):</b>	<b>Provider Reference:</b>	<b>Patient Identifiers</b>
		\$86.25	05/10/19	ACCT: 19-19079222	
	<b>Approx Mail Date:</b> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20				
	<b>Mail To Address:</b> PO BOX 392519 PITTSBURG PA 152519519				Payment amount based on \$1,360.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 7.92745% among all providers. <b>Patient Initials:</b> A.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1977

		<b>\$1,157.72</b>	05/28/20	ACCT: 20-20089352	Payment amount based on \$1,452.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20			Total Bills exceed maximum award. Payment is prorated at 99.66612% among all providers. <i>Patient Initials:</i> J.B.
		<i>Mail To Address:</i> PO BOX 392519 PITTSBURG PA 152519519			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 2007
<hr/>					
		<b>\$609.81</b>	07/23/20	ACCT: 20-20124895	Payment amount based on \$1,471.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20			Total Bills exceed maximum award. Payment is prorated at 51.81909% among all providers. <i>Patient Initials:</i> M.V.
		<i>Mail To Address:</i> PO BOX 392519 PITTSBURG PA 152519519			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1975
<hr/>					
		<b>\$1,059.20</b>	05/25/19	ACCT: 19-19089268	Payment amount based on \$1,324.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20			<i>Patient Initials:</i> T.J.
		<i>Mail To Address:</i> PO BOX 392519 PITTSBURG PA 152519519			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1973
<hr/>					
		<b>\$1,068.80</b>	10/03/18	ACCT: 18-18166788	Payment amount based on \$1,336.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> Requested from OSF 10/8/20 Expected to be mailed by 10/22/20			<i>Patient Initials:</i> E.P.
		<i>Mail To Address:</i> PO BOX 392519 PITTSBURG PA 152519519			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1974
<hr/>					
<b>9/18/2020</b>	<b>108476117</b>	<b>\$1,088.00</b>	06/17/18	ACCT: 18-18099801	Payment amount based on \$1,360.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 9/21/2020			<i>Patient Initials:</i> C.J.
		<i>Mail To Address:</i> PO BOX 392519 PITTSBURG PA 152519519			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1963
<hr/>					
<b>9/18/2020</b>	<b>108476119</b>	<b>\$243.99</b>	01/23/20	ACCT: 20-200144440	Payment amount based on \$1,357.25 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 9/21/2020			Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers. <i>Patient Initials:</i> S.G.
		<i>Mail To Address:</i> PO BOX 392519 PITTSBURG PA 152519519			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1983
<hr/>					
<b>9/18/2020</b>	<b>108476118</b>	<b>\$240.53</b>	09/19/19	ACCT: 19-19165866	Payment amount based on \$1,338.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 9/21/2020			Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers. <i>Patient Initials:</i> S.G.
		<i>Mail To Address:</i> PO BOX 392519 PITTSBURG PA 152519519			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1983
<hr/>					
<b>9/25/2020</b>	<b>108480173</b>	<b>\$1,088.00</b>	1/7/20-1/8/20	ACCT:1919001422	Payment amount based on \$1,360.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 9/28/2020			<i>Patient Initials:</i> C.B.
		<i>Mail To Address:</i> PO BOX 392519 PITTSBURG PA 152519519			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1970
<hr/>					
<b>8/26/2020</b>	<b>108464024</b>	<b>\$1,085.60</b>	03/01/20	ACCT: 20-20039095	Payment amount based on \$1,357.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 8/29/2020			<i>Patient Initials:</i> T.E.
		<i>Mail To Address:</i> PO BOX 392519 PITTSBURG PA 152519519			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1985

8/26/2020	108464025	\$151.46	05/27/20	ACCT: 20-20088787	Payment amount based on \$1,388.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 13.64039% among all providers. <b>Patient Initials:</b> S.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1996
	<b>Approx Mail Date:</b>	8/29/2020			
	<b>Mail To Address:</b>	PO BOX 392519 PITTSBURG PA 152519519			
8/26/2020	108464023	\$77.37	02/05/20	ACCT: 20-20022536	Payment amount based on \$1,528.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 6.329409% among all providers. <b>Patient Initials:</b> A.K. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1997
	<b>Approx Mail Date:</b>	8/29/2020			
	<b>Mail To Address:</b>	PO BOX 392519 PITTSBURG PA 152519519			
8/26/2020	108464021	\$1,107.20	03/10/19	ACCT: 19-19041298	Payment amount based on \$1,384.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> S.W. <b>Patient Birth Year:</b> 1996
	<b>Approx Mail Date:</b>	8/29/2020			
	<b>Mail To Address:</b>	PO BOX 392519 PITTSBURG PA 152519519			
8/26/2020	108464022	\$736.46	03/27/19	ACCT: 19-19052402	Payment amount based on \$1,408.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 65.3817% among all providers. <b>Patient Initials:</b> D.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1984
	<b>Approx Mail Date:</b>	8/29/2020			
	<b>Mail To Address:</b>	PO BOX 392519 PITTSBURG PA 152519519			
8/26/2020	108464020	\$1,097.60	04/13/18	ACCT: 1818060320	Payment amount based on \$1,372.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> C.K. <b>Patient Birth Year:</b> 1996
	<b>Approx Mail Date:</b>	8/29/2020			
	<b>Mail To Address:</b>	PO BOX 392519 PITTSBURG PA 152519519			
8/26/2020	108464019	\$467.45	04/22/16	ACCT: 16-16065008	Payment amount based on \$1,480.05 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 39.47931% among all providers. <b>Patient Initials:</b> E.R. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1974
	<b>Approx Mail Date:</b>	8/29/2020			
	<b>Mail To Address:</b>	PO BOX 392519 PITTSBURG PA 152519519			
		\$48.87	11/06/16	ACCT: 16-16181893	Payment amount based on \$1,360.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 4.49173% among all providers. <b>Patient Initials:</b> R.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1963
	<b>Approx Mail Date:</b>	Requested from OSF 1/9/18 Expected to be mailed by 1/23/18			
	<b>Mail To Address:</b>	PO BOX 392519 PITTSBURG PA 152519519			
7/28/2020	108449451	\$2,520.14	03/18/18, 05/19/18, AND 05/31/18	ACCT: 1818045593 - \$1,203.20; 1818082305 - \$1,116.80; 1818090836 - \$200.14	Payment amount based on \$3,150.18 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> J.W. <b>Patient Birth Year:</b> 1981
	<b>Approx Mail Date:</b>	7/31/2020			
	<b>Mail To Address:</b>	PO BOX 392519 PITTSBURG PA 152519519			
6/25/2020	108438864	\$1,268.00	8/7/19	ACCT:19-19137027	Payment amount based on \$1,585.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> N.S. <b>Patient Birth Year:</b> 1994
	<b>Approx Mail Date:</b>	6/28/2020			
	<b>Mail To Address:</b>	PO BOX 392519 PITTSBURG PA 152519519			

6/15/2020	108432711	\$160.41	01/09/19	ACCT: 19-19005060	Payment amount based on \$664.30 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 30.18452% among all providers. <i>Patient Initials:</i> B.D. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1999
	<i>Approx Mail Date:</i>	6/18/2020			
	<i>Mail To Address:</i>	PO BOX 392519 PITTSBURG PA 152519519			
5/19/2020	108421278	\$155.74	06/10/19	ACCT: 1919099138	Payment amount based on \$1,396.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 13.94428% among all providers. <i>Patient Initials:</i> B.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1995
	<i>Approx Mail Date:</i>	5/22/2020			
	<i>Mail To Address:</i>	PO BOX 392519 PITTSBURG PA 152519519			
5/19/2020	108421279	\$1,174.40	04/17/19	ACCT: 1919065614	Payment amount based on \$1,468.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> T.W. <i>Patient Birth Year:</i> 1961
	<i>Approx Mail Date:</i>	5/22/2020			
	<i>Mail To Address:</i>	PO BOX 392519 PITTSBURG PA 152519519			
5/19/2020	108421277	\$827.07	02/23/19	ACCT: 19031773	Payment amount based on \$1,348.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 76.69417% among all providers. <i>Patient Initials:</i> K.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1988
	<i>Approx Mail Date:</i>	5/22/2020			
	<i>Mail To Address:</i>	PO BOX 392519 PITTSBURG PA 152519519			
5/19/2020	108421276	\$782.53	08/16/18	ACCT: 1818136501	Payment amount based on \$1,324.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 73.87926% among all providers. <i>Patient Initials:</i> V.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1958
	<i>Approx Mail Date:</i>	5/22/2020			
	<i>Mail To Address:</i>	PO BOX 392519 PITTSBURG PA 152519519			
3/9/2020	108388683	\$1,100.80	08/20/19	ACCT: 19-19145519	Payment amount based on \$1,376.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> E.L. <i>Patient Birth Year:</i> 1981
	<i>Approx Mail Date:</i>	3/12/2020			
	<i>Mail To Address:</i>	PO BOX 392519 PITTSBURG PA 152519519			
2/21/2020	108379701	\$1,088.00	05/18/19	ACCT: 19-19084596	Payment amount based on \$1,360.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> A.A. <i>Patient Birth Year:</i> 1970
	<i>Approx Mail Date:</i>	2/24/2020			
	<i>Mail To Address:</i>	PO BOX 392519 PITTSBURG PA 152519519			
2/21/2020	108379700	\$1,068.80	12/01/18	ACCT: 18-18202085	Payment amount based on \$1,336.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> K.S. <i>Patient Birth Year:</i> 1991
	<i>Approx Mail Date:</i>	2/24/2020			
	<i>Mail To Address:</i>	PO BOX 392519 PITTSBURG PA 152519519			
1/21/2020	108360097	\$595.61	10/05/19	ACCT: 19-19176820	Payment amount based on \$1,490.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 49.96687% among all providers. <i>Patient Initials:</i> S.K. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1988
	<i>Approx Mail Date:</i>	1/24/2020			
	<i>Mail To Address:</i>	PO BOX 392519 PITTSBURG PA 152519519			



\$468.70 09/02/18 ACCT: 18-3361

Approx Mail Date: Requested from OSF 10/15/20 Expected to be mailed by 10/29/20

Mail To Address: 827 EAST LINCOLN ROAD  
IDABEL OK 74745

Payment amount based on \$585.88 patient balance after insurance and insurance adjustments.

Patient Initials: J.C.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1980

1/14/2020 108356538 \$792.43 8/1/2019 ACCT: 19-3222

Approx Mail Date: 1/17/2020

Mail To Address: 827 EAST LINCOLN ROAD  
IDABEL OK 74745

Payment amount based on \$990.54 patient balance after insurance and insurance adjustments.

Patient Initials: C.H.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1978

INTEGRIS SOUTHWEST MEDICAL CTR

Office of State Finance VendorID: 0000057735

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

7/28/2020 108449474 \$1,942.08 03/18/18 ACCT: 600963216

Approx Mail Date: 7/31/2020

Mail To Address: PO BOX 268908  
OKLAHOMA CITY OK 73126-8908

Payment amount based on \$2,427.60 patient balance after insurance and insurance adjustments.

Patient Initials: J.W.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1981

7/27/2020 108448976 \$192.64 8/1/2019 ACCT:109581141

Approx Mail Date: 7/30/2020

Mail To Address: PO BOX 268908  
OKLAHOMA CITY OK 73126-8908

Payment amount based on \$240.80 patient balance after insurance and insurance adjustments.

Patient Initials: G.G.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1984

7/27/2020 108448977 \$1,312.85 8/1/2019 ACCT: 6021155948

Approx Mail Date: 7/30/2020

Mail To Address: PO BOX 268908  
OKLAHOMA CITY OK 73126-8908

Payment amount based on \$1,641.06 patient balance after insurance and insurance adjustments.

Patient Initials: G.G.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1984

7/27/2020 108448975 \$6.72 8/1/2019 ACCT:109581324

Approx Mail Date: 7/30/2020

Mail To Address: PO BOX 268908  
OKLAHOMA CITY OK 73126-8908

Payment amount based on \$8.40 patient balance after insurance and insurance adjustments.

Patient Initials: G.G.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1984

7/27/2020 108448973 \$994.36 6/23/2019 ACCT: 602060466

Approx Mail Date: 7/30/2020

Mail To Address: PO BOX 268908  
OKLAHOMA CITY OK 73126-8908

Payment amount based on \$1,242.95 patient balance after insurance and insurance adjustments.

Patient Initials: E.P.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1972

7/27/2020 108448974 \$67.57 6/23/2019 ACCT: 109341652

Approx Mail Date: 7/30/2020

Mail To Address: PO BOX 268908  
OKLAHOMA CITY OK 73126-8908

Payment amount based on \$84.46 patient balance after insurance and insurance adjustments.

Patient Initials: E.P.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1972

7/27/2020 108448972 \$895.76 1/9/19 ACCT: 601642120

Payment amount based on \$1,119.70 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/30/2020

Patient Initials: M.P.

Mail To Address: PO BOX 268908  
OKLAHOMA CITY OK 73126-8908

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1974

**INTEGRIS MEDICAL CENTER**

Office of State Finance VendorID: 0000057438

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

9/25/2020 108480182 \$5,718.43 10/13/18-10/14/18 ACCOUNT: 601434252 DOS: 10/13/18-10/14/2018 ACCOUNT: 107730452 DOS: 10/13/18-10/14/18

Payment amount based on \$7,148.04 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/28/2020

Patient Initials: R.V.

Mail To Address: 4401 S WESTERN AVE  
OKLAHOMA CITY OK 73109-3413

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1965

**J. ROBERT RENEAU DDS**

Office of State Finance VendorID: 0000311759

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/16/2020 108358373 \$6,952.00 7/25/2019-1/9/2020 ACCT: P.N.

Payment amount based on \$8,690.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/19/2020

Patient Initials: P.N.

Mail To Address: 2751 N W EXPRESSWAY #5  
OKLAHOMA CITY OK 73112

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1988

**CARDIOLOGY CLINIC OF MUSKOGEE, INC.**

Office of State Finance VendorID: 0000057799

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/21/2020 108360058 \$18.89 04/14/18 ACCT: 73579A3442

Payment amount based on \$65.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/24/2020

Total Bills exceed maximum award. Payment is prorated at 36.32196% among all providers.

Patient Initials: R.H.

Mail To Address: DBA CCOM MEDICAL GROUP 350 SOUTH 40TH STREET  
MUSKOGEE OK 74401-4915

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1968

**A CHANCE TO CHANGE**

Office of State Finance VendorID:

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$48.93 01/08/19 - 01/21/20 ACCT: 0000003494

Payment amount based on \$61.16 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 7/14/20 Expected to be mailed by 7/28/20

Patient Initials: J.W.

Mail To Address: 2113 W BRITTON RD  
OKLAHOMA CITY OK 73120

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1981

**SINOR EMS**

Office of State Finance VendorID: 0000057953

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

4/29/2020 108413399 \$623.52 ACCT: 123983

Approx Mail Date: 5/2/2020

Mail To Address: PO BOX 1072  
CLINTON OK 73601-1072

Payment amount based on \$779.40 patient balance after insurance and insurance adjustments.

Patient Initials: P.W.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1991

REGIONAL MEDICAL LAB, INC.

Office of State Finance VendorID: 0000057970

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/26/2020 108464173 \$760.43 12/19/19 AND 01/03/20 ACCT: 4174589

Payment amount based on \$950.54 patient balance after insurance and insurance adjustments.

Patient Initials: B.P.

Approx Mail Date: 8/29/2020

Mail To Address: 1923 S UTICA AVE  
TULSA OK 74104-6520

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1998

REGIONAL MEDICAL LAB

Office of State Finance VendorID: 0000057970

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/18/2020 108394582 \$191.32 11/05/19 ACCT: R34990006 - \$47.68;  
R35065605 - \$143.64

Payment amount based on \$239.15 patient balance after insurance and insurance adjustments.

Patient Initials: T.H.

Approx Mail Date: 3/21/2020

Mail To Address: DEP 1728  
TULSA OK 74182

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1979

3/18/2020 108394581 \$153.09 05/29/19 ACCT: 3961603

Payment amount based on \$564.00 patient balance after insurance and insurance adjustments.

Patient Initials: D.A.

Approx Mail Date: 3/21/2020

Mail To Address: DEP 1728  
TULSA OK 74182

Total Bills exceed maximum award. Payment is prorated at 33.92995% among all providers.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1982

REGIONAL MEDICAL LAB

Office of State Finance VendorID: 0000057970

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/27/2020 108363784 \$94.43 11/18/2019 ACCT: 2260857

Payment amount based on \$118.04 patient balance after insurance and insurance adjustments.

Patient Initials: J.S.

Approx Mail Date: 1/30/2020

Mail To Address: DEPT 2803  
TULSA OK 74182

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2000

MUSKOGEE CO. EMS

Office of State Finance VendorID: 0000058026

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

7/28/2020 108449506 \$1,923.70 01/14/20 ACCT: 87484

Payment amount based on patient balance after insurance and insurance adjustments.

Patient Initials: W.G.

