

Victim Comp Checks Issued to Service Providers in Last 12 Months

Updated Wednesday, January 27, 2021 9:46 AM

ASPEN DENTAL SHERMAN TX

Office of State Finance VendorID:

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		\$1,084.00	06/09/20	ACCT: 12729099-0	
<i>Approx Mail Date:</i> Requested from OSF 11/10/20 Expected to be mailed by 11/24/20 <i>Mail To Address:</i> 3207 US HWY 75 N SHERMAN TX 75090					Payment amount based on \$1,355.00 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.B. <i>Patient Birth Year:</i> 1969

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	
<i>Approx Mail Date:</i> 10/19/2020 <i>Mail To Address:</i> PO BOX 207339 DALLAS TX 75320-7339					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>Patient Initials:</i> C.F. <i>Patient Birth Year:</i> 1983
8/12/2020	108456705	\$233.05	010901796	ACCT: EP292911	
<i>Approx Mail Date:</i> 8/15/2020 <i>Mail To Address:</i> PO BOX 207339 DALLAS TX 75320-7339					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>Patient Initials:</i> D.J. <i>Patient Birth Year:</i> 1974

RAY & MARTHA'S FUNERAL HOME

Office of State Finance VendorID: 0000315213

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
12/17/2020	108521303	\$7,500.00	08/11/20	ACCT: M.H.	
<i>Approx Mail Date:</i> 12/20/2020 <i>Mail To Address:</i> ESCHITI SERVICES LLC HOBART OK 73651					Payment amount based on \$10,628.90 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.H. <i>Patient Birth Year:</i> 1961

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	
<i>Approx Mail Date:</i> 6/18/2020 <i>Mail To Address:</i> PO BOX 198962 ATLANTA GA 30384-8962					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>Patient Initials:</i> W.E. <i>Patient Birth Year:</i> 1998

GREEN CO ER PHYS TULSA PLLC

Office of State Finance VendorID: 0000271109

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
10/21/2020	108492679	\$1,277.32	03/27/20	ACCT: 2582003270021	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. <i>Patient Initials:</i> J.C. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1986
<i>Approx Mail Date:</i> 10/24/2020					
<i>Mail To Address:</i> P O BOX 268938 OKLAHOMA CITY OK 73126					
4/14/2020	108406846	\$864.00	12/26/18	ACCT: 2591812260067	Payment amount based on \$1,080.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> D.S. <i>Patient Birth Year:</i> 1988
<i>Approx Mail Date:</i> 4/17/2020					
<i>Mail To Address:</i> P O BOX 268938 OKLAHOMA CITY OK 73126					

GREEN COUNTRY EMERG PHYS GROUP TULSA

Office of State Finance VendorID: 0000271109

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
10/21/2020	108492678	\$341.60	04/09/20	ACCT: M045666423	Payment amount based on \$427.00 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.S. <i>Patient Birth Year:</i> 1976
<i>Approx Mail Date:</i> 10/24/2020					
<i>Mail To Address:</i> PO BOX 21050 DEPT 201 TULSA OK 74121-1050					
10/16/2020	108490773	\$907.20	12-25-19	ACCT: 020785510	Payment amount based on \$1,134.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> G.M. <i>Patient Birth Year:</i> 1965
<i>Approx Mail Date:</i> 10/19/2020					
<i>Mail To Address:</i> PO BOX 21050 DEPT 201 TULSA OK 74121-1050					
8/26/2020	108464045	\$324.80	11/27/19	ACCT: M042744909	Payment amount based on \$406.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> L.C. <i>Patient Birth Year:</i> 1959
<i>Approx Mail Date:</i> 8/29/2020					
<i>Mail To Address:</i> PO BOX 21050 DEPT 201 TULSA OK 74121-1050					
5/20/2020	108422000	\$1,191.20	10/27/2018 and 10/29/2018	ACCT: M040444706	Payment amount based on \$1,489.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> S.R. <i>Patient Birth Year:</i> 1991
<i>Approx Mail Date:</i> 5/23/2020					
<i>Mail To Address:</i> PO BOX 21050 DEPT 201 TULSA OK 74121-1050					
5/19/2020	108421296	\$619.20	05/27/19	ACCT: 2581905270083	Payment amount based on \$774.00 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.C. <i>Patient Birth Year:</i> 1977
<i>Approx Mail Date:</i> 5/22/2020					
<i>Mail To Address:</i> PO BOX 21050 DEPT 201 TULSA OK 74121-1050					

