Ohio Bureau of Workers' Compensation

ATTENDING PHYSICIAN'S —FEE BILL—

BWC Claim Number: OD 34780-22

INSTRUCTIONS:
- Complete all applicable portions of this bill and mail to nearest district office of the Bureau of Workers' Compensation.
- Your bill must be filed within 2 years from the date services were rendered.

CLAIMANT

Name: Joseph Succi
Address: 1767 Griggs Rd.
City, State, Zip Code: Jefferson, OH 44047
Phone Number (optional):
Injury Date: Oct. 1988

EMPLOYER

Name: General Tire
Address: P.O. Box 3545
City, State, Zip Code: Akron, OH 44309

BWC USE ONLY R. M.

PHYSICIAN'S REPORT

1. Give claimant's present condition/diagnosis.

2. Is present condition solely the result of the injury? YES [ ] [ ] NO if **no**, explain

3. **Does claimant have a disability as a result of the injury?** YES [ ] [ ] NO **if yes, complete all items below.**

Check One	*Check One*		*Check type of Rehabilitation Recommended*		*Give date(s) claimant was/will be able to return to work.*	
Temporary	Total		Medical	Both	Light Work	
Permanent	Partial	Give % of Disability %	Vocational	None	Regular Work	

4. Physician's Remarks *(Use reverse side of form if more space is required)*

5. Are treatments soley for recognized conditions ? YES [ ] [ ] NO if **no**, indicate those which are not.

TREATMENT & BILLING ITEMIZATION

Date Of Service	Place (Hospital, Office, Home)	Service Description (Specify Part of Body Treated)	Charges
9-8-88 to 9-18-88	Hospital	Hospital Care	283.06
9-23-88	Office	Office Visit	18.00
10-7-88	Office	Office Visit	18.00
10-17-88	Office	Office Visit	18.00
11-10-88	Office	Office Visit	18.00
11-17-88	Office	Office Visit	18.00
11-28-88	Office	Office Visit	18.00
12-8-88	Office	Office Visit	18.00
12-10-88 to 12-14-88	Hospital	Hospital Care	189.51
12-22-88	Office	Office Visit	18.00

Do Not Write In This Space —Received BWC—

RECEIVED MAR 3 1989 WORKER'S COMPENSATION DEPT.

FEB 27 PM 12:10

REIMBURSEMENT: If any part of this bill has been paid indicate Amount . . . . . ▶ $

see next page ◀ TOTAL AMOUNT CHARGED

Designate by whom paid ▶ *(Name & Address)* Name
Address
City, State, Zip Code

PAYEE IDENTIFICATION *(Payee No. must be present to process payment)*

Payee Number	Billing Code/Date (not to exceed 10 digits)	Federal I.D. No. (optional)
47304-01	2-23-89	34-1398289

BWC USE ONLY

I hereby certify that the information contained on this form is true and correct to the best of my knowledge and belief.

X _____ 2/23/89
Physician's Signature *Date*

NOTE: This form must be signed in the Physician's own handwriting-For fraud penalties see sections 2921.13, 2913.02, 2901.23, 2929.11, 2929.21, and 2929.31 Ohio Revised code.

Payee's name, address, city, state, zip code and phone No. *(Please print, stamp, or type)*

HARLAN S. WAID, JR., M.D. INC.
125 S. CHESTNUT STREET
JEFFERSON, OHIO - 44047
TELEPHONE (216) 576 - 9111

BWC USE NLY
- Use this section when denying or partially paying bill by codes 1-30 or Code 77
- Use only the 70 spaces provided

DCN

Code	EIN Stamp	Date	Signature

BWC-1124 (Rev. 9/83)
C-19 DD/ag 2/14/89

HAND WRITTEN SIGNATURE

Completion of this form is required to receive payment of claims

GENC 002682

Ohio Bureau of Workers' Compensation

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City, State, Zip Code: Akron, OH 44309

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TREATMENT & BILLING ITEMIZATION

Date Of Service	Place (Hospital, Office, Home)	Service Description (Specify Part of Body Treated)	Charges
12-30-88	Office	Office Visit	18.00
1-1-89 to 1-8-89	Hospital	Hospital Care	370.95

Do Not Write In This Space —Received BWC— FEB 21 2:12:10

REIMBURSEMENT: If any part of this bill has been paid indicate Amount . . . . . ▶ $ 469.97 | 1,005.52 ◀ TOTAL AMOUNT CHARGED

Designate by whom paid ▶ *(Name & Address)*
Name: Joseph Succi
Address: 1767 Griggs Road
City, State, Zip Code: Jefferson, OH 44047

BWC USE ONLY

PAYEE IDENTIFICATION *(Payee No. must be present to process payment)*

Payee Number	Billing Code/Date (not to exceed 10 digits)	Federal I.D. No. (optional)
47304-01	2-23-89	34-1398289

I hereby certify that the information contained on this form is true and correct to the best of my knowledge and belief.

X [signature] 2/23/89
Physician's Signature *Date*

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Payee's name, address, city, state, zip code and phone No. *(Please print, stamp, or type)*

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DCN

Code	EIN Stamp	Date	Signature

BWC-1124 (Rev. 9/83)
C-19

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GENC 002683