Approx Mail Date: 7/31/2020

Mail To Address: 200 CALLAHAN ST  
MUSKOGEE OK 74403-5126

Patient Birth Year: 1963

**RICHARD H. SWINK**

*Office of State Finance VendorID:* 0000058044

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/2/2020	108384768	\$18.26	03/29/19 - 05/24/19	ACCT: WAGEKE001	Payment amount based on \$30.44 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/5/2020					<i>Patient Initials:</i> K.W.
<i>Mail To Address:</i> 1616 E 19TH ST, SUITE 103 EDMOND OK 73013					<i>Patient Birth Year:</i> 1969

**KIESAU LEE FUNERAL HOME**

*Office of State Finance VendorID:* 0000058114

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
7/28/2020	108449483	\$3,185.25	06/01/18	ACCT: C.D.S.	Payment amount based on \$3,185.25 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 7/31/2020					<i>Patient Initials:</i> C.S.
<i>Mail To Address:</i> 2500 W MODELLE AVE CLINTON OK 73601					<i>Patient Birth Year:</i> 1994

**CREEK CO. EMERGENCY AMBULANCE**

*Office of State Finance VendorID:* 0000058163

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/31/2020	108400167	\$979.20	07/05/19	ACCT: 19-5748	Payment amount based on \$1,224.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/3/2020					<i>Patient Initials:</i> A.K.
<i>Mail To Address:</i> 123 E HOBSON ST SAPULPA OK 74066					<i>Patient Birth Year:</i> 1990

**MARSHALL COUNTY EMS AMBULANCE**

*Office of State Finance VendorID:* 0000177795

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/29/2020	108365941	\$538.24	08/21/19	ACCT: 0008855	Payment amount based on \$672.80 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 2/1/2020					<i>Patient Initials:</i> K.J.
<i>Mail To Address:</i> PO BOX 707 MADILL OK 73446-0707					<i>Patient Birth Year:</i> 1974

**WILLIS GRANITE PRODUCTS CO.**

*Office of State Finance VendorID:* 0000074166

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
6/25/2020	108438978	\$3,378.56	1-11-20	ACCOUNT:R.T.	Payment amount based on \$3,378.56 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 6/28/2020					<i>Patient Initials:</i> R.T.
<i>Mail To Address:</i> PO BOX 727 GRANITE OK 73547-0727					<i>Patient Birth Year:</i> 2017

INTER ID

Office of State Finance VendorID: 0000178332

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/18/2020 108394512 \$33.51 09/13/19, 09/16/19, AND 11/01/19 ACCT: 1-58375

Payment amount based on \$450.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/21/2020

Total Bills exceed maximum award. Payment is prorated at 9.308603% among all providers. Patient Initials: S.S.

Mail To Address: 6565 S YALE AVE STE 812 TULSA OK 74136-8309

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1984

OKLAHOMA DIAGNOSTIC IMAGING

Office of State Finance VendorID: 0000058497

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/9/2020 108388753 \$120.00 09/26/19 ACCT: 180055

Payment amount based on \$150.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/12/2020

Patient Initials: A.B.

Mail To Address: PO BOX 268822 OKLAHOMA CITY OK 73126

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1990

MARY HURLEY HOSP. dba COAL CO. GENERAL HOSP.

Office of State Finance VendorID: 0000178608

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/3/2020 108427390 \$40.00 09/16/19 ACCT: 2010

Payment amount based on \$50.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/6/2020

Patient Initials: R.B.

Mail To Address: 6 N COVINGTON COALGATE OK 74538

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1996

CHOCTAW CO. AMBULANCE

Office of State Finance VendorID: 0000058623

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

9/18/2020 108476096 \$765.52 08/07/18 ACCT: 227-2271801569:1

Payment amount based on \$956.90 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/21/2020

Patient Initials: J.A.

Mail To Address: PO BOX 567 HUGO OK 74743-0567

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1998

TULSA FAMILY DEVELOPMENT CENTER

Office of State Finance VendorID: 0000058645

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

2/12/2020 108373868 \$24.00 12/18/2019 ACCT: 19936

Payment amount based on \$30.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/15/2020

Patient Initials: C.M.

Mail To Address: 4520 S HARVARD SUITE 200A TULSA OK 74135

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 2001

**HOME HEALTH PRODUCTS***Office of State Finance VendorID:* 0000179259

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/29/2020	108365781	\$52.18	10/08/19	ACCT:18411-98043	Payment amount based on \$65.23 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 2/1/2020					<i>Patient Initials:</i> T.K.
<i>Mail To Address:</i> 1208 E TAMARACK ROAD ALTUS OK 73521					<i>Patient Birth Year:</i> 1967

**BIBLE BAPTIST CHURCH***Office of State Finance VendorID:* 0000505391

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
4/7/2020	108403243	\$600.00	12/20/19	FUNERAL REIMBURSEMENT	Payment amount based on \$600.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/10/2020					<i>Patient Initials:</i> J.M.
<i>Mail To Address:</i> DBA SOUTH POINTE BAPTIST CHURCH PO BOX 1187 GUTHRIE OK 73044					<i>Patient Birth Year:</i> 1989

**RADIOLOGY ASSOC. OF EASTERN OKLAHOMA***Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$20.00	08/25/19	ACCT: 36519	Payment amount based on \$25.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 3/4/20 Expected to be mailed by 3/18/20					<i>Patient Initials:</i> R.H.
<i>Mail To Address:</i> 1 E. CLARK BASS BLVD MCALESTER OK 74501					<i>Patient Birth Year:</i> 1972

**WILLIAMSON FUNERAL HOME***Office of State Finance VendorID:* 0000208275

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/26/2020	108463983	\$1,095.00	12/10/2008	ACCT: P.W.	Payment amount based on \$1,095.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 8/29/2020					<i>Patient Initials:</i> P.W.
<i>Mail To Address:</i> 221 SOUTH MAIN WETUMKA OK 74883					<i>Patient Birth Year:</i> 1937

**WARREN CLINIC***Office of State Finance VendorID:* 0000074753

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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\$2,478.67

09/20/18 - 04/03/19

ACCT: 3083528801 - \$115.73;  
3083528781 - \$94.50; 3083528771 -  
\$265.71; 3083528792 - \$818.31;  
3083528751 - \$118.65; 3085346831 -  
\$681.93; 3098827040 - \$341.36;  
3098646500 - \$42.47

Payment amount based on \$9,337.80 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

*Mail To Address:* 6600 S YALE AVE STE 1400  
TULSA OK 74136-3348

Total Bills exceed maximum award. Payment is prorated at 33.18064% among all providers. *Patient Initials:* M.M.

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1988

8/26/2020 108464225 \$2,115.37

07/17/18 - 08/24/18

ACCT: 3081622180 - \$763.02;  
3081322861 - \$519.44; 3090746070 -  
\$68.05; 3090746080 - \$147.16;  
3090746060 - \$617.70

Payment amount based on \$9,171.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 8/29/2020

*Mail To Address:* 6600 S YALE AVE STE 1400  
TULSA OK 74136-3348

Total Bills exceed maximum award. Payment is prorated at 28.83237% among all providers. *Patient Initials:* I.M.

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1996

7/28/2020 108449589 \$1,555.41

08/07/17 - 08/22/17

ACCT: 3112536830 - \$406.79;  
3112536840 - \$314.29; 3112536790 -  
\$485.06; 3112536800 - \$90.73;  
3112536820 - \$258.54

Payment amount based on \$2,623.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 7/31/2020

*Mail To Address:* 6600 S YALE AVE STE 1400  
TULSA OK 74136-3348

Total Bills exceed maximum award. Payment is prorated at 74.12385% among all providers. *Patient Initials:* T.A.

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1969

4/22/2020 108410410 \$824.80

02/12/17 - 02/15/17

ACCT: 1470757

Payment amount based on \$1,031.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 4/25/2020

*Mail To Address:* 6600 S YALE AVE STE 1400  
TULSA OK 74136-3348

*Patient Initials:* G.S.

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1966

3/18/2020 108394646 \$3.66

07/29/19

ACCT: 3103475361

Payment amount based on \$49.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 3/21/2020

*Mail To Address:* 6600 S YALE AVE STE 1400  
TULSA OK 74136-3348

Total Bills exceed maximum award. Payment is prorated at 9.308603% among all providers. *Patient Initials:* S.S.

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1984

2/18/2020 108376785 \$113.57

02/06/19

ACCT: 3102738480

Payment amount based on \$245.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 2/21/2020

*Mail To Address:* 6600 S YALE AVE STE 1400  
TULSA OK 74136-3348

Total Bills exceed maximum award. Payment is prorated at 57.94448% among all providers. *Patient Initials:* J.S.

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1990

**ST. JOHN CLINIC**

*Office of State Finance VendorID:* 0000179816

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

8/26/2020 108464203 \$206.80

12/30/19 - 01/08/20

ACCT: 3623581A7661

Payment amount based on \$258.50 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 8/29/2020

*Mail To Address:* PO BOX 13292  
BELFAST ME 04915-4023

*Patient Initials:* B.P.

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1998



**ST. JOHN CLINIC**

*Office of State Finance VendorID:* 0000179816

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
10/16/2020	108490835	\$26.68	8//2019	ACCT: 3567034	Payment amount based on \$33.35 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 10/19/2020				<i>Patient Initials:</i> R.B.
		<i>Mail To Address:</i> 1920 S. UTICA AVE. TULSA OK 74104			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1964

**ST JOHN PHYSICIANS**

*Office of State Finance VendorID:* 0000179816

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
9/18/2020	108476199	\$276.80	03/10/20	ACT: 3670163A7661	Payment amount based on \$346.00 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 9/21/2020				<i>Patient Initials:</i> J.S.
		<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1988
7/27/2020	108449015	\$413.60	11/24/2018	ACCT: 5743924V7661	Payment amount based on \$517.00 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 7/30/2020				<i>Patient Initials:</i> C.S.
		<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1977
3/18/2020	108394606	\$262.02	06/19/19 - 07/02/19	ACCT: 3514588A7661	Payment amount based on \$1,296.00 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 3/21/2020			Total Bills exceed maximum award. Payment is prorated at 25.27231% among all providers.	<i>Patient Initials:</i> J.H.
		<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1971
3/18/2020	108394607	\$114.25	07/19/19 - 07/23/19	ACCT: 3532643	Payment amount based on \$777.50 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 3/21/2020			Total Bills exceed maximum award. Payment is prorated at 18.36885% among all providers.	<i>Patient Initials:</i> T.S.
		<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1968
1/29/2020	108366113	\$400.00	07/10/18	ACCT: 5284621V7661	Payment amount based on \$500.00 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 2/1/2020				<i>Patient Initials:</i> B.M.
		<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1981

**OKLAHOMA OTOLARYNGOLOGY ASSOC.**

*Office of State Finance VendorID:* 0000179890

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
8/12/2020	108456758	\$163.57	4/19/2019	ACCT:1488545	Payment amount based on \$204.46 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 8/15/2020				<i>Patient Initials:</i> K.B.
		<i>Mail To Address:</i> PO BOX 960119 OKLAHOMA CITY OK 73196-0119			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1968

**WILBERN CROWDIS**

*Office of State Finance VendorID:* 0000500948

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/29/2020	108366202	\$2,590.00	04/11/19	ACCT: A.S.D.	Payment amount based on \$2,590.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 2/1/2020					<i>Patient Initials:</i> A.S.
<i>Mail To Address:</i> DBA JONES MONUMENT CO DUNCAN OK 73533					<i>Patient Birth Year:</i> 1983

**EAGLE PEAK MONUMENTS**

*Office of State Finance VendorID:* 0000343113

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
10/16/2020	108490759	\$2,819.63	8/20/20	ACCT:D.T.	Payment amount based on \$2,819.63 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 10/19/2020					<i>Patient Initials:</i> D.T.
<i>Mail To Address:</i> 603 N. MISSION SAPULPA OK 74066					<i>Patient Birth Year:</i> 1982
4/14/2020	108406838	\$2,099.63	03/06/20	ACCT: J.H.	Payment amount based on \$2,099.63 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/17/2020					<i>Patient Initials:</i> S.H.
<i>Mail To Address:</i> 603 N. MISSION SAPULPA OK 74066					<i>Patient Birth Year:</i> 1982

**PALMER MARLER FUNERAL HOME**

*Office of State Finance VendorID:* 0000180327

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
2/21/2020	108379760	\$6,661.37	02/15/19	ACCT: K.OB.	Payment amount based on \$9,494.37 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 2/24/2020					<i>Patient Initials:</i> K.O.
<i>Mail To Address:</i> 5106 N. WASHINGTON STILLWATER OK 74075					<i>Patient Birth Year:</i> 2007

**THE EYE INSTITUTE**

*Office of State Finance VendorID:* 0000059547

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
6/25/2020	108438869	\$1,403.47	9/1/19 - 9/25/19	ACCT:1190650	Payment amount based on \$1,835.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 6/28/2020					<i>Patient Initials:</i> T.H.
<i>Mail To Address:</i> PO BOX 21228 TULSA OK 74121-1228					<i>Patient Birth Year:</i> 1979

**THE HOLLOWAY GROUP**

*Office of State Finance VendorID:* 0000181022

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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7/8/2020 108441720 \$787.50 01/17/19 - 09/26/19 ACCT: COLNAT

Payment amount based on \$1,050.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/11/2020

Patient Initials: N.C.

Mail To Address: 6613 N MERIDIAN AVE  
OKLAHOMA CITY OK 73116

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1981

ALTUS NEUROLOGY, P.C.

Office of State Finance VendorID: 0000079189

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/9/2020 108388616 \$300.00 07/03/18 ACCT: 29136

Payment amount based on \$375.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/12/2020

Patient Initials: K.B.

Mail To Address: PO BOX 1137  
ALTUS OK 73522-1137

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1999

HARMON MEMORIAL HOSPITAL

Office of State Finance VendorID: 0000059604

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/21/2020 108360118 \$1,547.27 03/10/18 ACCT: 014989

Payment amount based on \$5,318.24 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/24/2020

Total Bills exceed maximum award. Payment is prorated at 36.36716% among all providers.

Patient Initials: J.R.

Mail To Address: PO BOX 791  
HOLLIS OK 73550-0791

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1975

ALAN CONGER, PSYD

Office of State Finance VendorID:

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$312.00 8/16/18-02/28/2019 ACCT:3266OAC

Payment amount based on \$390.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/9/20 Expected to be mailed by 10/23/20

Patient Initials: A.M.

Mail To Address: 5512 S LEWIS  
TULSA OK 74105-7116

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2007

COMANCHE CO. HEALTHCARE CORP

Office of State Finance VendorID: 0000059705

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/18/2020 108394472 \$1,017.14 05/29/19 - 06/08/19 ACCT: 1585496 - \$799.39; 1606349 - \$115.54; 1596659 - \$53.91; 1596661 - \$48.30

Payment amount based on \$3,622.50 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/21/2020

Total Bills exceed maximum award. Payment is prorated at 35.09816% among all providers.

Patient Initials: M.B.

Mail To Address: 3811 W. GORE BLVD. SUITE 2  
LAWTON OK 73505-6328

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1979

THERAPY IN MOTION

Office of State Finance VendorID: 0000059800

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/31/2020 108400245 \$1,728.00 10/01/19 - 10/30/19 ACCT: 18817NS

Payment amount based on \$2,160.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 4/3/2020

Patient Initials: N.S.

Mail To Address: 2475 BOARDWALK  
NORMAN OK 73069

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1994

LOCKSTONE FUNERAL HOME OF THOMAS

Office of State Finance VendorID: 0000254344

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

7/28/2020 108449491 \$1,034.35 4/24/19 ACCT: H.B.

Payment amount based on \$1,034.35 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/31/2020

Patient Initials: H.B.

Mail To Address: PO BOX 663  
THOMAS OK 73669-0663

Patient Birth Year: 1973

NEUROSURGICAL SPECIALISTS OF TULSA

Office of State Finance VendorID: 0000059905

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

2/18/2020 108376715 \$372.70 02/03/19 - 03/01/19 ACCT: SMIJU002

Payment amount based on \$804.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/21/2020

Total Bills exceed maximum award. Payment is prorated at 57.94448% among all providers. Patient Initials: J.S.

Mail To Address: PO BOX 52028  
TULSA OK 74152-0028

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1990

BRUMLEY FUNERAL HOME

Office of State Finance VendorID: 0000199498

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/31/2020 108400235 \$274.76 12/12/19 ACCT: L.M.

Payment amount based on \$274.76 patient balance after insurance and insurance adjustments.

Approx Mail Date: 4/3/2020

Patient Initials: L.M.

Mail To Address: 500 NORTH PARK DR.  
BROKEN BOW OK 74728

Patient Birth Year: 1945

3/9/2020 108388793 \$6,603.54 09/29/18 ACCT: L.D.

Payment amount based on \$6,603.54 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/12/2020

Patient Initials: L.D.

Mail To Address: 500 NORTH PARK DR.  
BROKEN BOW OK 74728

Patient Birth Year: 1982

GRIFFITH MEMORIAL FUNERAL HOME

Office of State Finance VendorID: 0000060054

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/12/2020 108456719 \$1,719.07 7/16/20 ACCT: C.B.

Payment amount based on \$1,719.07 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/15/2020

Patient Initials: C.B.