FULL GOSPEL ASSEMBLY INT'L MINISTRY

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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\$3,547.50 12/19/19 FUNERAL REIMBURSEMENT FOR S.P. Payment amount based on \$3,547.50 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 9/11/20 Expected to be mailed by 9/25/20

Patient Initials: S.P.

Mail To Address: 7401 S. MEMORIAL DR.
TULSA OK 74133

Patient Birth Year: 2009

\$5,626.50 12/19/19 FUNERAL REIMBURSEMENT FOR P.K. Payment amount based on \$5,626.50 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 9/11/20 Expected to be mailed by 9/25/20

Patient Initials: P.K.

Mail To Address: 7401 S. MEMORIAL DR.
TULSA OK 74133

Patient Birth Year: 2011

MEMORIAL PARK CEMETERY

Office of State Finance VendorID: 0000506881

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

5/20/2020 108422026 (\$725.00) 2/8/20 CHECK WAS RETURNED UNCASHED BY PROVIDER Payment amount based on (\$725.00) patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/23/2020

Patient Initials: D.R.

Mail To Address: 7600 OLD TAFT ROAD
MUSKOGEE OK 74401

Patient Birth Year: 1991

5/20/2020 108422026 \$725.00 2/8/20 ACCT: D.R. Payment amount based on \$725.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/23/2020

Patient Initials: D.R.

Mail To Address: 7600 OLD TAFT ROAD
MUSKOGEE OK 74401

Patient Birth Year: 1991

MEDICAL EXPRESS PSI

Office of State Finance VendorID:

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

\$49.60 02/07/20 ACCT: 5401164 Payment amount based on \$62.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 1/8/21 Expected to be mailed by 1/22/21

Patient Initials: R.F.

Mail To Address: PO BOX 27044
SALT LAKE CITY UT 84127-0044

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

KIAMICHI FAMILY MEDICAL CLINIC

Office of State Finance VendorID:

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

\$16.00 4/2/20 ACCT: 321572 Payment amount based on \$20.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 1/19/21 Expected to be mailed by 2/2/21

Patient Initials: C.G.

Mail To Address: 403 S. INDIAN RD
IDABEL OK 74745

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1969

GOODWIN CHIROPRACTIC

Office of State Finance VendorID:

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

\$127.46 07/23/15 - 08/06/15 ACCT: 3155

Approx Mail Date: Requested from OSF 12/8/20 Expected to be mailed by 12/22/20

Mail To Address: PO BOX 172 CATOOSA OK 74015

Payment amount based on \$850.00 patient balance after insurance and insurance adjustments.

Patient Initials: M.T.

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

Patient Birth Year: 1995

BETHEL MONUMENT COMPANY

Office of State Finance VendorID: 0000517091

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

Patient Identifiers

12/11/2020 108517629 \$1,969.18 4/5/2019 ACCT J.M.

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

Patient Initials: J.M.

Approx Mail Date: 12/14/2020

Mail To Address: 17900 HWY 102 SHAWNEE OK 74801

Patient Birth Year: 2014

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.

Patient Initials: J.B.

Approx Mail Date: 6/28/2020

Mail To Address: P O BOX 707001 TULSA OK 74170-7001

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

Patient Birth Year: 1989

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.

Patient Initials: B.P.

Approx Mail Date: 8/29/2020

Mail To Address: 4502 E. 41ST ST., 2H37 TULSA OK 74135

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

Patient Birth Year: 1998

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.

Patient Initials: G.B.

