

INTERMEDIARY NAME/ADDRESS/CITY/STATE/ZIP/PHONE NUMBER FILENAME: D.WP

FACILITY PROVIDER NUMBER/NAME PART A PAID DATE: 06/25/95 REMIT#: 1 PAGE:

PATIENT NAME	PATIENT CNTRL NUMBER	RC	REM	DRG#	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT			
HIC NUMBER	ICN NUMBER	RC	REM	OUTCD	CAPCD	DRG CAP AMT	ESRD NET ADJ	PER DIEM			
FROM DT	THRU DT	NACHG	HICHG	TOB	RC	REM	PROF COMP	MSP PAYMT	NCOVD CHGS	INTEREST	HCPCS AMOUNT
CLM STATUS	COVDY	NCOVDY	RC	REM	DRG OPR AMT	DEDUCTIBLES	CHGS	CHGS	CHGS	NET REIMB	
MOUSE	M L 130787536	MA01	483	D	C	29084.43	15036.00	.00	.00	.00	30402.05
09829805A	19503703606806					5974.41	128627.00				
.00	01/30/95	05/27/95	74	N	111	.00	.00	.00	.00	.00	
.00	01	117	117			63166.11	716.00	.00	.00	.00	82472.95
SUBTOTAL FISCAL YEAR											
.00						.00	15036.00	.00	.00	.00	30402.05
.00						.00	128627.00	.00	.00	.00	
SUBTOTAL PART A											
.00						.00	15036.00	.00	.00	.00	30402.05
.00						.00	128627.00	.00	.00	.00	
SUBTOTAL											
.00						63166.11	716.00	.00	.00	.00	82472.95