Mail To Address: 4424 S 33RD WEST AVE  
TULSA OK 74107-6400

Patient Birth Year: 1975

**BUNCH-ROBERTS FUNERAL HOME***Office of State Finance VendorID:* 0000182001

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
9/18/2020	108476187	\$2,317.75	07/30/18	ACCT: R.P.	Payment amount based on \$2,317.75 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 9/21/2020					<i>Patient Initials:</i> R.P.
<i>Mail To Address:</i> P O BOX 1112 GUYMON OK 73942					<i>Patient Birth Year:</i> 1992

**KEITH BIGLOW FUNERAL DIRECTORS***Office of State Finance VendorID:* 0000060171

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
9/18/2020	108476140	\$4,159.06	05/02/20	ACCT: D.O.	Payment amount based on \$8,318.12 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 9/21/2020					<i>Patient Initials:</i> D.O.
<i>Mail To Address:</i> PO BOX 2411 MUSKOGEE OK 74402-2411					<i>Patient Birth Year:</i> 1974

**KEITH D BIGLOW FUNERAL DIRECTORS INC***Office of State Finance VendorID:* 0000060171

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
9/18/2020	108476139	\$3,487.36	04/24/20	ACCT: D.W.	Payment amount based on \$3,487.36 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 9/21/2020					<i>Patient Initials:</i> T.W.
<i>Mail To Address:</i> 1414 N NORFOLK TULSA OK 74106					<i>Patient Birth Year:</i> 2000

**MISSY ISKI, LPC***Office of State Finance VendorID:* 0000212434

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/12/2020	108456754	\$293.14	12/3/2018-1/3/2020	ACCT: C.R.	Payment amount based on \$366.43 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Initials:</i> C.R.
<i>Mail To Address:</i> 4825 SOUTH PEROIA, STE 7 TULSA OK 74105					<i>Patient Birth Year:</i> 1999
3/31/2020	108400199	\$784.00	08/28/18 - 12/09/19	ACCT: 15659-10561	Payment amount based on \$980.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/3/2020					<i>Patient Initials:</i> M.C.
<i>Mail To Address:</i> 4825 SOUTH PEROIA, STE 7 TULSA OK 74105					<i>Patient Birth Year:</i> 1989

**NORTHWEST ANESTHESIA***Office of State Finance VendorID:* 0000060573

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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8/17/2020 108459252 \$93.60 12/03/19 ACCT: 54639926

Payment amount based on \$117.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/20/2020

Patient Initials: R.J.

Mail To Address: PO BOX 26168  
OKLAHOMA CITY OK 73126-0168

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2000

**JOHN M. IRELAND FUNERAL HOME**

Office of State Finance VendorID: 0000060607

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/10/2020 108389636 \$525.57 9/14/2019 ACCT: J.W.

Payment amount based on \$525.57 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/13/2020

Patient Initials: J.W.

Mail To Address: 120 S BROADWAY ST  
MOORE OK 73160-5212

Patient Birth Year: 1990

**CENTRAL STATES ORTHOPEDIC SPECIALISTS, INC.**

Office of State Finance VendorID: 0000060771

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/27/2020 108363699 \$476.65 12/19/2016-2/14/2017 ACCT: 748999

Payment amount based on \$595.81 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/30/2020

Patient Initials: D.W.

Mail To Address: DEPT 100 PO BOX 22063  
TULSA OK 74121-2063

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2007

**OU PHYSICIANS GROUP**

Office of State Finance VendorID: 0000061010

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$1,182.08 05/10/19 - 05/15/19 ACCT: 2969380

Payment amount based on \$18,639.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

Total Bills exceed maximum award. Payment is prorated at 7.92745% among all providers.

Patient Initials: A.M.

Mail To Address: PO BOX 269026  
OKLAHOMA CITY OK 73126-9026

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1977

\$1,874.64 05/28/20 - 06/15/20 ACCT: 3044864

Payment amount based on \$2,351.15 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

Total Bills exceed maximum award. Payment is prorated at 99.66612% among all providers.

Patient Initials: J.B.

Mail To Address: PO BOX 269026  
OKLAHOMA CITY OK 73126-9026

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2007

\$1,402.22 07/23/20 - 08/05/20 ACCT: 3055391

Payment amount based on \$3,382.50 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

Total Bills exceed maximum award. Payment is prorated at 51.81909% among all providers.

Patient Initials: M.V.

Mail To Address: PO BOX 269026  
OKLAHOMA CITY OK 73126-9026

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1975

\$828.72 09/08/19 ACCT: 2995061

Payment amount based on \$2,540.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

Total Bills exceed maximum award. Payment is prorated at 40.78328% among all providers.

Patient Initials: R.F.

Mail To Address: PO BOX 269026  
OKLAHOMA CITY OK 73126-9026

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1968

		<b>\$49.43</b>	02/22/20	ACCT: 309907	Payment amount based on \$171.05 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	K.P.
		<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20				<i>Patient Birth Year:</i>	1971
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.		
		<b>\$108.59</b>	01/25/20	ACCT: 3025014	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.F.
		<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20				<i>Patient Birth Year:</i>	1978
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026					
		<b>\$1,680.00</b>	05/25/19	ACCT: 289808	Payment amount based on \$2,100.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	T.J.
		<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20				<i>Patient Birth Year:</i>	1973
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.		
<b>9/18/2020</b>	<b>108476089</b>	<b>\$538.42</b>	02/08/20 - 02/10/20	ACCT: 2979526	Payment amount based on \$710.05 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	K.C.
		<i>Approx Mail Date:</i> 9/21/2020			Total Bills exceed maximum award. Payment is prorated at 94.78569% among all providers.	<i>Patient Birth Year:</i>	1989
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.		
<b>9/18/2020</b>	<b>108476084</b>	<b>\$10,174.11</b>	03/22/20 - 04/21/20	ACCT: 3036540	Payment amount based on \$23,981.80 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	C.C.
		<i>Approx Mail Date:</i> 9/21/2020			Total Bills exceed maximum award. Payment is prorated at 53.03037% among all providers.	<i>Patient Birth Year:</i>	1987
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.		
<b>9/18/2020</b>	<b>108476085</b>	<b>\$1,832.80</b>	06/17/18 - 07/03/18	ACCT: 273696	Payment amount based on \$2,291.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	C.J.
		<i>Approx Mail Date:</i> 9/21/2020				<i>Patient Birth Year:</i>	1963
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.		
<b>9/18/2020</b>	<b>108476086</b>	<b>\$455.25</b>	07/13/19 - 02/24/20	ACCT: 2982573	Payment amount based on \$27,706.50 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	P.C.
		<i>Approx Mail Date:</i> 9/21/2020			Total Bills exceed maximum award. Payment is prorated at 2.053886% among all providers.	<i>Patient Birth Year:</i>	1987
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.		
<b>9/18/2020</b>	<b>108476087</b>	<b>\$4,457.70</b>	09/19/19 - 02/14/20	ACCT: 1174810	Payment amount based on \$24,796.65 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	S.G.
		<i>Approx Mail Date:</i> 9/21/2020			Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers.	<i>Patient Birth Year:</i>	1983
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.		
<b>9/18/2020</b>	<b>108476088</b>	<b>\$3,177.92</b>	12/21/19 - 12/23/19	ACCT: 3018169	Payment amount based on \$3,972.40 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	D.M.
		<i>Approx Mail Date:</i> 9/21/2020				<i>Patient Birth Year:</i>	1992
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.		

9/18/2020	108476083	\$10.53	10/19/18	ACCT: 216064	Payment amount based on \$26.33 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.C.
						<i>Patient Birth Year:</i>	1989
8/26/2020	108463971	\$2,342.19	03/02/20 - 03/13/20	ACCT: 1204558	Payment amount based on \$3,637.15 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	S.S.
					Total Bills exceed maximum award. Payment is prorated at 80.49522% among all providers.	<i>Patient Birth Year:</i>	1975
8/26/2020	108463972	\$9,752.47	02/09/20 - 03/06/20	ACCT: 589880	Payment amount based on \$19,033.80 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.S.
					Total Bills exceed maximum award. Payment is prorated at 64.04706% among all providers.	<i>Patient Birth Year:</i>	1987
8/26/2020	108463973	\$3,997.40	04/13/20 - 04/15/20	ACCT: 164101	Payment amount based on \$4,996.75 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	C.A.
						<i>Patient Birth Year:</i>	1989
8/26/2020	108463974	\$1,069.70	05/27/20 - 05/28/20	ACCT: 3044687	Payment amount based on \$9,802.65 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	S.L.
					Total Bills exceed maximum award. Payment is prorated at 13.64039% among all providers.	<i>Patient Birth Year:</i>	1996
8/26/2020	108463970	\$481.09	02/28/20	ACCT: 2629414	Payment amount based on \$1,995.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.N.
					Total Bills exceed maximum award. Payment is prorated at 30.14325% among all providers.	<i>Patient Birth Year:</i>	1962
8/26/2020	108463969	\$824.41	02/06/20 - 02/17/20	ACCT: 2257036	Payment amount based on \$16,281.25 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	A.K.
					Total Bills exceed maximum award. Payment is prorated at 6.329409% among all providers.	<i>Patient Birth Year:</i>	1997
8/26/2020	108463967	\$1,000.00	03/10/19 - 03/26/19	ACCT: 2236338	Payment amount based on \$1,250.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	S.W.
						<i>Patient Birth Year:</i>	1996
8/26/2020	108463968	\$8,802.47	03/27/19 - 04/07/19	ACCT: 343246	Payment amount based on \$16,829.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	D.M.
					Total Bills exceed maximum award. Payment is prorated at 65.3817% among all providers.	<i>Patient Birth Year:</i>	1984

8/26/2020	108463964	\$243.04	12/17/16	ACCT: 2791125	Payment amount based on \$491.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 61.87445% among all providers. <i>Patient Initials:</i> F.R. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1976
		<i>Approx Mail Date:</i> 8/29/2020			
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			
8/26/2020	108463965	\$7,375.20	04/13/18 - 05/01/18	ACCT: 1264091	Payment amount based on \$9,219.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> C.K. <i>Patient Birth Year:</i> 1996
		<i>Approx Mail Date:</i> 8/29/2020			
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			
8/26/2020	108463963	\$821.38	04/22/16 - 11/30/16	ACCT: 2530278	Payment amount based on \$2,600.68 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 39.47931% among all providers. <i>Patient Initials:</i> E.R. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1974
		<i>Approx Mail Date:</i> 8/29/2020			
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			
8/26/2020	108463966	\$6,863.76	08/19/18	ACCT: 2913503	Payment amount based on \$13,027.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 65.86092% among all providers. <i>Patient Initials:</i> R.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1964
		<i>Approx Mail Date:</i> 8/29/2020			
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			
8/26/2020	108463975	\$12.80	6/18/19	ACCT: 2977436	Payment amount based on \$16.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> J.W. <i>Patient Birth Year:</i> N/A
		<i>Approx Mail Date:</i> 8/29/2020			
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			
		\$570.49	11/06/16 - 02/19/19	ACCT: 446537	Payment amount based on \$15,876.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 4.49173% among all providers. <i>Patient Initials:</i> R.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1963
		<i>Approx Mail Date:</i> Requested from OSF 1/9/18 Expected to be mailed by 1/23/18			
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			
8/12/2020	108456664	\$7.50	2-12-20	ACCT: 1491544	Payment amount based on \$9.38 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> M.S. <i>Patient Birth Year:</i> 1999
		<i>Approx Mail Date:</i> 8/15/2020			
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			
7/28/2020	108449423	\$89.89	02/22/20	ACCT: 124957	Payment amount based on patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 45.40086% among all providers. <i>Patient Initials:</i> T.J. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1968
		<i>Approx Mail Date:</i> 7/31/2020			
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			
7/28/2020	108449422	\$5,895.55	08/27/19	ACCT: 2927180	Payment amount based on \$7,369.43 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> A.Q. <i>Patient Birth Year:</i> 1993
		<i>Approx Mail Date:</i> 7/31/2020			
		<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026			

7/27/2020	108448944	\$3.20	2/7/2020	ACCT: 2225974	Payment amount based on \$4.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	T.D.
						<i>Patient Birth Year:</i>	1964
7/28/2020	108449421	\$7,543.40	09/15/18 - 12/11/18	ACCT: 2919345	Payment amount based on \$12,111.50 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	D.R.
					Total Bills exceed maximum award. Payment is prorated at 77.85373% among all providers.	<i>Patient Birth Year:</i>	1977
7/28/2020	108449420	\$5,787.36	05/04/18 - 08/15/19	ACCT: 2891758	Payment amount based on \$15,516.63 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	C.J.
					Total Bills exceed maximum award. Payment is prorated at 46.62222% among all providers.	<i>Patient Birth Year:</i>	1986
7/28/2020	108449419	\$1,074.47	10/16/17 - 03/15/18	ACCT: 2439686	Payment amount based on \$4,100.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	M.S.
					Total Bills exceed maximum award. Payment is prorated at 32.75809% among all providers.	<i>Patient Birth Year:</i>	1958
7/28/2020	108449418	\$6,527.36	07/30/17 - 01/28/20	ACCT: 596110	Payment amount based on \$8,159.20 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	L.N.
					Total Bills exceed maximum award. Payment is prorated at 44.03599% among all providers.	<i>Patient Birth Year:</i>	1991
6/15/2020	108432662	\$10,769.24	01/09/19 - 02/29/20	ACCT: 755877	Payment amount based on \$44,597.51 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	B.D.
					Total Bills exceed maximum award. Payment is prorated at 30.18452% among all providers.	<i>Patient Birth Year:</i>	1999
6/15/2020	108432663	\$158.53	03/01/20	ACCT: 2861754	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	C.A.
					Total Bills exceed maximum award. Payment is prorated at 44.03599% among all providers.	<i>Patient Birth Year:</i>	1998
6/15/2020	108432661	\$11,312.98	11/14/18 - 12/30/18	ACCT: 2932960	Payment amount based on \$33,807.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	D.R.
					Total Bills exceed maximum award. Payment is prorated at 41.82931% among all providers.	<i>Patient Birth Year:</i>	1989
5/19/2020	108421246	\$454.62	08/18/19 - 08/24/19	ACCT: 714584	Payment amount based on \$613.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	D.F.
					Total Bills exceed maximum award. Payment is prorated at 92.70327% among all providers.	<i>Patient Birth Year:</i>	1991

5/19/2020	108421247	\$19,792.38	03/19/19 - 04/24/19	ACCT: 2577561	Payment amount based on \$81,174.50 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 30.47813% among all providers. <b>Patient Initials:</b> J.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1988
	<b>Approx Mail Date:</b> 5/22/2020				
	<b>Mail To Address:</b> PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
5/19/2020	108421243	\$530.55	05/27/19 - 05/31/19	ACCT: 2972581	Payment amount based on \$5,850.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 11.33645% among all providers. <b>Patient Initials:</b> R.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1995
	<b>Approx Mail Date:</b> 5/22/2020				
	<b>Mail To Address:</b> PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
5/19/2020	108421244	\$17,613.18	06/10/19 - 09/03/19	ACCT: 235777	Payment amount based on \$157,888.96 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 13.94428% among all providers. <b>Patient Initials:</b> B.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1995
	<b>Approx Mail Date:</b> 5/22/2020				
	<b>Mail To Address:</b> PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
5/19/2020	108421245	\$1,880.00	04/17/19- 05/01/19	ACCT: 549312	Payment amount based on \$2,350.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> T.W. <b>Patient Birth Year:</b> 1961
	<b>Approx Mail Date:</b> 5/22/2020				
	<b>Mail To Address:</b> PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
5/19/2020	108421242	\$6,901.86	02/23/19 - 02/26/19	ACCT: 2953050	Payment amount based on \$11,249.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 76.69417% among all providers. <b>Patient Initials:</b> K.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1988
	<b>Approx Mail Date:</b> 5/22/2020				
	<b>Mail To Address:</b> PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
5/19/2020	108421241	\$1,189.98	07/23/18	ACCT: 2577561	Payment amount based on \$9,158.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 16.24235% among all providers. <b>Patient Initials:</b> J.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1988
	<b>Approx Mail Date:</b> 5/22/2020				
	<b>Mail To Address:</b> PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
5/19/2020	108421240	\$8,488.06	09/28/18 - 10/20/18	ACCT: 957950	Payment amount based on \$16,508.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 64.27231% among all providers. <b>Patient Initials:</b> B.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1988
	<b>Approx Mail Date:</b> 5/22/2020				
	<b>Mail To Address:</b> PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
4/22/2020	108410376	\$1,368.00	11/20/18	ACCT: 1756959	Payment amount based on \$1,710.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> S.G. <b>Patient Birth Year:</b> 1984
	<b>Approx Mail Date:</b> 4/25/2020				
	<b>Mail To Address:</b> PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
3/31/2020	108400216	\$1,860.80	12/01/18	ACCT: 2936723	Payment amount based on \$2,326.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> A.A. <b>Patient Birth Year:</b> 1989
	<b>Approx Mail Date:</b> 4/3/2020				
	<b>Mail To Address:</b> PO BOX 269026 OKLAHOMA CITY OK 73126-9026				