Approx Mail Date: 6/18/2020

Mail To Address: 4502 E. 41ST ST., 2H37 TULSA OK 74135

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

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.

Patient Initials: D.T.

Approx Mail Date: 6/18/2020

Mail To Address: 6585 SOUTH YALE SUITE 640 TULSA OK 74136

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

HOSPITALIST MEDICINE PHYSICIANS OF TEXAS PLLC

Office of State Finance VendorID:

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		\$141.70	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 <i>Mail To Address:</i> PO BOX 743522 LOS ANGELES CA 90074-3522					Payment amount based on \$788.21 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers. <i>Patient Initials:</i> S.G. 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

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

SCHAUDT'S FUNERAL SVS AND CREM.

Office of State Finance VendorID: 0000291627

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
12/22/2020	108523969	\$2,112.06	8/25/20	ACCOUNT: E.E.	
<i>Approx Mail Date:</i> 12/25/2020 <i>Mail To Address:</i> 5757 S. MEMORIAL DR. TULSA OK 74145					Payment amount based on \$2,112.06 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> E.E. <i>Patient Birth Year:</i> 1998

CHRISTIAN PILGRIM, DDS

Office of State Finance VendorID: 0000383839

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

MCBRIDE ORTHOPEDIC HOSPITAL

Office of State Finance VendorID: 0000310462

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
1/12/2021	108530343	\$4,035.51	10/07/18	ACCT: 219164	
<i>Approx Mail Date:</i> 1/15/2021 <i>Mail To Address:</i> PO BOX 268921 OKLAHOMA CITY OK 73126-8921					Payment amount based on \$5,044.39 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> 1986

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>
		\$89.14	03/30/18	ACCT: 880429	
<i>Approx Mail Date:</i> Requested from OSF 11/10/20 Expected to be mailed by 11/24/20					Payment amount based on \$210.00 patient balance after insurance and insurance adjustments.
<i>Mail To Address:</i> P O BOX 2728 AUSTIN TX 78768-2728					Total Bills exceed maximum award. Payment is prorated at 53.05898% among all providers. <i>Patient Initials:</i> K.S.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1985
		\$212.00	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 AUSTIN TX 78768-2728					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> J.A.
					<i>Patient Birth Year:</i> 1998

LAB MEDICINE OF GREATER TULSA PC

Office of State Finance VendorID: 0000238140

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
12/17/2020	108521257	\$87.03	06/18/20 - 06/20/20	ACCT: 374399377-0	
<i>Approx Mail Date:</i> 12/20/2020					Payment amount based on \$566.00 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 19.22044% among all providers. <i>Patient Initials:</i> W.F.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1968
12/15/2020	108519532	\$38.40	06/23/20	ACCT: 374563964	
<i>Approx Mail Date:</i> 12/18/2020					Payment amount based on \$48.00 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> E.F.
					<i>Patient Birth Year:</i> 1992
11/19/2020	108507361	\$72.07	05/10/20 - 05/12/20	ACCT: 373294324-0	
<i>Approx Mail Date:</i> 11/22/2020					Payment amount based on \$85.60 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 84.17979% among all providers. <i>Patient Initials:</i> A.T.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1977
10/21/2020	108492694	\$126.06	02/29/20	ACCT: 371287030	
<i>Approx Mail Date:</i> 10/24/2020					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 Payment amount based on patient balance after insurance and insurance adjustments.
Approx Mail Date: 7/31/2020 *Patient Initials:* W.G.
Mail To Address: 2738 E 51ST STREET, SUITE 240 *Patient Birth Year:* 1963
TULSA OK 74105-6271

6/15/2020 108432743 \$155.98 03/19/20 ACCT: 371931659 Payment amount based on patient balance after insurance and insurance adjustments.
Total Bills exceed maximum award. Payment is prorated at 99.47671% among all providers. *Patient Initials:* G.M.
Approx Mail Date: 6/18/2020 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1999
Mail To Address: 2738 E 51ST STREET, SUITE 240
TULSA OK 74105-6271