2/18/2020	108376728	\$1,405.98	09/16/17 - 09/24/17	ACCT: 2166878	Payment amount based on \$27,232.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 6.453729% among all providers. <b>Patient Initials:</b> N.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1995
<i>Approx Mail Date:</i> 2/21/2020					
<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026					
1/29/2020	108365996	\$6,294.52	02/21/18 - 01/08/19	ACCT: 2877785	Payment amount based on \$136,611.08 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 5.75953% among all providers. <b>Patient Initials:</b> A.V. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1988
<i>Approx Mail Date:</i> 2/1/2020					
<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026					
1/29/2020	108365997	\$3,116.70	01/09/18 - 06/04/19	ACCT: 2867907	Payment amount based on \$3,895.88 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> A.C. <b>Patient Birth Year:</b> 2003
<i>Approx Mail Date:</i> 2/1/2020					
<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026					
1/21/2020	108360187	\$468.88	10/05/19	ACCT: 1591458	Payment amount based on \$1,173.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 49.96687% among all providers. <b>Patient Initials:</b> S.K. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1988
<i>Approx Mail Date:</i> 1/24/2020					
<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026					
1/21/2020	108360186	\$460.00	03/10/19	ACCT: 2325007	Payment amount based on \$575.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> L.P. <b>Patient Birth Year:</b> 1966
<i>Approx Mail Date:</i> 1/24/2020					
<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026					
1/14/2020	108356558	\$309.46	6/11/19 & 6/18/19	ACCT: 2975754	Payment amount based on \$386.83 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> R.H. <b>Patient Birth Year:</b> 1990
<i>Approx Mail Date:</i> 1/17/2020					
<i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026					

**WESTERN MEDICAL EQUIPMENT #1**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$68.69	05/09/18	ACCT: 33898	
<i>Approx Mail Date:</i> Requested from OSF 7/14/20 Expected to be mailed by 7/28/20					
<i>Mail To Address:</i> P O BOX 236 TALOGA OK 73667-0236					
					Payment amount based on \$184.18 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 46.62222% among all providers. <b>Patient Initials:</b> C.J. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1986

**N.R.H. EMSSTAT AMBULANCE SERVICES.**

*Office of State Finance VendorID:* 0000061102

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
6/18/2020	108434702	\$976.00	12/8/18	ACCT: N00885973	
<i>Approx Mail Date:</i> 6/21/2020					
<i>Mail To Address:</i> PO BOX 268961 OKLAHOMA CITY OK 73126					
					Payment amount based on \$1,220.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> C.C. <b>Patient Birth Year:</b> 1997

3/19/2020	108395083	\$118.16	7/4/2019	ACCT: N00887798818	Payment amount based on \$147.70 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.G.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1979
2/18/2020	108376719	\$1,054.38	11/06/18	ACCT: N00885642161	Payment amount based on \$1,720.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.A.
					Total Bills exceed maximum award. Payment is prorated at 76.626% among all providers.	<i>Patient Birth Year:</i> 1988
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
1/21/2020	108360175	\$1,256.00	04/18/19	ACCT: N00887292434	Payment amount based on \$1,570.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.D.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1999

**OSBORN DRUGS #2**

*Office of State Finance VendorID:* 0000266165

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
1/21/2020	108360182	\$91.24	02/18/18 - 05/18/18	ACCT: J.S.	Payment amount based on \$114.05 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.S.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1970

**SOUTHWEST ORTHOPAEDIC**

*Office of State Finance VendorID:* 0000061138

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
7/28/2020	108449563	\$58.18	10/11/17	ACCT: SOS-284119	Payment amount based on \$222.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.S.
					Total Bills exceed maximum award. Payment is prorated at 32.75809% among all providers.	<i>Patient Birth Year:</i> 1958
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	
5/19/2020	108421383	\$2,624.80	02/11/19 - 05/09/19	ACCT: SOS789334-03 - \$320.80; 791534-02 - \$1,092.80; 793551-02 - \$72.00; 796219-02 - \$72.00; 802818-02 - \$923.20; 807119-01 - \$72.00; 81588-02 - \$72.00	Payment amount based on \$3,281.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.W.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1972
3/19/2020	108395110	\$36.00	07/29/19	ACCTI 295282	Payment amount based on \$36.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> W.T.
						<i>Patient Birth Year:</i> 1954

**THE PHYSICIANS GROUP**

*Office of State Finance VendorID:* 0000061214

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
9/4/2020	108469000	\$158.46	9/13/19-3/6/20	ACCT:0413315	Payment amount based on \$198.08 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 9/7/2020					<i>Patient Initials:</i> T.G.
<i>Mail To Address:</i> P O BOX 1998 OKLAHOMA CITY OK 73101-1998					<i>Patient Birth Year:</i> 1969

**LOWELL-TIMS FUNERAL HOME**

*Office of State Finance VendorID:* 0000239539

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
7/8/2020	108441735	\$3,465.25	09/21/19	ACCT: T.M.	Payment amount based on \$3,465.25 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 7/11/2020					<i>Patient Initials:</i> T.M.
<i>Mail To Address:</i> 1100 E TAMARACK RD ALTUS OK 73521-1232					<i>Patient Birth Year:</i> 1989

**REACT-EMS**

*Office of State Finance VendorID:* 0000061247

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
9/18/2020	108476183	\$1,806.73	02/08/19	ACCT: 63869	Payment amount based on \$2,382.65 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 9/21/2020					Total Bills exceed maximum award. Payment is prorated at 94.78569% among all providers. <i>Patient Initials:</i> K.C.
<i>Mail To Address:</i> 2316 N AIRPORT DR SHAWNEE OK 74802-3700					<i>Patient Birth Year:</i> 1989

**MMS OF OKLAHOMA CITY, INC**

*Office of State Finance VendorID:* 0000183678

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
9/18/2020	108476147	\$606.94	08/17/18 AND 03/29/19	ACCT: 46466	Payment amount based on \$909.96 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 9/21/2020					Total Bills exceed maximum award. Payment is prorated at 83.37431% among all providers. <i>Patient Initials:</i> J.H.
<i>Mail To Address:</i> MAJORS MEDICAL SUPPLY OKLAHOMA CITY OK 73116					<i>Patient Birth Year:</i> 1978

**ALLIANCE HEALTH MIDWEST**

*Office of State Finance VendorID:* 0000061360

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$3,859.38	01/03/19	ACCT: 844972501	Payment amount based on \$4,824.23 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20					<i>Patient Initials:</i> L.J.
<i>Mail To Address:</i> PO BOX 405970 ATLANTA GA 30384					<i>Patient Birth Year:</i> 1988



9/25/2020 108480201 \$3,151.49 82171528 ALLIANCE HEALTH MW ACCT: 8396012 EMERG SVC MWC Payment amount based on \$3,939.36 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 9/28/2020 *Patient Initials:* H.K.  
*Mail To Address:* PO BOX 405970 *Patient Birth Year:* 1993  
 ATLANTA GA 30384-5970  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**MERCY HOSPITAL ARDMORE**

*Office of State Finance VendorID:* 0000076081

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
7/28/2020	108449499	\$418.95	10/24/18 AND 10/31/18	ACCT: 54000331360 - \$298.95; 54000334512 - \$120.00	
<i>Approx Mail Date:</i> 7/31/2020					<i>Patient Initials:</i> A.Q.
<i>Mail To Address:</i> PO BOX 776066					<i>Patient Birth Year:</i> 1993
CHICAGO IL 60677-6066					

Payment amount based on \$523.69 patient balance after insurance and insurance adjustments.  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**DR. ERROL J. ALLISON, DDS**

*Office of State Finance VendorID:* 0000061795

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
10/1/2020	108482936	\$3,452.80	05/08/20 - 05/20/20	ACCT: 1778300	
<i>Approx Mail Date:</i> 10/4/2020					<i>Patient Initials:</i> B.B.
<i>Mail To Address:</i> ONE PLAZA SOUTH PMB 149					<i>Patient Birth Year:</i> 1969
TAHLEQUAH OK 74464					

Payment amount based on \$4,316.00 patient balance after insurance and insurance adjustments.  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**NEUROSCIENCE SPECIALISTS, PC**

*Office of State Finance VendorID:* 0000076209

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/18/2020	108394548	\$2,424.71	02/15/19	ACCT: 0006000000053181	
<i>Approx Mail Date:</i> 3/21/2020					<i>Patient Initials:</i> J.S.
<i>Mail To Address:</i> 4120 W MEMORIAL RD STE 300					<i>Patient Birth Year:</i> 1957
OKLAHOMA CITY OK 73120-9322					

Payment amount based on \$3,030.89 patient balance after insurance and insurance adjustments.  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**ANESTHESIA SCHEDULING SERVICES**

*Office of State Finance VendorID:* 0000062008

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
5/19/2020	108421214	\$425.54	10/02/18	ACCT: APC355184	
<i>Approx Mail Date:</i> 5/22/2020					<i>Patient Initials:</i> V.M.
<i>Mail To Address:</i> 608 NW 9TH ST. SUITE 6210					<i>Patient Birth Year:</i> 1958
OKLAHOMA CITY OK 73102					

Payment amount based on \$720.00 patient balance after insurance and insurance adjustments.  
 Total Bills exceed maximum award. Payment is prorated at 73.87926% among all providers.  
 Acceptance of payment may require a provider write-off. EOB will accompany payment.

**EMERGENCY PHYSICIANS OF MIDWEST CITY, LLC**

*Office of State Finance VendorID:* 0000062051

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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		<b>\$941.60</b>	01/03/19	ACCT: 0078749979	Payment amount based on \$1,177.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> L.J.
		<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1988
		<i>Mail To Address:</i> PO BOX 96408 OKLAHOMA CITY OK 73143				
<b>9/25/2020</b>	<b>108480174</b>	<b>\$977.60</b>	3/4/2019	ACCT: 0080128188	Payment amount based on \$1,222.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> K.Z.
		<i>Approx Mail Date:</i> 9/28/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1979
		<i>Mail To Address:</i> PO BOX 96408 OKLAHOMA CITY OK 73143				
<b>9/4/2020</b>	<b>108468949</b>	<b>\$2,023.30</b>	2/16/2018	ACCT: 82170453	Payment amount based on \$2,688.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> M.J.
		<i>Approx Mail Date:</i> 9/7/2020			Total Bills exceed maximum award. Payment is prorated at 94.08936% among all providers.	<b>Patient Birth Year:</b> 1974
		<i>Mail To Address:</i> PO BOX 96408 OKLAHOMA CITY OK 73143			Acceptance of payment may require a provider write-off. EOB will accompany payment.	
<b>8/26/2020</b>	<b>108464027</b>	<b>\$1,321.41</b>	08/22/19	ACCT: 0083461989	Payment amount based on \$1,800.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> J.S.
		<i>Approx Mail Date:</i> 8/29/2020			Total Bills exceed maximum award. Payment is prorated at 91.76457% among all providers.	<b>Patient Birth Year:</b> 1979
		<i>Mail To Address:</i> PO BOX 96408 OKLAHOMA CITY OK 73143			Acceptance of payment may require a provider write-off. EOB will accompany payment.	
<b>8/12/2020</b>	<b>108456709</b>	<b>\$106.66</b>	2/14/2019	ACCT:0082-00008457617	Payment amount based on \$133.33 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> K.B.
		<i>Approx Mail Date:</i> 8/15/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1968
		<i>Mail To Address:</i> PO BOX 96408 OKLAHOMA CITY OK 73143				
<b>6/3/2020</b>	<b>108427406</b>	<b>\$131.52</b>	04/23/19	ACCT: 0081218983	Payment amount based on \$164.40 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> S.D.
		<i>Approx Mail Date:</i> 6/6/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1959
		<i>Mail To Address:</i> PO BOX 96408 OKLAHOMA CITY OK 73143				
<b>5/19/2020</b>	<b>108421284</b>	<b>\$2,032.00</b>	02/02/19	ACCT: 0079392872	Payment amount based on \$2,540.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> S.G.
		<i>Approx Mail Date:</i> 5/22/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1985
		<i>Mail To Address:</i> PO BOX 96408 OKLAHOMA CITY OK 73143				
<b>2/18/2020</b>	<b>108376649</b>	<b>\$1,440.00</b>	10/23/19	ACCT: 0084794360	Payment amount based on \$1,800.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> J.M.
		<i>Approx Mail Date:</i> 2/21/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1984
		<i>Mail To Address:</i> PO BOX 96408 OKLAHOMA CITY OK 73143				
<b>1/14/2020</b>	<b>108356501</b>	<b>\$1,080.80</b>	8/11/2019	ACCT: 0083422548	Payment amount based on \$1,351.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> W.C.
		<i>Approx Mail Date:</i> 1/17/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1974
		<i>Mail To Address:</i> PO BOX 96408 OKLAHOMA CITY OK 73143				

**THE ORTHOPAEDIC CENTER**

*Office of State Finance VendorID:* 0000062172

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

3/18/2020 108394621 \$14.16 09/24/19 ACCT: 268627

Payment amount based on \$70.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 3/21/2020

Total Bills exceed maximum award. Payment is prorated at 25.27231% among all providers. *Patient Initials:* J.H.

*Mail To Address:* PO BOX 21228 DEPT 338  
TULSA OK 74121-1228

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1971

**OKLAHOMA SPINE HOSPITAL**

*Office of State Finance VendorID:* 0000062245

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

3/18/2020 108394554 \$520.00 11/06/18 ACCT: 386851

Payment amount based on \$650.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 3/21/2020

*Patient Initials:* J.S.

*Mail To Address:* 14101 PARKWAY COMMONS DR  
OKLAHOMA CITY OK 73134-6012

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1957

**FACIAL SURGERY CENTER**

*Office of State Finance VendorID:* 0000062333

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

8/26/2020 108464133 \$630.60 02/12/20 - 02/28/20 ACCT: 771146

Payment amount based on \$2,615.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 8/29/2020

Total Bills exceed maximum award. Payment is prorated at 30.14325% among all providers. *Patient Initials:* J.N.

*Mail To Address:* PO BOX 108818  
OKLAHOMA CITY OK 73101

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1962

**MASON C. LAWRENCE MD PC**

*Office of State Finance VendorID:*

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

\$252.44 03/17/19 ACCT: ML35549

Payment amount based on \$650.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 7/14/20 Expected to be mailed by 7/28/20

Total Bills exceed maximum award. Payment is prorated at 48.54606% among all providers. *Patient Initials:* S.L.

*Mail To Address:* PO BOX 6405  
NORMAN OK 73070-6405

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1996

**TULSA BONE AND JOINT ASSOCIATES**

*Office of State Finance VendorID:* 0000062557

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

10/1/2020 108482988 \$21.60 01/02/20 - 05/05/20 ACCT: 230546

Payment amount based on \$1,717.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 10/4/2020

Total Bills exceed maximum award. Payment is prorated at 1.572509% among all providers. *Patient Initials:* D.B.

*Mail To Address:* PO BOX 258813  
OKLAHOMA CITY OK 73125-8813

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1973



**JACKS CHAPEL, INC**

*Office of State Finance VendorID:* 0000062704

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
10/16/2020	108490788	\$2,330.72	8/8/20	ACCT: D.T.	Payment amount based on \$2,330.72 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 10/19/2020					<i>Patient Initials:</i> D.T.
<i>Mail To Address:</i> 801 E 36TH ST N TULSA OK 74106-1926					<i>Patient Birth Year:</i> 1982
3/31/2020	108400185	\$3,809.28	03/09/20	ACCT: D.H.	Payment amount based on \$5,079.04 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 4/3/2020					<i>Patient Initials:</i> D.H.
<i>Mail To Address:</i> 801 E 36TH ST N TULSA OK 74106-1926					<i>Patient Birth Year:</i> 1991

**ALL SAINTS HOME MEDICAL**

*Office of State Finance VendorID:* 0000220718

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
5/19/2020	108421213	\$48.27	07/16/19	ACCT: 141653	Payment amount based on \$151.83 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 5/22/2020					<i>Patient Initials:</i> M.H.
<i>Mail To Address:</i> PO BOX 700231 TULSA OK 74170-0231					<i>Patient Birth Year:</i> 1970
Total Bills exceed maximum award. Payment is prorated at 39.7409% among all providers.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

**MUSKOGEE MARBLE & GRANITE, LLC**

*Office of State Finance VendorID:* 0000062940

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
7/9/2020	108442371	\$1,194.40	03/24/20	ACCT: G.B.	Payment amount based on \$1,194.40 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 7/12/2020					<i>Patient Initials:</i> G.B.
<i>Mail To Address:</i> PO BOX 1528 MUSKOGEE OK 74402-1528					<i>Patient Birth Year:</i> 1967

**SIMPSON PHYSICAL THERAPY**

*Office of State Finance VendorID:* 0000503877

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/2/2020	108384777	\$147.43	01/14/19 - 07/24/19	ACCT: 00004313	Payment amount based on \$184.29 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 3/5/2020					<i>Patient Initials:</i> C.M.
<i>Mail To Address:</i> 1525 E MAIN CUSHING OK 74023-3039					<i>Patient Birth Year:</i> 1980
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

**MORAD EL-RAHEB MD, INC**

*Office of State Finance VendorID:* 0000063014

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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8/26/2020 108464103 \$120.00 11/19/19 ACCT: COLLA005

Payment amount based on \$150.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2020

Patient Initials: L.C.

Mail To Address: P O BOX 700930  
TULSA OK 74170

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1959

SOUTHEAST OK ORAL & MAXILLOFACIAL SURGERY

Office of State Finance VendorID: 0000063038

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

7/8/2020 108441767 \$1,103.20 02/17/20 - 05/12/20 ACCT: 23841

Payment amount based on \$1,379.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/11/2020

Patient Initials: P.A.

Mail To Address: R. TODD BOONE, DDS 803 N MONTE VISTA  
ADA OK 74820

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1968

ORTHOPEDIC HOSPITAL OF OKLAHOMA

Office of State Finance VendorID: 0000063071

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/19/2020 108395086 \$3,629.48 8/20/2018 ACCT: 454581

Payment amount based on \$19,408.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/22/2020

Total Bills exceed maximum award. Payment is prorated at 23.37621% among all providers.

Patient Initials: Y.T.

Mail To Address: P O BOX 878206  
KANSAS CITY MO 64187-8206

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1979

OKLAHOMA SURGICAL HOSPITAL

Office of State Finance VendorID: 0000063071

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/15/2020 108432766 \$9,245.23 03/21/18 ACCT: 35372174040

Payment amount based on \$15,827.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/18/2020

Total Bills exceed maximum award. Payment is prorated at 73.01783% among all providers.

Patient Initials: D.T.

Mail To Address: 2408 E. 81ST ST SUITE 300  
TULSA OK 74137-4230

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1990

5/19/2020 108421339 \$1,711.51 03/29/17 - 07/22/19 AND 01/27/20 ACCT: 383383160547

Payment amount based on \$3,541.84 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/22/2020

Patient Initials: B.P.

Mail To Address: 2408 E. 81ST ST SUITE 300  
TULSA OK 74137-4230

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1943

FIDELITY MENTAL HEALTH SERVICES

Office of State Finance VendorID: 0000399209

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/14/2020 108356507 \$103.93 4/26/2017-9/27/2017 ACCT: 1918

Payment amount based on \$173.23 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/17/2020

Patient Initials: K.W.

Mail To Address: 4601 N CLASSEN BLVD  
OKLAHOMA CITY OK 73118

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1969

OU PATHOLOGY

Office of State Finance VendorID: 0000185546

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		<b>\$65.80</b>	05/28/20	ACCT: 5062*99900704717	Payment amount based on \$82.53 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20			Total Bills exceed maximum award. Payment is prorated at 99.66612% among all providers. <i>Patient Initials:</i> J.B.
		<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 2007
		<b>\$14.97</b>	02/22/20	ACCT: 5062*99900540909.1	Payment amount based on \$51.75 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20			<i>Patient Initials:</i> K.P.
		<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1971
<b>9/18/2020</b>	<b>108476159</b>	<b>\$184.53</b>	02/08/20 - 02/10/20	ACCT: 5062*99900539235	Payment amount based on \$243.35 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 9/21/2020			Total Bills exceed maximum award. Payment is prorated at 94.78569% among all providers. <i>Patient Initials:</i> K.C.
		<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1989
<b>9/18/2020</b>	<b>108476156</b>	<b>\$1,341.03</b>	03/22/20 - 04/21/20	ACCT: 5062*99900544565	Payment amount based on \$3,161.00 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 9/21/2020			Total Bills exceed maximum award. Payment is prorated at 53.03037% among all providers. <i>Patient Initials:</i> C.C.
		<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1987
<b>9/18/2020</b>	<b>108476157</b>	<b>\$22.92</b>	07/12/19 - 08/20/19	ACT: 5062*999000218579	Payment amount based on \$1,395.10 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 9/21/2020			Total Bills exceed maximum award. Payment is prorated at 2.053886% among all providers. <i>Patient Initials:</i> P.C.
		<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1987
<b>9/18/2020</b>	<b>108476158</b>	<b>\$370.11</b>	09/19/19 - 09/30/19	ACCT: 5062*9990520628	Payment amount based on \$2,058.80 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 9/21/2020			Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers. <i>Patient Initials:</i> S.G.
		<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1983
<b>8/26/2020</b>	<b>108464130</b>	<b>\$281.96</b>	03/02/20 - 03/07/20	ACCT: 5062*99900542131	Payment amount based on \$437.85 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 8/29/2020			Total Bills exceed maximum award. Payment is prorated at 80.49522% among all providers. <i>Patient Initials:</i> S.S.
		<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1975
<b>8/26/2020</b>	<b>108464129</b>	<b>\$15.14</b>	02/05/20 - 02/27/20	ACCT: 5062*99900538815	Payment amount based on \$299.10 patient balance after insurance and insurance adjustments.
		<i>Approx Mail Date:</i> 8/29/2020			Total Bills exceed maximum award. Payment is prorated at 6.329409% among all providers. <i>Patient Initials:</i> A.K.
		<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048			Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1997

9/4/2020	108468995	\$144.84	4/30/2019 - 5/6/2019	ACCT: 997000210207 \$100.60 997000210304 \$35.44 997000210617 \$8.80	Payment amount based on \$181.05 patient balance after insurance and insurance adjustments.		
			<i>Approx Mail Date:</i> 9/7/2020				<i>Patient Initials:</i> R.J.
			<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048		Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 2003
8/26/2020	108464128	\$1,281.12	04/13/18 - 04/21/18	ACCT: 997000191002	Payment amount based on \$1,601.40 patient balance after insurance and insurance adjustments.		
			<i>Approx Mail Date:</i> 8/29/2020				<i>Patient Initials:</i> C.K.
			<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048		Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1996
8/26/2020	108464131	\$100.60	6/19/2019	ACCT: 5062*99900807834	Payment amount based on \$125.75 patient balance after insurance and insurance adjustments.		
			<i>Approx Mail Date:</i> 8/29/2020				<i>Patient Initials:</i> J.W.
			<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048		Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> N/A
		\$86.33	11/06/16 - 02/19/19	ACCT: 5062*99900397839 - \$48.36; 656860321 - \$2.08; 997000186945 - \$3.40; 187330 - \$2.60; 187467 - \$0.40; 187584 - \$1.09; 187613 - \$8.68; 187754 - \$8.33; 198128 - \$2.15; 187887 - \$4.19; 188053 - \$1.92; 194884 - \$2.74; 205189 - \$0.40	Payment amount based on \$2,402.50 patient balance after insurance and insurance adjustments.		
			<i>Approx Mail Date:</i> Requested from OSF 1/9/18 Expected to be mailed by 1/23/18		Total Bills exceed maximum award. Payment is prorated at 4.49173% among all providers.		<i>Patient Initials:</i> R.L.
			<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048		Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1963
7/28/2020	108449515	\$20.30	10/16/17	ACCT: 5062*660041612	Payment amount based on \$77.45 patient balance after insurance and insurance adjustments.		
			<i>Approx Mail Date:</i> 7/31/2020		Total Bills exceed maximum award. Payment is prorated at 32.75809% among all providers.		<i>Patient Initials:</i> M.S.
			<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048		Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1958
7/28/2020	108449514	\$133.64	07/30/17	ACCT: 5062*659256929	Payment amount based on \$167.05 patient balance after insurance and insurance adjustments.		
			<i>Approx Mail Date:</i> 7/31/2020				<i>Patient Initials:</i> L.N.
			<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048		Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1991
6/15/2020	108432770	\$2,377.73	02/04/19	ACCT: 99900489959	Payment amount based on \$9,846.65 patient balance after insurance and insurance adjustments.		
			<i>Approx Mail Date:</i> 6/18/2020		Total Bills exceed maximum award. Payment is prorated at 30.18452% among all providers.		<i>Patient Initials:</i> B.D.
			<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048		Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1999
6/3/2020	108427465	\$40.40	09/17/19	ACCT: 5062*667321891	Payment amount based on \$50.50 patient balance after insurance and insurance adjustments.		
			<i>Approx Mail Date:</i> 6/6/2020				<i>Patient Initials:</i> R.B.
			<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048		Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1996

5/19/2020	108421342	\$215.66	08/22/19	ACCT: 5062*99900516073	Payment amount based on \$290.80 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 92.70327% among all providers. <b>Patient Initials:</b> D.F. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1991
	<b>Approx Mail Date:</b> 5/22/2020				
	<b>Mail To Address:</b> PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
5/19/2020	108421341	\$93.16	04/17/19	ACCT: 5062*99900500044	Payment amount based on \$116.45 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> T.W. <b>Patient Birth Year:</b> 1961
	<b>Approx Mail Date:</b> 5/22/2020				
	<b>Mail To Address:</b> PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
5/19/2020	108421340	\$30.51	05/27/19 - 05/28/19	ACCT: 5062*99900504775	Payment amount based on \$336.40 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 11.33645% among all providers. <b>Patient Initials:</b> R.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1995
	<b>Approx Mail Date:</b> 5/22/2020				
	<b>Mail To Address:</b> PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
3/31/2020	108400208	\$186.92	08/07/19	ACCT: 99900514649.1	Payment amount based on \$233.65 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> N.S. <b>Patient Birth Year:</b> 1994
	<b>Approx Mail Date:</b> 4/3/2020				
	<b>Mail To Address:</b> PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
3/18/2020	108394556	\$186.93	08/04/19	ACCT: 5062*99900514132	Payment amount based on \$233.65 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> T.M. <b>Patient Birth Year:</b> 1966
	<b>Approx Mail Date:</b> 3/21/2020				
	<b>Mail To Address:</b> PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
3/9/2020	108388756	\$37.40	09/24/19	ACCT: 5062*667381948	Payment amount based on \$46.75 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> S.J. <b>Patient Birth Year:</b> 1964
	<b>Approx Mail Date:</b> 3/12/2020				
	<b>Mail To Address:</b> PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
2/18/2020	108376725	\$24.67	09/16/17 - 09/26/17	ACCT: 5062*99900425400	Payment amount based on \$477.85 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 6.453729% among all providers. <b>Patient Initials:</b> N.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1995
	<b>Approx Mail Date:</b> 2/21/2020				
	<b>Mail To Address:</b> PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
1/21/2020	108360181	\$26.27	03/10/18	ACCT: 5062*661494028	Payment amount based on \$90.30 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 36.36716% among all providers. <b>Patient Initials:</b> J.R. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1975
	<b>Approx Mail Date:</b> 1/24/2020				
	<b>Mail To Address:</b> PO BOX 269048 OKLAHOMA CITY OK 73126-9048				

**BAKER & BAKER**

*Office of State Finance VendorID:* 0000033109

*Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers*

6/15/2020 108432655 \$93.46 05/09/19 AND 05/16/19 ACCT: D.T.

Approx Mail Date: 6/18/2020

Mail To Address: 214 S. CENTRAL  
OKMULGEE OK 74447

Payment amount based on \$160.00 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 73.01783% among all providers. Patient Initials: D.T.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1990

**BROWN'S FUNERAL SERVICE**

Office of State Finance VendorID: 0000063314

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/14/2020 108356446 \$7,500.00 5/30/2019 ACCT: S.S.

Payment amount based on \$7,500.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/17/2020

Patient Initials: S.S.

Mail To Address: 718 WEST 13TH  
ATOKA OK 74525

Patient Birth Year: 1969

**BROWN'S DURANT FUNERAL HOME**

Office of State Finance VendorID: 0000063316

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

9/25/2020 108480155 \$128.06 4/20/20 ACCOUNT: L.G.

Payment amount based on \$128.06 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/28/2020

Patient Initials: L.G.

Mail To Address: PO BOX 966  
DURANT OK 74702-0966

Patient Birth Year: 2020

9/25/2020 108480154 \$7,143.50 4/20/20 ACCOUNT: L.G.

Payment amount based on \$7,143.50 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/28/2020

Patient Initials: L.G.

Mail To Address: PO BOX 966  
DURANT OK 74702-0966

Patient Birth Year: 2020

**PARKS FUNERAL HOME**

Office of State Finance VendorID: 0000243236

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$838.80 2/29/2020 ACCT: T.R.

Payment amount based on \$838.80 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/16/20 Expected to be mailed by 10/30/20

Patient Initials: T.R.

Mail To Address: P O BOX 271  
OKEMAH OK 74859

Patient Birth Year: 1998

6/3/2020 108427473 \$4,612.00 02/29/20 ACCT: T.B.

Payment amount based on \$4,612.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/6/2020

Patient Initials: T.B.

Mail To Address: P O BOX 271  
OKEMAH OK 74859

Patient Birth Year: 1962

**PAUL FIRTH MD PC**

Office of State Finance VendorID: 0000185706

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/9/2020 108388764 \$121.60 09/04/18 ACCT: 103569

Payment amount based on \$152.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/12/2020

Patient Initials: K.B.

Mail To Address: 503 W COUNTRY CLUB BLVD  
ELK CITY OK 73644-1647

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1999

TULSA HOSPITALISTS, INC.

Office of State Finance VendorID: 0000063457

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/26/2020 108464217 \$388.00 11/19/19 - 11/20/19 ACCT: COLLA009

Payment amount based on \$485.00 patient balance after insurance and insurance adjustments.

Patient Initials: L.C.

Approx Mail Date: 8/29/2020

Mail To Address: PO BOX 700930  
TULSA OK 74170-0930

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1959

1/21/2020 108360250 \$415.20 06/24/19 - 06/26/19 ACCT: GAROR001

Payment amount based on \$519.00 patient balance after insurance and insurance adjustments.

Patient Initials: O.G.

Approx Mail Date: 1/24/2020

Mail To Address: PO BOX 700930  
TULSA OK 74170-0930

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1986

1/21/2020 108360251 \$40.26 11/08/19 - 11/22/19 ACCT: DELEL001

Payment amount based on \$1,700.00 patient balance after insurance and insurance adjustments.

Patient Initials: E.D.

Approx Mail Date: 1/24/2020

Mail To Address: PO BOX 700930  
TULSA OK 74170-0930

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1991

MEDICAL X-RAY CONSULTANTS PLLC

Office of State Finance VendorID: 0000063461

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$911.20 09/28/19 ACCT: 353687

Payment amount based on \$1,139.00 patient balance after insurance and insurance adjustments.

Patient Initials: B.S.

Approx Mail Date: Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

Mail To Address: PO BOX 2419  
ADA OK 74821-2419

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2002

GRAND LAKE IMAGING PC

Office of State Finance VendorID: 0000063547

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/29/2020 108365757 \$456.80 08/21/19 ACCT: 47138

Payment amount based on \$571.00 patient balance after insurance and insurance adjustments.

Patient Initials: K.J.

Approx Mail Date: 2/1/2020

Mail To Address: PO BOX 448  
ROWLETT TX 75030-0448

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1974

HUDSON-PHILLIPS FUNERAL HOME

Office of State Finance VendorID: 0000200961

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

4/14/2020 108406898 \$6,995.85 08/28/18 ACCT: J.R.T Payment amount based on \$6,995.85 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 4/17/2020 *Patient Initials:* J.T.  
*Mail To Address:* 301 EAST MAIN *Patient Birth Year:* 1963  
 HOLDENVILLE OK 74848

**TULSA SPINE HOSPITAL**

*Office of State Finance VendorID:* 0000063642

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
4/22/2020	108410402	\$200.00	11/06/19	ACCT: H2100007767901	Payment amount based on \$250.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> D.S.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1988

*Approx Mail Date:* 4/25/2020  
*Mail To Address:* P O BOX 108809  
 OKLAHOMA CITY OK 73101

**HEART & SOUL PROFESSIONAL CNSLG. SVS.**

*Office of State Finance VendorID:* 0000063721

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		\$3,872.00	12/26/17-1/23/2018	M.S 12/26/17-1/31/2019 \$1350. M.P 12/26/2017-1/29/19 \$1100. C.S. 1/12/2017-1/23/19 \$1190 K.P. 1/12/2017/1/23/19 \$1190.	Payment amount based on \$4,840.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> T.T.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1981

*Approx Mail Date:* Requested from OSF 9/22/20 Expected to be mailed by 10/6/20  
*Mail To Address:* PO BOX 643 WEATHERFORD OK 73096

**SHAWN SMITH MD**

*Office of State Finance VendorID:* 0000063750

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
6/15/2020	108432806	\$206.70	03/01/19 - 07/10/19	ACCT: 14879	Payment amount based on \$856.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> B.D.
					Total Bills exceed maximum award. Payment is prorated at 30.18452% among all providers.	<i>Patient Birth Year:</i> 1999
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	

*Approx Mail Date:* 6/18/2020  
*Mail To Address:* P O BOX 960261  
 OKLAHOMA CITY OK 73196-0261

**INTEGRIS CANADIA VALLEY HOSPITAL**

*Office of State Finance VendorID:* 0000063758

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
7/27/2020	108448970	\$20.00	5/14/2019	ACCT:109100209	Payment amount based on \$25.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.M.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1991

*Approx Mail Date:* 7/30/2020  
*Mail To Address:* P O BOX 268871  
 OKLAHOMA CITY OK 73126