UTICA PARK CLINIC

Office of State Finance VendorID: 0000224911

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
12/17/2020	108521166	\$86.30	06/05/15 - 07/01/15	ACCT: 1022507	
				Payment amount based on \$575.50 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.T.
				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1995
				<i>Approx Mail Date:</i> 12/20/2020	
				<i>Mail To Address:</i> DEPT 2852	
				TULSA OK 74182-0001	

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>
1/22/2021	108536077	\$17,456.70	08/31/19	ACCT: 602233743 - \$15,992.86; 109779805 - \$1,463.84	
				Payment amount based on \$21,820.88 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> D.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> 1/25/2021	
				<i>Mail To Address:</i> PO BOX 258877	
				DEPT #88801	
				OKLAHOMA CITY OK 73125	
12/21/2020	108523104	\$3,417.20	11/20/18	ACCT: 601531094	
				Payment amount based on \$4,271.50 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.A.
				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1995
				<i>Approx Mail Date:</i> 12/24/2020	
				<i>Mail To Address:</i> PO BOX 258877	
				DEPT #88801	
				OKLAHOMA CITY OK 73125	
12/11/2020	108517640	\$776.21	6/9/20	ACCT:602922717	
				Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.D.
				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1989
				<i>Approx Mail Date:</i> 12/14/2020	
				<i>Mail To Address:</i> PO BOX 258877	
				DEPT #88801	
				OKLAHOMA CITY OK 73125	
11/4/2020	108500071	\$600.00	12/04/18	ACCT: 601549742 **REPLACEMENT WARRANT**	
				Payment amount based on \$750.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.S.
				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1978
				<i>Approx Mail Date:</i> 11/7/2020	
				<i>Mail To Address:</i> PO BOX 258877	
				DEPT #88801	
				OKLAHOMA CITY OK 73125	

4/22/2020	-108410348	(\$600.00)	12/04/18	ACCT: 601549742 **VOID OF STALE-DATED CHECK**	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			DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i>	1978
11/18/2020	108506263	\$307.69	1/13/2019	ACCT: 601650170	Payment amount based on \$384.61 patient balance after insurance and insurance adjustments.		
	<i>Approx Mail Date:</i> 11/21/2020					<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>	1973
11/18/2020	108506262	\$265.76	8/24/17-8/25/17	ACCT:600502352	Payment amount based on \$332.20 patient balance after insurance and insurance adjustments.		
	<i>Approx Mail Date:</i> 11/21/2020					<i>Patient Initials:</i>	L.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>	1999
10/21/2020	108492686	\$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.		
	<i>Approx Mail Date:</i> 10/24/2020				Total Bills exceed maximum award. Payment is prorated at 94.43523% among all providers.	<i>Patient Initials:</i>	K.C.
	<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>	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.		
	<i>Approx Mail Date:</i> 10/19/2020					<i>Patient Initials:</i>	K.B.
	<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>	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.		
	<i>Approx Mail Date:</i> 10/19/2020					<i>Patient Initials:</i>	M.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>	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.		
	<i>Approx Mail Date:</i> 9/21/2020					<i>Patient Initials:</i>	R.A.
	<i>Mail To Address:</i> PO BOX 258877 OKLAHOMA CITY OK 73125			DEPT #88801		<i>Patient Birth Year:</i>	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			DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.		<i>Patient Birth Year:</i> 1972

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.
Approx Mail Date: 5/22/2020 *Patient Initials:* M.W.
Mail To Address: PO BOX 258877 DEPT #88801 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1972
 OKLAHOMA CITY OK 73125

4/22/2020 108410348 \$600.00 12/04/18 ACCT: 601549742 **STALE DATED, Payment amount based on \$750.00 patient balance after insurance and insurance adjustments.
Approx Mail Date: 4/25/2020 *Patient Initials:* K.S.
Mail To Address: PO BOX 258877 DEPT #88801 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1978
 OKLAHOMA CITY OK 73125