7/27/2020	108448971	\$12.00	1/23/2019	ACCT:108346959	Payment amount based on \$15.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.M.
	<i>Approx Mail Date:</i> 7/30/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1991
	<i>Mail To Address:</i> P O BOX 268871 OKLAHOMA CITY OK 73126					
7/27/2020	108448968	\$28.54	1/17/2019	ACCT:108218455	Payment amount based on \$35.68 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.M.
	<i>Approx Mail Date:</i> 7/30/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1991
	<i>Mail To Address:</i> P O BOX 268871 OKLAHOMA CITY OK 73126					
7/27/2020	108448969	\$32.00	12/31/2018	ACCT: 601618432	Payment amount based on \$40.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.M.
	<i>Approx Mail Date:</i> 7/30/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1991
	<i>Mail To Address:</i> P O BOX 268871 OKLAHOMA CITY OK 73126					

**POTEAU VISION SOURCE PC**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		\$17.63	07/25/19	ACCT: 00017396	Payment amount based on \$120.00 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> Requested from OSF 3/10/20 Expected to be mailed by 3/24/20				Total Bills exceed maximum award. Payment is prorated at 18.36885% among all providers.	<i>Patient Initials:</i> T.S.
	<i>Mail To Address:</i> 1104 DEWEY AVE POTEAU OK 74953				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1968

**PEDIATRIC CARDIOLOGY OF OKLAHOMA**

*Office of State Finance VendorID:* 0000063825

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
7/28/2020	108449526	\$1,192.96	01/23/18	ACCT: 198135	Payment amount based on \$1,491.21 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> L.C.
	<i>Approx Mail Date:</i> 7/31/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> N/A
	<i>Mail To Address:</i> 6151 S. YALE AVE. SUITE 2402 TULSA OK 74136					

**OPTIONS COUNSELING SERVICE**

*Office of State Finance VendorID:* 0000076463

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
3/10/2020	108389682	\$32.00	5/8/2017 & 5/31/2017	ACCT: R.R.	Payment amount based on \$80.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> R.R.
	<i>Approx Mail Date:</i> 3/13/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1989
	<i>Mail To Address:</i> 2211 S 4TH STREET STE 1 CHICKASHA OK 73018					

**CREMATION SOCIETY OF OK**

*Office of State Finance VendorID:* 0000063923

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
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7/8/2020	108441758	\$2,281.07	06/15/20	ACCT: J.T.	Payment amount based on \$2,281.07 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.T.
	<i>Approx Mail Date:</i> 7/11/2020					<i>Patient Birth Year:</i> 1979
	<i>Mail To Address:</i> PO BOX 1029 PONCA CITY OK 74602					

**ARKANSAS VISION DEVELOPMENT CENTER**

*Office of State Finance VendorID:* 0000510320

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
8/12/2020	108456651	\$32.00	5/4/17	ACCT:731724452	Payment amount based on \$40.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.C.
	<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Birth Year:</i> 1996
	<i>Mail To Address:</i> 1021 SOUTH WALDRON ROAD FORT SMITH AR 72903-2555				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

**BROKEN ARROW FIRE DEPARTMENT**

*Office of State Finance VendorID:* 0000064268

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
3/10/2020	108389572	\$157.26	7/8/2019	ACCT: 19-980303	Payment amount based on \$196.58 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.B.
	<i>Approx Mail Date:</i> 3/13/2020					<i>Patient Birth Year:</i> 1955
	<i>Mail To Address:</i> PO BOX 863 LEWISVILLE NC 27023-0863				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

**CITY OF CHICKASHA EMS**

*Office of State Finance VendorID:* 0000064271

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
7/8/2020	108441694	\$523.20	04/10/19	ACCT: 00190072322	Payment amount based on \$654.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> G.J.
	<i>Approx Mail Date:</i> 7/11/2020					<i>Patient Birth Year:</i> 1966
	<i>Mail To Address:</i> 1700 HARLY DAY DRIVE CHICKASHA OK 73018-1640				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

**CITY OF GUTHRIE EMS**

*Office of State Finance VendorID:* 0000064282

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		\$423.93	02/22/20	ACCT: 56340607	Payment amount based on \$1,467.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.P.
	<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20					<i>Patient Birth Year:</i> 1971
	<i>Mail To Address:</i> PO BOX 908 GUTHRIE OK 73044-0908				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
7/28/2020	108449434	\$532.82	02/22/20	ACCT: 56340609	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> T.J.
	<i>Approx Mail Date:</i> 7/31/2020				Total Bills exceed maximum award. Payment is prorated at 45.40086% among all providers.	<i>Patient Birth Year:</i> 1968
	<i>Mail To Address:</i> PO BOX 908 GUTHRIE OK 73044-0908				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

1/14/2020 108356486 \$140.00 5/23/2019 ACCT: 52808935

Payment amount based on \$175.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/17/2020

Patient Initials: J.W.

Mail To Address: PO BOX 908  
GUTHRIE OK 73044-0908

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1974

**GUTHRIE FIRE DEPARTMENT**

Office of State Finance VendorID: 0000064282

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/18/2020 108394464 \$2,039.51 08/04/19 ACCT: 2019-1837

Payment amount based on \$2,549.39 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/21/2020

Patient Initials: T.M.

Mail To Address: PO BOX 941608  
HOUSTON TX 77094-8608

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1966

**GUYMON AMBULANCE SERVICE**

Office of State Finance VendorID: 0000064283

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

2/18/2020 108376621 \$1,776.00 08/23/19 ACCT: 10221

Payment amount based on \$2,220.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/21/2020

Patient Initials: E.O.

Mail To Address: 219 NW 4TH ST  
GUYMON OK 73942-4708

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1971

**OKLAHOMA TAX COMMISSION**

Office of State Finance VendorID: 0000000695

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

9/23/2020 108478740 \$2,075.52 ACCOUNT MAINTENANCE DIVISION  
VENDOR: 000120021  
TAX WARRANT: 153139744

Payment amount based on \$2,075.52 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/26/2020

Patient Initials: A.B.

Mail To Address: PO BOX 269058  
OKLAHOMA CITY OK 73126-9058

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1977

**DEAN A. MCGEE EYE INSTITUTE**

Office of State Finance VendorID: 0000064505

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

8/12/2020 108456701 \$43.59 12/19/2019-2/4/20 ACCT:335433

Payment amount based on \$54.49 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/15/2020

Patient Initials: D.J.

Mail To Address: PO BOX 27167  
SALT LAKE CITY UT 84127-0167

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1974

**NORTHEASTERN HEALTH SYSTEM**

Office of State Finance VendorID: 0000386462

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

9/18/2020	108476151	\$14,623.28	02/07/20 AND 02/19/20	ACCT: 120162029 - \$13,913.76; 120181118 - \$224.75; 120247853 - \$484.77	Payment amount based on \$29,019.54 patient balance after insurance and insurance adjustments.	
			<i>Approx Mail Date:</i> 9/21/2020		Total Bills exceed maximum award. Payment is prorated at 62.9889% among all providers. <i>Patient Initials:</i> T.F.	
			<i>Mail To Address:</i> 1400 E DOWNING ST TAHLEQUAH OK 74464		Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1974	
8/17/2020	108459251	\$2,723.98	10/05/18	ACCT: 21026649	Payment amount based on \$3,404.98 patient balance after insurance and insurance adjustments.	
			<i>Approx Mail Date:</i> 8/20/2020		<i>Patient Initials:</i> R.H.	
			<i>Mail To Address:</i> 1400 E DOWNING ST TAHLEQUAH OK 74464		Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1997	
7/28/2020	108449511	\$19,982.00	08/01/19 - 09/02/19	ACCT: 1021455 - 2000063065 - \$650.83; 2000051778 - \$3.05; 2000054474 - \$20.92; 2000043376 - \$18,718.83; 1021502 - 2000043376 - \$588.36	Payment amount based on \$130,831.63 patient balance after insurance and insurance adjustments.	
			<i>Approx Mail Date:</i> 7/31/2020		Total Bills exceed maximum award. Payment is prorated at 19.09133% among all providers. <i>Patient Initials:</i> J.B.	
			<i>Mail To Address:</i> 1400 E DOWNING ST TAHLEQUAH OK 74464		Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1992	

**NORMAN REGIONAL HOSPITAL**

*Office of State Finance VendorID:* 0000064400

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		\$2,936.40	01/07/20	ACCT: N00890281150 - \$122.00; N008924521 - \$2,814.40	Payment amount based on patient balance after insurance and insurance adjustments.	
			<i>Approx Mail Date:</i> Requested from OSF 10/15/20 Expected to be mailed by 10/29/20			<i>Patient Initials:</i> S.D.
			<i>Mail To Address:</i> PO BOX 268961 OKLAHOMA CITY OK 73126			<i>Patient Birth Year:</i> 1981
8/26/2020	108464110	\$2,598.49	08/27/18	ACCT: N00884520444	Payment amount based on \$4,931.78 patient balance after insurance and insurance adjustments.	
			<i>Approx Mail Date:</i> 8/29/2020		Total Bills exceed maximum award. Payment is prorated at 65.86092% among all providers. <i>Patient Initials:</i> R.S.	
			<i>Mail To Address:</i> PO BOX 268961 OKLAHOMA CITY OK 73126		Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1964	
7/28/2020	108449509	\$1,950.40	12/11/19	ACCT: N00884221919	Payment amount based on \$2,438.00 patient balance after insurance and insurance adjustments.	
			<i>Approx Mail Date:</i> 7/31/2020		<i>Patient Initials:</i> J.W.	
			<i>Mail To Address:</i> PO BOX 268961 OKLAHOMA CITY OK 73126		Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1981	
7/28/2020	108449510	\$16,434.91	03/17/19	ACCT: N00886607008	Payment amount based on \$42,317.85 patient balance after insurance and insurance adjustments.	
			<i>Approx Mail Date:</i> 7/31/2020		Total Bills exceed maximum award. Payment is prorated at 48.54606% among all providers. <i>Patient Initials:</i> S.L.	
			<i>Mail To Address:</i> PO BOX 268961 OKLAHOMA CITY OK 73126		Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1996	



3/18/2020	108394496	\$3,741.10	07/19/19	ACCT: 436396 - \$3,186.50; 441560 - \$554.60	Payment amount based on \$25,458.16 patient balance after insurance and insurance adjustments.
					Total Bills exceed maximum award. Payment is prorated at 18.36885% among all providers. <b>Patient Initials:</b> T.S.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1968

*Approx Mail Date:* 3/21/2020  
*Mail To Address:* PO BOX 1148  
 POTEAU OK 74953-1148

**COMANCHE COUNTY MEMORIAL HOSPITAL**

*Office of State Finance VendorID:* 0000064418

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/18/2020	108394474	\$18,214.32	05/28/19 - 07/06/19	ACCT: 2019392824 - \$13,913.52; 2019400083 - \$3,771.78; 2019422980 - \$276.82; 2019422379 - \$252.19	
					Payment amount based on \$64,869.21 patient balance after insurance and insurance adjustments.
					Total Bills exceed maximum award. Payment is prorated at 35.09816% among all providers. <b>Patient Initials:</b> M.B.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1979

*Approx Mail Date:* 3/21/2020  
*Mail To Address:* P.O. BOX 289  
 LAWTON OK 73502-0289

**COMANCHE COUNTY MEMORIAL HOSPITAL**

*Office of State Finance VendorID:* 0000064418

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
2/12/2020	108373713	\$1,752.02	8/15/2019	ACCT: 2019453854-0001	
					Payment amount based on \$3,754.33 patient balance after insurance and insurance adjustments.
					<b>Patient Initials:</b> L.G.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 2000

*Approx Mail Date:* 2/15/2020  
*Mail To Address:* 3401 W GORE BLVD  
 LAWTON OK 73505-6332

**LAWTON MEDI-EQUIP**

*Office of State Finance VendorID:* 0000064418

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/18/2020	108394473	\$34.28	06/03/19	ACCT: 52421	
					Payment amount based on \$122.08 patient balance after insurance and insurance adjustments.
					Total Bills exceed maximum award. Payment is prorated at 35.09816% among all providers. <b>Patient Initials:</b> M.B.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1979

*Approx Mail Date:* 3/21/2020  
*Mail To Address:* 924 NW 38TH ST.  
 LAWTON OK 73505

**GRADY MEMORIAL HOSPITAL**

*Office of State Finance VendorID:* 0000064451

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/26/2020	108464043	\$697.73	02/07/20	ACCT: G001185831	
					Payment amount based on \$2,893.41 patient balance after insurance and insurance adjustments.
					Total Bills exceed maximum award. Payment is prorated at 30.14325% among all providers. <b>Patient Initials:</b> J.N.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1962

*Approx Mail Date:* 8/29/2020  
*Mail To Address:* 2220 W IOWA AVE  
 CHICKASHA OK 73018



8/26/2020	108464011	\$34.97	02/24/20	ACCT: 546615	Payment amount based on \$145.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 30.14325% among all providers. <b>Patient Initials:</b> J.N. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1962
<i>Approx Mail Date:</i> 8/29/2020					
<i>Mail To Address:</i> PO BOX 26507 OKLAHOMA CITY OK 73126					
7/28/2020	108449446	\$197.53	05/06/19 - 06/06/19	ACCT: 638744	Payment amount based on \$246.91 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> A.N. <b>Patient Birth Year:</b> 1992
<i>Approx Mail Date:</i> 7/31/2020					
<i>Mail To Address:</i> PO BOX 26507 OKLAHOMA CITY OK 73126					
7/28/2020	108449445	\$177.80	05/09/18 AND 10/16/18	ACCT: 620532	Payment amount based on \$476.70 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 46.62222% among all providers. <b>Patient Initials:</b> C.J. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1986
<i>Approx Mail Date:</i> 7/31/2020					
<i>Mail To Address:</i> PO BOX 26507 OKLAHOMA CITY OK 73126					
5/19/2020	108421268	\$25.39	06/17/19 - 07/30/19	ACCT: 640500	Payment amount based on \$280.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 11.33645% among all providers. <b>Patient Initials:</b> R.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Birth Year:</b> 1995
<i>Approx Mail Date:</i> 5/22/2020					
<i>Mail To Address:</i> PO BOX 26507 OKLAHOMA CITY OK 73126					
3/19/2020	108395031	\$39.01	06/19/19 AND 07/24/19	ACCT: 0000370148	Payment amount based on \$39.01 patient balance after insurance and insurance adjustments. <b>Patient Initials:</b> W.T. <b>Patient Birth Year:</b> 1954
<i>Approx Mail Date:</i> 3/22/2020					
<i>Mail To Address:</i> PO BOX 26507 OKLAHOMA CITY OK 73126					

**STEPHENS GENERAL DENTISTRY**

*Office of State Finance VendorID:* 0000064519

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
4/14/2020	108406901	\$1,226.16	06/13/18 - 08/16/18	ACCT: 2026900	Payment amount based on \$1,532.70 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> S.G. <b>Patient Birth Year:</b> 1965
<i>Approx Mail Date:</i> 4/17/2020					
<i>Mail To Address:</i> 3518 CHANDLER ROAD MUSKOGEE OK 74403					

**ELKVIEW GENERAL HOSPITAL**

*Office of State Finance VendorID:* 0000064523

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/31/2020	108400171	\$2,740.80	04/21/19	ACCT: 28488-0020-001U	Payment amount based on \$3,426.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <b>Patient Initials:</b> J.P. <b>Patient Birth Year:</b> 1970
<i>Approx Mail Date:</i> 4/3/2020					
<i>Mail To Address:</i> 429 W ELM ST HOBART OK 73651-1615					

**PERRY MEMORIAL HOSPITAL**

*Office of State Finance VendorID:* 0000064543

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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**SHERMAN RADIOLOGY ASSOC**

*Office of State Finance VendorID:* 0000065149

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

**\$132.01** 05/05/20 ACCT: 9006553870

Payment amount based on patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 10/15/20 Expected to be mailed by 10/29/20

*Patient Initials:* R.W.

*Mail To Address:* PO BOX 340  
SHERMAN TX 75090-0340

*Patient Birth Year:* 2001

**TEXAS RADIOLOGY ASSOCIATES**

*Office of State Finance VendorID:* 0000065178

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

**\$810.40** 05/16/20 ACCT: 695539

Payment amount based on \$1,013.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

*Patient Initials:* J.B.

*Mail To Address:* P O BOX 2285  
INDIANAPOLIS IN 46206-2285

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1994

**LIVE OAK COUNSELING**

*Office of State Finance VendorID:*

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

**\$22.50** 7/9/2014-8/15/2019 ACCT: A.J.

Payment amount based on \$28.13 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* Requested from OSF 3/16/20 Expected to be mailed by 3/30/20

*Patient Initials:* A.J.

*Mail To Address:* 3417 GASTON AVE, STE 815  
DALLAS TX 75246

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1983

**MARK R CAMPBELL MD**

*Office of State Finance VendorID:* 0000065564

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

**9/18/2020 108476148 \$452.00** 08/07/18 AND 08/09/18 ACCT: 20234C2K - \$320.00 20234C2L - \$132.00

Payment amount based on \$565.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 9/21/2020

*Patient Initials:* J.A.

*Mail To Address:* 420 N COLLEGIATE STE 300  
PARIS TX 75460-3460

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1998

**3/18/2020 108394536 \$362.70** 05/21/18 - 05/30/18 ACCT: 20051

Payment amount based on \$511.00 patient balance after insurance and insurance adjustments.

*Approx Mail Date:* 3/21/2020

Total Bills exceed maximum award. Payment is prorated at 88.72186% among all providers.