RADIOLOGY ASSOCIATES

Office of State Finance VendorID: 0000266907

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

1/22/2021 108536115 \$27.93 12/27/19 - 02/07/20 ACCT: 125686 Payment amount based on \$34.91 patient balance after insurance and insurance adjustments.
Approx Mail Date: 1/25/2021 *Patient Initials:* L.H.
Mail To Address: 3433 NW 56TH ST. #C40 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1966
 OKLAHOMA CITY OK 73112-4455

11/18/2020 108506238 \$21.96 11/23/18 ACCT: 393456 Payment amount based on \$224.26 patient balance after insurance and insurance adjustments.
Approx Mail Date: 11/21/2020 *Patient Initials:* A.R.
Mail To Address: 3433 NW 56TH ST. #C40 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1999
 OKLAHOMA CITY OK 73112-4455

8/12/2020 108456764 \$244.00 1/6/20 ACCT: 128870 Payment amount based on patient balance after insurance and insurance adjustments.
Approx Mail Date: 8/15/2020 *Patient Initials:* K.O.
Mail To Address: 3330 NW 56TH ST STE 206 *Patient Birth Year:* 1988
 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.
Approx Mail Date: 7/31/2020 *Patient Initials:* Z.Z.
Mail To Address: 3330 NW 56TH ST STE 206 *Patient Birth Year:* 1957
 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.
Approx Mail Date: 7/30/2020 *Patient Initials:* C.M.
Mail To Address: 3330 NW 56TH ST STE 206 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1991
 OKLAHOMA CITY OK 73112-4426

THE SESSIONS GROUP

Office of State Finance VendorID: 0000508631

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

8/21/2020 108462115 \$192.80 1/23/20 ACCT: M4574

Payment amount based on \$241.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/24/2020

Patient Initials: D.L.

Mail To Address: P.O. BOX 55066
LITTLE ROCK AR 72215-5066

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

Patient Birth Year: N/A

ACUTE SURGICAL CARE SPECIALIST LLP

Office of State Finance VendorID: 0000337084

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

Patient Identifiers

12/17/2020 108521163 \$11,140.31 07/13/18 ACCT: 218367

Payment amount based on \$15,326.59 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/20/2020

Total Bills exceed maximum award. Payment is prorated at 90.85773% among all providers. Patient Initials: E.A.

Mail To Address: P O BOX 703847
DALLAS TX 75370-3847

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1997

M. RACHELLE HARDIN-MONIZ, LCSW

Office of State Finance VendorID: 0000483920

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

Patient Identifiers

7/8/2020 108441736 \$620.00 10/14/19 - 11/21/19 ACCT: K.M.

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

Approx Mail Date: 7/11/2020

Patient Initials: K.M.

Mail To Address: PO BOX 5423
NORMAN OK 73070-5423

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1969

4/22/2020 108410359 \$1,498.01 02/20/19 - 12/18/19 ACCT: K.N.

Payment amount based on \$3,750.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 4/25/2020

Patient Initials: K.N.

Mail To Address: PO BOX 5423
NORMAN OK 73070-5423

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

HAMID MAHMOOD, MD

Office of State Finance VendorID:

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

Patient Identifiers

\$212.54 01/12/20 ACCT: HF275004368

Payment amount based on \$265.68 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 1/12/21 Expected to be mailed by 1/26/21

Patient Initials: L.H.

Mail To Address: 1104 E ST HWY 152
MUSTANG OK 73064-5116

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1966

ALLIANCE HEALTH DEACONESS

Office of State Finance VendorID: 0000406786

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

Patient Identifiers

9/25/2020 108480132 \$6,275.52 1/7/19-1/8/19 ACCT: 601645348

Payment amount based on \$7,844.40 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/28/2020