*Patient Initials:* C.S.

*Mail To Address:* 420 N COLLEGIATE STE 300  
PARIS TX 75460-3460

Acceptance of payment may require a provider write-off. EOB will accompany payment.

*Patient Birth Year:* 1994

**TAUSHA BRADSHAW**

*Office of State Finance VendorID:*

*Check Date: Check #: Amount: Service Date(s): Provider Reference:*

*Patient Identifiers*

\$208.00 2/12/20-6/17/20 ACCT: K.K.

Approx Mail Date: Requested from OSF 10/16/20 Expected to be mailed by 10/30/20

Mail To Address: 6010 E. HWY 191 SUITE 246  
ODESSA TX 79762

Payment amount based on \$260.00 patient balance after insurance and insurance adjustments.

Patient Initials: K.K.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1964

EMERGENCY STAFFING SOLUTIONS

Office of State Finance VendorID: 0000276638

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/18/2020 108394495 \$431.45 ACCT: 0083681046 - \$169.43;  
0082701946 \$262.01

Payment amount based on \$2,936.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/21/2020

Total Bills exceed maximum award. Payment is prorated at 18.36885% among all providers.

Patient Initials: T.S.

Mail To Address: P O BOX 96408  
OKLAHOMA CITY OK 73143-345

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1968

MOBILITY LIVING, INC

Office of State Finance VendorID: 0000187709

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/15/2020 108432751 \$270.04 07/19/19 ACCT: 34603, INVOICE: 30502,  
ORDER: 16826

Payment amount based on \$337.55 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/18/2020

Patient Initials: B.D.

Mail To Address: 1215 SE 44TH ST.  
OKLAHOMA CITY OK 73129-6813

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1999

RESTHAVEN FUNERAL HOME

Office of State Finance VendorID: 0000065883

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/9/2020 108388647 \$4,121.44 12/22/19 ACCT: R.T.

Payment amount based on \$4,121.44 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/12/2020

Patient Initials: R.T.

Mail To Address: 500 SW 104TH ST  
OKLAHOMA CITY OK 73139-5528

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2017

SAINTS MEDICAL GROUP, LLC

Office of State Finance VendorID: 0000299824

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

10/1/2020 108482976 \$2,184.88 11/01/19 - 06/09/20 ACCT: 406000020568

Payment amount based on \$2,731.10 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/4/2020

Patient Initials: M.D.

Mail To Address: PO BOX 268986  
OKLAHOMA CITY OK 73126

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2013

SSM HEALTH MEDICAL GROUP

Office of State Finance VendorID: 0000299824

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/15/2020 108432804 \$274.85 12/27/19 AND 04/02/20 ACCT: 401000308681

Approx Mail Date: 6/18/2020

Mail To Address: PO BOX 956542  
ST LOUIS MO 63195

Payment amount based on \$343.56 patient balance after insurance and insurance adjustments.

Patient Initials: J.N.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1979

5/19/2020 108421378 \$921.49 12/21/18 ACCT: P35750370

Approx Mail Date: 5/22/2020

Mail To Address: PO BOX 956542  
ST LOUIS MO 63195

Payment amount based on \$1,151.86 patient balance after insurance and insurance adjustments.

Patient Initials: M.G.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1974

HILLCREST HEALTH CENTER

Office of State Finance VendorID: 0000056219

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$14,024.19 03/27/20 ACCT: 20004509484

Approx Mail Date: Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

Mail To Address: DEPT 572  
TULSA OK 74182

Payment amount based on \$20,893.83 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 83.90154% among all providers.

Patient Initials: J.C.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1986

8/26/2020 108464050 \$14,166.89 11/18/19- 11/27/19 ACCT: H2000377320700 - \$12,355.69;  
H2000383355000 - \$1,811.20

Approx Mail Date: 8/29/2020

Mail To Address: DEPT 572  
TULSA OK 74182

Payment amount based on \$17,708.61 patient balance after insurance and insurance adjustments.

Patient Initials: L.C.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1959

7/28/2020 108449467 \$1,131.01 09/19/16 ACCT: A1626301275

Approx Mail Date: 7/31/2020

Mail To Address: DEPT 572  
TULSA OK 74182

Payment amount based on \$1,413.76 patient balance after insurance and insurance adjustments.

Patient Initials: S.C.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1984

SOUTHWEST RADIOLOGY

Office of State Finance VendorID: 0000296161

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/18/2020 108394596 \$10.40 07/06/19 ACCT: 4398\*2019422379

Approx Mail Date: 3/21/2020

Mail To Address: P O BOX 2309 SECTION #5  
LAWTON OK 73502

Payment amount based on \$37.00 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 35.09816% among all providers.

Patient Initials: M.B.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1979

2/12/2020 108373854 \$104.54 8/15/2019 ACCT: 4398\*2019453854

Approx Mail Date: 2/15/2020

Mail To Address: P O BOX 2309 SECTION #5  
LAWTON OK 73502

Payment amount based on \$224.00 patient balance after insurance and insurance adjustments.

Patient Initials: L.G.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2000

BRENDA HOOPER, DC

Office of State Finance VendorID:

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$436.00 09/23/19 - 10/14/19 ACCT: 2376

Approx Mail Date: Requested from OSF 3/4/20 Expected to be mailed by 3/18/20

Mail To Address: 520 W 15TH ST.  
EDMOND OK 73013

Payment amount based on \$545.00 patient balance after insurance and insurance adjustments.

Patient Initials: A.B.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1990

QUESTCARE EM OKLAHOMA, LLC

Office of State Finance VendorID: 0000372132

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

9/18/2020 108476179 \$381.11 09/19/19 - 09/30/19 ACCT: qke1199900520628

Payment amount based on \$2,120.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/21/2020

Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers.

Patient Initials: S.G.

Mail To Address: PO BOX 678216  
DALLAS TX 75267-8216

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1983

\$32.88 11/06/16 ACCT: 63-E002768539

Payment amount based on \$915.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 1/9/18 Expected to be mailed by 1/23/18

Total Bills exceed maximum award. Payment is prorated at 4.49173% among all providers.

Patient Initials: R.L.

Mail To Address: PO BOX 678216  
DALLAS TX 75267-8216

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1963

7/28/2020 108449532 \$128.15 10/12/17 ACCT: QKE110660027802

Payment amount based on \$489.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/31/2020

Total Bills exceed maximum award. Payment is prorated at 32.75809% among all providers.

Patient Initials: M.S.

Mail To Address: PO BOX 678216  
DALLAS TX 75267-8216

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1958

3/10/2020 108389693 \$1,186.80 7/8/2017 & 7/23/2017 ACCT: 63-W00350573

Payment amount based on \$1,483.50 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/13/2020

Total Bills exceed maximum award. Payment is prorated at 4.49173% among all providers.

Patient Initials: M.N.

Mail To Address: PO BOX 678216  
DALLAS TX 75267-8216

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1987

2/18/2020 108376733 \$54.33 09/16/17 ACCT: 63-E002811892

Payment amount based on \$1,052.25 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/21/2020

Total Bills exceed maximum award. Payment is prorated at 6.453729% among all providers.

Patient Initials: N.S.

Mail To Address: PO BOX 678216  
DALLAS TX 75267-8216

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1995

1/21/2020 108360201 \$954.97 10/05/19 ACT: QKE1199900522925

Payment amount based on \$2,389.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/24/2020

Total Bills exceed maximum award. Payment is prorated at 49.96687% among all providers.

Patient Initials: S.K.

Mail To Address: PO BOX 678216  
DALLAS TX 75267-8216

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1988

QUESTCARE EM OKLAHOMA, LLC

Office of State Finance VendorID: 0000372132

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$494.62 09/08/19 ACCT: 10002191236

Payment amount based on \$1,516.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

Total Bills exceed maximum award. Payment is prorated at 40.78328% among all providers.

Patient Initials: R.F.

Mail To Address: PO BOX 99083  
LAS VEGAS NV 89193-9083

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1968

		<b>\$707.15</b>	02/22/20	ACCT: 540909	Payment amount based on \$2,447.00 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i>	Requested from OSF 10/13/20 Expected to be mailed by 10/27/20				<i>Patient Initials:</i> K.P.
	<i>Mail To Address:</i>	PO BOX 99083 LAS VEGAS NV 89193-9083			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1971
<hr/>						
		<b>\$161.92</b>	01/25/20	ACCT: QKE1199900537368	Payment amount based on patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i>	Requested from OSF 10/15/20 Expected to be mailed by 10/29/20				<i>Patient Initials:</i> J.F.
	<i>Mail To Address:</i>	PO BOX 99083 LAS VEGAS NV 89193-9083				<i>Patient Birth Year:</i> 1978
<hr/>						
<b>9/18/2020</b>	<b>108476180</b>	<b>\$778.00</b>	02/08/20	ACCT: QKE1199900539235	Payment amount based on \$1,026.00 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i>	9/21/2020			Total Bills exceed maximum award. Payment is prorated at 94.78569% among all providers.	<i>Patient Initials:</i> K.C.
	<i>Mail To Address:</i>	PO BOX 99083 LAS VEGAS NV 89193-9083			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1989
<hr/>						
<b>9/18/2020</b>	<b>108476178</b>	<b>\$39.25</b>	07/12/19	ACCT: 119990051112QKE	Payment amount based on \$2,389.00 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i>	9/21/2020			Total Bills exceed maximum award. Payment is prorated at 2.053886% among all providers.	<i>Patient Initials:</i> P.C.
	<i>Mail To Address:</i>	PO BOX 99083 LAS VEGAS NV 89193-9083			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1987
<hr/>						
<b>8/26/2020</b>	<b>108464168</b>	<b>\$1,538.42</b>	03/02/20	ACCT: QKE1199900542131	Payment amount based on \$2,389.00 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i>	8/29/2020			Total Bills exceed maximum award. Payment is prorated at 80.49522% among all providers.	<i>Patient Initials:</i> S.S.
	<i>Mail To Address:</i>	PO BOX 99083 LAS VEGAS NV 89193-9083			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1975
<hr/>						
<b>8/26/2020</b>	<b>108464167</b>	<b>\$164.70</b>	02/09/20	ACCT: QKE110668890506	Payment amount based on \$683.00 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i>	8/29/2020			Total Bills exceed maximum award. Payment is prorated at 30.14325% among all providers.	<i>Patient Initials:</i> J.N.
	<i>Mail To Address:</i>	PO BOX 99083 LAS VEGAS NV 89193-9083			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1962
<hr/>						
<b>8/26/2020</b>	<b>108464166</b>	<b>\$80.97</b>	02/05/20	ACCT: QKE1199900538815	Payment amount based on \$1,599.00 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i>	8/29/2020			Total Bills exceed maximum award. Payment is prorated at 6.329409% among all providers.	<i>Patient Initials:</i> A.K.
	<i>Mail To Address:</i>	PO BOX 99083 LAS VEGAS NV 89193-9083			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1997
<hr/>						
<b>8/26/2020</b>	<b>108464165</b>	<b>\$820.80</b>	03/10/19	ACCT: QKE1199900495647	Payment amount based on \$1,026.00 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i>	8/29/2020				<i>Patient Initials:</i> S.W.
	<i>Mail To Address:</i>	PO BOX 99083 LAS VEGAS NV 89193-9083			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1996
<hr/>						
<b>8/26/2020</b>	<b>108464164</b>	<b>\$1,911.20</b>	04/13/18	ACCT: QKE1199900449133	Payment amount based on \$2,389.00 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i>	8/29/2020				<i>Patient Initials:</i> C.K.
	<i>Mail To Address:</i>	PO BOX 99083 LAS VEGAS NV 89193-9083			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1996



<b>3/31/2020</b>	<b>108400225</b>	<b>\$820.80</b>	08/07/19	ACCT: QKE1199900514649	Payment amount based on \$1,026.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> N.S.
	<i>Approx Mail Date:</i> 4/3/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1994
	<i>Mail To Address:</i> PO BOX 99083 LAS VEGAS NV 89193-9083					
<b>3/31/2020</b>	<b>108400224</b>	<b>\$1,279.20</b>	10/27/19	ACCT: QKE1199900525680	Payment amount based on \$1,599.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> A.S.
	<i>Approx Mail Date:</i> 4/3/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1993
	<i>Mail To Address:</i> PO BOX 99083 LAS VEGAS NV 89193-9083					
<b>3/18/2020</b>	<b>108394576</b>	<b>\$1,212.80</b>	08/04/19	ACCT: QKE1199900514132	Payment amount based on \$1,516.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> T.M.
	<i>Approx Mail Date:</i> 3/21/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1966
	<i>Mail To Address:</i> PO BOX 99083 LAS VEGAS NV 89193-9083					
<b>3/9/2020</b>	<b>108388779</b>	<b>\$1,212.80</b>	09/24/19	ACCT: QKE110667381948	Payment amount based on \$1,516.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> S.J.
	<i>Approx Mail Date:</i> 3/12/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1964
	<i>Mail To Address:</i> PO BOX 99083 LAS VEGAS NV 89193-9083					
<b>1/14/2020</b>	<b>108356565</b>	<b>\$625.60</b>	3/17/2018	ACCT: QKE110661555585	Payment amount based on \$1,564.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> G.H.
	<i>Approx Mail Date:</i> 1/17/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1996
	<i>Mail To Address:</i> PO BOX 99083 LAS VEGAS NV 89193-9083					

**ASPEN DENTAL**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		<b>\$464.00</b>	04/14/20	ACCT: 12650910	Payment amount based on patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> Requested from OSF 9/25/20 Expected to be mailed by 10/9/20					<b>Patient Initials:</b> I.R.
	<i>Mail To Address:</i> 5510 E 41ST ST., SUITE C TULSA OK 74135					<b>Patient Birth Year:</b> 2000

**WILLIAM A. STUEVER**

*Office of State Finance VendorID:* 0000411300

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
<b>8/12/2020</b>	<b>108456712</b>	<b>\$80.00</b>	8/17/15	ACCT: 17994	Payment amount based on \$100.00 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> 8/15/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Initials:</b> D.B.
	<i>Mail To Address:</i> 1619 N. 5TH ST PONCA CITY OK 74601-2703					<b>Patient Birth Year:</b> 1970

**UKPSYCH LLC**

*Office of State Finance VendorID:* 0000494864

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
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<b>6/25/2020</b>	<b>108438962</b>	<b>\$26.10</b>	04-21-20	ACCT: L.C.	Payment amount based on \$46.60 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> L.C.
			<i>Approx Mail Date:</i> 6/28/2020			<b>Patient Birth Year:</b> 1973
			<i>Mail To Address:</i> 8988 S SHERIDAN RD, SUITE D2 TULSA OK 74133		Acceptance of payment may require a provider write-off. EOB will accompany payment.	

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<b>1/9/2020</b>	<b>108353667</b>	<b>\$245.00</b>	01/26/19 - 10/19/19	ACCT: L.L.	Payment amount based on \$350.00 patient balance after insurance and insurance adjustments.	<b>Patient Initials:</b> L.C.
			<i>Approx Mail Date:</i> 1/12/2020			<b>Patient Birth Year:</b> 1973
			<i>Mail To Address:</i> 8988 S SHERIDAN RD, SUITE D2 TULSA OK 74133		Acceptance of payment may require a provider write-off. EOB will accompany payment.	

**MOORE CARE LLC**

*Office of State Finance VendorID:* 0000515031

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
<b>9/23/2020</b>	<b>108478732</b>	<b>\$382.38</b>	03/30/20 - 06/15/20	ACCT: HF283380449	Payment amount based on \$593.80 patient balance after insurance and insurance adjustments.	
			<i>Approx Mail Date:</i> 9/26/2020		Total Bills exceed maximum award. Payment is prorated at 80.49522% among all providers.	<b>Patient Initials:</b> S.S.
			<i>Mail To Address:</i> 507 NE 12TH ST. MOORE OK 73160-5833		Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1975

**DENTAL DEPOT RENO & ROCKWELL**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		<b>\$440.00</b>	05/09/19 - 01/22/20	ACCT: 12653	Payment amount based on \$550.00 patient balance after insurance and insurance adjustments.	
			<i>Approx Mail Date:</i> Requested from OSF 5/12/20 Expected to be mailed by 5/26/20			<b>Patient Initials:</b> S.C.
			<i>Mail To Address:</i> 25 N ROCKWELL OKLAHOMA CITY OK 73127-6112		Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 2001

**KEISAU FUNERAL HOME**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		<b>\$10.00</b>	8/13/2019	ACCT: E.A.	Payment amount based on \$10.00 patient balance after insurance and insurance adjustments.	
			<i>Approx Mail Date:</i> Requested from OSF 8/21/20 Expected to be mailed by 9/4/20			<b>Patient Initials:</b> E.A.
			<i>Mail To Address:</i> 2500 W MODELLE AVE CLINTON OK 73601-3726			<b>Patient Birth Year:</b> 1966

**ADVANCED ORTHOPEDICS OF OKLAHOMA**

*Office of State Finance VendorID:* 0000466629

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
<b>3/19/2020</b>	<b>108394990</b>	<b>\$67.19</b>	8/14/2018	ACCT: 456673	Payment amount based on \$359.28 patient balance after insurance and insurance adjustments.	
			<i>Approx Mail Date:</i> 3/22/2020		Total Bills exceed maximum award. Payment is prorated at 23.37621% among all providers.	<b>Patient Initials:</b> Y.T.
			<i>Mail To Address:</i> PO BOX 844222 KANSAS CITY MO 64184-4222		Acceptance of payment may require a provider write-off. EOB will accompany payment.	<b>Patient Birth Year:</b> 1979

1/29/2020 108365554 \$538.90 11/25/18 - 02/15/19 ACCT: 463684

Approx Mail Date: 2/1/2020

Mail To Address: PO BOX 844222  
KANSAS CITY MO 64184-4222

Payment amount based on \$673.63 patient balance after insurance and insurance adjustments.

Patient Initials: C.D.

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1978

CORNERSTONE PHYSICIAN PARTNERS

Office of State Finance VendorID:

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$723.97 05/21/18 ACCT: 15553

Approx Mail Date: Requested from OSF 3/10/20 Expected to be mailed by 3/24/20

Mail To Address: 5100 ELDORADO PKWY STE 102  
MC KINNEY TX 75070-7295

Payment amount based on \$1,020.00 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 88.72186% among all providers. Patient Initials: C.S.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1994

RESTORE BEHAVIORAL HEALTH

Office of State Finance VendorID: 0000480611

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

1/29/2020 108366049 \$104.00 11/05/19 ACCT: 0137 P.M.

Approx Mail Date: 2/1/2020

Mail To Address: 2212 WESTPARK DRIVE  
NORMAN OK 73072

Payment amount based on \$130.00 patient balance after insurance and insurance adjustments.

Patient Initials: P.M.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 2004

ST. FRANCIS HOSPITAL MUSKOGEE

Office of State Finance VendorID: 0000490340

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

5/19/2020 108421377 \$19,976.26 01/23/20 AND 02/05/20 ACCT: 86025970600 - \$11,101.47;  
86026929501 - \$8,874.79

Approx Mail Date: 5/22/2020

Mail To Address: PO BOX 707001  
TULSA OK 74170

Payment amount based on patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 98.92601% among all providers. Patient Initials: D.S.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1988

4/14/2020 108406892 \$1,606.77 12/26/18 ACCT: 860076630

Approx Mail Date: 4/17/2020

Mail To Address: PO BOX 707001  
TULSA OK 74170

Payment amount based on \$2,008.46 patient balance after insurance and insurance adjustments.

Patient Initials: D.S.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1988

3/31/2020 108400231 \$2,874.24 05/24/19 ACCT:3688793

Approx Mail Date: 4/3/2020

Mail To Address: PO BOX 707001  
TULSA OK 74170

Payment amount based on \$3,592.80 patient balance after insurance and insurance adjustments.

Patient Initials: M.F.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1992

1/21/2020 108360217 \$408.77 04/13/18 AND 04/14/18 ACCT: 400813002 - \$225.03; w400810875 - \$183.75

Payment amount based on \$1,406.80 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/24/2020  
Mail To Address: PO BOX 707001  
TULSA OK 74170

Total Bills exceed maximum award. Payment is prorated at 36.32196% among all providers. Patient Initials: R.H.  
Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1968

CLARISSA M. WRIGHT LPC PLLC

Office of State Finance VendorID: 0000517368

Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers

10/1/2020 108482920 \$1,234.87 09/25/19 - 09/09/20 ACCT: J.G.

Payment amount based on \$1,543.59 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/4/2020  
Mail To Address: 1212 S AIR DEPOT BLVD STE 19B  
MIDWEST CITY OK 73110

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: M.Y.  
Patient Birth Year: 1988

LINDSEY DEAL MSW, LCSW

Office of State Finance VendorID: 0000498803

Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers

6/25/2020 -108438904 (\$468.00) 1/30/20-3/12/20 \*\*RESCIND\*\*

Payment amount based on (\$585.00) patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/28/2020  
Mail To Address: 2529 S KELLY AVE, SUITE C  
EDMOND OK 73013

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: S.J.  
Patient Birth Year: 1957

6/25/2020 108438904 \$468.00 1/13/20 - 3/12/20 ACCT: CJ

Payment amount based on \$585.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/28/2020  
Mail To Address: 2529 S KELLY AVE, SUITE C  
EDMOND OK 73013

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: S.J.  
Patient Birth Year: 1957

1/27/2020 108363752 \$128.00 11/26/2019-1/16/2020 ACCT: C.J.

Payment amount based on \$160.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/30/2020  
Mail To Address: 2529 S KELLY AVE, SUITE C  
EDMOND OK 73013

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: S.J.  
Patient Birth Year: 1957

AZE ENTERPRISES LLC

Office of State Finance VendorID: 0000437007

Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers

1/14/2020 108356480 \$600.00 11/9/2013 ACCT: J.K.

Payment amount based on \$600.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/17/2020  
Mail To Address: CHECOTAH FUNERAL & CREMATION 211 W OKMULGEE  
CHECOTAH OK 74426

Patient Initials: J.K.  
Patient Birth Year: 1977

CASSANDRA REYNOLDS MD PC

Office of State Finance VendorID: 0000503040

Check Date: Check #: Amount: Service Date(s): Provider Reference: Patient Identifiers

2/18/2020 108376618 \$260.00 08/26/19 ACCT: 6155

Payment amount based on \$325.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/21/2020

Patient Initials: E.O.

Mail To Address: PO BOX 909  
COLORADO SPRING CO 80901-0909

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1971

**EMERGENCHEALTH LLC**

Office of State Finance VendorID:

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$4,698.49 04/03/20 ACCT: E125245

Payment amount based on patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/13/20 Expected to be mailed by 10/27/20

Total Bills exceed maximum award. Payment is prorated at 83.90154% among all providers. Patient Initials: J.C.

Mail To Address: PO BOX 207529  
DALLAS TX 75320-7529

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1986

**OU MEDICINE, INC**

Office of State Finance VendorID: 0000463452

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

2/12/2020 108373810 \$280.00 6/14/2019-6/23/2019 ACCT: 99900507226

Payment amount based on \$350.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/15/2020

Patient Initials: R.G.

Mail To Address: OU MEDICAL CENTER PO BOX 277362  
ATLANTA GA 30384-7362

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1958

1/14/2020 108356557 \$1,467.00 6/11/2019 ACCT: 666281995

Payment amount based on \$1,833.75 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/17/2020

Patient Initials: R.H.

Mail To Address: OU MEDICAL CENTER PO BOX 277362  
ATLANTA GA 30384-7362

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1990

1/14/2020 108356556 \$236.06 3/17/2018 ACCT: 99900446492

Payment amount based on \$590.15 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/17/2020

Patient Initials: G.H.

Mail To Address: OU MEDICAL CENTER PO BOX 277362  
ATLANTA GA 30384-7362

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1996

**NEW HOPE CHRISTIAN COUNSELING LLC**

Office of State Finance VendorID: 0000491494

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

6/25/2020 108438921 \$504.00 2/27/20 - 4/23/20 ACCT: K.S.

Payment amount based on \$630.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/28/2020

Patient Initials: K.S.

Mail To Address: 1823 TEXAS AVE  
WOODWARD OK 73801

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1981

3/10/2020 108389675 \$576.00 12/5/2019-2/20/2020 ACCT: K.S.

Payment amount based on \$720.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/13/2020

Patient Initials: K.S.

Mail To Address: 1823 TEXAS AVE  
WOODWARD OK 73801

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1981

**TOUCHSTONE IMAGING OF OKLAHOMA, LLC**

*Office of State Finance VendorID:* 0000486274

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
2/18/2020	108376767	\$49.86	08/13/19	ACCT: 86279	Payment amount based on \$140.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 44.51862% among all providers. <i>Patient Initials:</i> J.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1969
<i>Approx Mail Date:</i> 2/21/2020					
<i>Mail To Address:</i> SERVANT MEDICAL IMAGING PO BOX 306205 NASHVILLE TN 37230-6205					
1/29/2020	108366168	\$33.88	11/29/19	ACCT: 0927161139	Payment amount based on \$42.35 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> B.D. <i>Patient Birth Year:</i> 1971
<i>Approx Mail Date:</i> 2/1/2020					
<i>Mail To Address:</i> SERVANT MEDICAL IMAGING PO BOX 306205 NASHVILLE TN 37230-6205					

**SERENITY FUNERAL SERVICE**

*Office of State Finance VendorID:* 0000459272

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/31/2020	108400234	\$7,500.00	11/17/19	ACCT: J.E.W.	Payment amount based on \$7,888.26 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> J.W. <i>Patient Birth Year:</i> 1971
<i>Approx Mail Date:</i> 4/3/2020					
<i>Mail To Address:</i> PO BOX 255 ANTLERS OK 74523-0255					

**HARMON COUNTY FUNERAL HOME**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$3,583.10	12/21/19	ACCT: V.G.	Payment amount based on \$3,583.10 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> V.G. <i>Patient Birth Year:</i> 2007
<i>Approx Mail Date:</i> Requested from OSF 7/14/20 Expected to be mailed by 7/28/20					
<i>Mail To Address:</i> 417 E BROADWAY HOLLIS OK 73550					

**TRIPLE WILLOW MENTAL HEALTH CLINIC, INC**

*Office of State Finance VendorID:* 0000498804

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/14/2020	108356586	\$940.00	9/17/2019-10/25/2019	ACCT: M.M.	Payment amount based on \$1,175.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> J.I. <i>Patient Birth Year:</i> 1963
<i>Approx Mail Date:</i> 1/17/2020					
<i>Mail To Address:</i> 7300 HANOVER GREEN DRIVE, SUITE 100 MECHANICSVILLE VA 23111-1705					

**ELIZABETH WILLIAMS LPC PLLC**

*Office of State Finance VendorID:* 0000495969

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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4/22/2020 108410333 \$80.00 11/08/19 - 12/13/19 ACCT: W204745509 Payment amount based on \$100.00 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 4/25/2020 *Patient Initials:* J.G.  
*Mail To Address:* 2529 S KELLY AVE SUITE C Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1961  
 EDMOND OK 73013

1/29/2020 108365732 \$280.00 07/19/19 - 10/11/19 ACCT: D.K. Payment amount based on \$350.00 patient balance after insurance and insurance adjustments.  
*Approx Mail Date:* 2/1/2020 *Patient Initials:* J.G.  
*Mail To Address:* 2529 S KELLY AVE SUITE C Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1961  
 EDMOND OK 73013

**NJJ COUNSELING SERVICES, LLC**

*Office of State Finance VendorID:* 0000492398

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
3/19/2020	108395081	\$6,714.62	12/11/19 - 04/11/20	ACCT: BB121119	
<i>Approx Mail Date:</i> 3/22/2020					Payment amount based on \$8,592.00 patient balance after insurance and insurance adjustments.
<i>Mail To Address:</i> DBA BRAIN BALANCE NORMAN 1806 24TH AVE NW					Total Bills exceed maximum award. Payment is prorated at 97.6871% among all providers. <i>Patient Initials:</i> A.A.
NORMAN OK 73069					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 2013

**GILLISPIE COUNSELING**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$240.00	7/7/20-8/24/20	ACCOUNT: R.N.	
<i>Approx Mail Date:</i> Requested from OSF 10/16/20 Expected to be mailed by 10/30/20					Payment amount based on \$300.00 patient balance after insurance and insurance adjustments.
<i>Mail To Address:</i> 23 N 8TH					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> R.N.
DUNCAN OK 73533					<i>Patient Birth Year:</i> 1958

**ROGERS FUNERAL HOME**

*Office of State Finance VendorID:* 0000224723

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
8/11/2020	108455935	\$3,379.00	2/21/20	ACCOUNT: S.M.	
<i>Approx Mail Date:</i> 8/14/2020					Payment amount based on \$3,379.00 patient balance after insurance and insurance adjustments.
<i>Mail To Address:</i> 1302 WEST MAIN					<i>Patient Initials:</i> S.G.
HENRYETTA OK 74437					<i>Patient Birth Year:</i> 1986
3/19/2020	108395102	\$1,500.00	2/7/2020	ACCT: F.S.	
<i>Approx Mail Date:</i> 3/22/2020					Payment amount based on \$1,500.00 patient balance after insurance and insurance adjustments.
<i>Mail To Address:</i> 1302 WEST MAIN					<i>Patient Initials:</i> F.S.
HENRYETTA OK 74437					<i>Patient Birth Year:</i> 1970

**THOMAS EYE CARE**

*Office of State Finance VendorID:* 0000496838

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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1/29/2020	108366148	\$96.00	12/17/19	ACCT: J.O.	Payment amount based on \$120.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.O.
	<i>Approx Mail Date:</i> 2/1/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1985
	<i>Mail To Address:</i> 12406 E 86TH ST N OWASSO OK 74055					

**BIO SERVICES, LLC**

*Office of State Finance VendorID:* 0000498536

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		\$2,000.00	09/27/19	ACCT: 917	Payment amount based on \$2,000.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> R.F.
	<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20					<i>Patient Birth Year:</i> 1968
	<i>Mail To Address:</i> BIO-ONE OKC MUSTANG OK 73064				60 N MUSTANG RD, PO BOX 545	

3/9/2020	108388641	\$2,000.00	12/20/19	ACCT: 1212	Payment amount based on \$2,000.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> R.T.
	<i>Approx Mail Date:</i> 3/12/2020					<i>Patient Birth Year:</i> 2017
	<i>Mail To Address:</i> BIO-ONE OKC MUSTANG OK 73064				60 N MUSTANG RD, PO BOX 545	

**BELMAR EMERGENCY GROUP PC**

*Office of State Finance VendorID:* 0000500654

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
1/14/2020	108356472	\$1,845.60	8/1/2019	ACCT: 14X61100245	Payment amount based on \$2,307.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.H.
	<i>Approx Mail Date:</i> 1/17/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1978
	<i>Mail To Address:</i> PO BOX 731584 DALLAS TX 75373-1584					

**HEART CLINIC PC**

*Office of State Finance VendorID:*

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
		\$23.74	02/05/20	ACCT: SANDA000	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> D.S.
	<i>Approx Mail Date:</i> Requested from OSF 5/12/20 Expected to be mailed by 5/26/20				Total Bills exceed maximum award. Payment is prorated at 98.92601% among all providers.	<i>Patient Birth Year:</i> 1988
	<i>Mail To Address:</i> 2720 W BROADWAY ST MUSKOGEE OK 74401-2141				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

**MELISSA HOLLY SHOCKLEY**

*Office of State Finance VendorID:* 0000501344

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
7/8/2020	108441772	\$768.00	12/28/18 - 03/27/19	ACCT: N.C.	Payment amount based on \$960.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> N.C.
	<i>Approx Mail Date:</i> 7/11/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1981
	<i>Mail To Address:</i> THRIVE CHRISTIAN COUNSELING OKLAHOMA CITY OK 73013				13939 TECHNOLOGY DRIVE	

CLINT METCALF DDS

Office of State Finance VendorID:

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$166.40 03/04/20 ACCT: FR0066

Payment amount based on patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 10/15/20 Expected to be mailed by 10/29/20

Patient Initials: J.F.

Mail To Address: 1325 S SANGRE RD STILLWATER OK 74074

Patient Birth Year: 1978

COUNTRYSIDE COUNSELING, PLLC

Office of State Finance VendorID: 0000504266

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/19/2020 108395028 \$336.00 8/23/2019-9/13/2019 ACCT: C.G.

Payment amount based on \$420.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/22/2020

Patient Initials: C.G.

Mail To Address: 44038 E 45TH STREET SHAWNEE OK 74804

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1979

RADIOLOGY IMAGING ASSOCIATES

Office of State Finance VendorID: 0000303568

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

2/18/2020 108376737 \$1,083.20 08/24/19 - 08/25/19 ACCT: 1394094 - \$772.80; 1378671 - \$310.40

Payment amount based on \$1,354.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 2/21/2020

Patient Initials: E.O.

Mail To Address: P O BOX 272011 DENVER CO 80227-9011

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1971

HEATHER R MARTIN, MA, LPC-C

Office of State Finance VendorID: 0000504750

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

3/19/2020 108395075 \$1,302.78 8/12/2019-2/3/2020 ACCT: K.H.

Payment amount based on \$1,628.48 patient balance after insurance and insurance adjustments.

Approx Mail Date: 3/22/2020

Patient Initials: M.H.

Mail To Address: MARTIN MENTAL HEALTH AND WELLNESS, L 425 S FRETZ, SUITE C EDMOND OK 73003

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1971

WADE PEDIATRICS

Office of State Finance VendorID:

Check Date: Check #: Amount: Service Date(s): Provider Reference:

Patient Identifiers

\$92.00 5/13/2019 ACCT: KAIHEA0002

Payment amount based on \$115.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 7/16/20 Expected to be mailed by 7/30/20

Patient Initials: H.K.

Mail To Address: 3505 W. BROADWAY MUSKOGEE OK 74401

Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 2008

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
5/19/2020	108421336	\$212.43	11/02/18 - 11/05/18	ACCT: 29525	Payment amount based on \$265.54 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 5/22/2020				<i>Patient Initials:</i> O.P.
		<i>Mail To Address:</i> 5701 N PORTLAND STE 205 OKLAHOMA CITY OK 73112			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1995