Patient Initials: C.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: 1970

COMMUNITY HOSPITAL

Office of State Finance VendorID: 0000258452

<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	108468944	\$691.39	3/6/20	ACCT: 3272033	Payment amount based on \$864.24 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> T.G.
<i>Approx Mail Date:</i> 9/7/2020					<i>Patient Birth Year:</i> 1969
<i>Mail To Address:</i> PO BOX 248823 OKLAHOMA CITY OK 73124-8823					Acceptance of payment may require a provider write-off. EOB will accompany payment.
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. <i>Patient Initials:</i> D.J.
<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Birth Year:</i> 1974
<i>Mail To Address:</i> PO BOX 248823 OKLAHOMA CITY OK 73124-8823					Acceptance of payment may require a provider write-off. EOB will accompany payment.
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. <i>Patient Initials:</i> M.G.
<i>Approx Mail Date:</i> 5/22/2020					<i>Patient Birth Year:</i> 1974
<i>Mail To Address:</i> PO BOX 248823 OKLAHOMA CITY OK 73124-8823					Acceptance of payment may require a provider write-off. EOB will accompany payment.

VALIR REHABILITATION HOSPITAL

Office of State Finance VendorID: 0000278414

<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	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. <i>Patient Initials:</i> S.G.
<i>Approx Mail Date:</i> 9/21/2020					<i>Patient Birth Year:</i> 1983
<i>Mail To Address:</i> 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.

CARL L. SYLVESTER, MD, PC

Office of State Finance VendorID: 0000328632

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
12/11/2020		\$23.16	10/9/2018 - 10/24/2018	ACCT: 6597032	Payment amount based on \$28.95 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> H.H.
<i>Approx Mail Date:</i> 12/14/2020					<i>Patient Birth Year:</i> 1989
<i>Mail To Address:</i> DEPT. 96-0392 OKLAHOMA CITY OK 73196					Acceptance of payment may require a provider write-off. EOB will accompany payment.

STILLWATER RADIOLOGY

Office of State Finance VendorID: 0000366930

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
10/21/2020	108492760	\$61.60	08/08/20	ACCT: SW100052501101	Payment amount based on \$77.00 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> E.Q.
<i>Approx Mail Date:</i> 10/24/2020					<i>Patient Birth Year:</i> 1989
<i>Mail To Address:</i> 4721 W. 6TH AVE STILLWATER OK 74074					Acceptance of payment may require a provider write-off. EOB will accompany payment.
					STE 130

8/17/2020	108459281	\$188.80	08/25/19	ACCT: SW100064463401	Payment amount based on \$236.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.B.
	<i>Approx Mail Date:</i>	8/20/2020				
	<i>Mail To Address:</i>	4721 W. 6TH AVE STILLWATER OK 74074		STE 130	Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 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.	<i>Patient Initials:</i> C.L.
	<i>Approx Mail Date:</i>	6/6/2020				
	<i>Mail To Address:</i>	4721 W. 6TH AVE STILLWATER OK 74074		STE 130	Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1990

SMITH-GALLO FUNERAL HOME

Office of State Finance VendorID: 0000476297

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
10/14/2020	108489584	\$7,266.15	07/22/20	ACCT: L.H.	Payment amount based on \$7,266.15 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> L.H.
	<i>Approx Mail Date:</i>	10/17/2020				<i>Patient Birth Year:</i> 1964
	<i>Mail To Address:</i>	220 N 1ST ST GUTHRIE OK 73044-3113				
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.	<i>Patient Initials:</i> A.S.
	<i>Approx Mail Date:</i>	4/17/2020				<i>Patient Birth Year:</i> 1989
	<i>Mail To Address:</i>	220 N 1ST ST GUTHRIE OK 73044-3113				

RIVERSIDE GARDENS CEMETERY

Office of State Finance VendorID: 0000310575

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
10/14/2020	108489579	\$3,150.00	07/01/20	ACCT: A.C.	Payment amount based on \$3,150.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.C.
	<i>Approx Mail Date:</i>	10/17/2020				<i>Patient Birth Year:</i> 2004
	<i>Mail To Address:</i>	4720 NE 36TH ST. OKLAHOMA CITY OK 73121				
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.	<i>Patient Initials:</i> T.M.
	<i>Approx Mail Date:</i>	9/28/2020				<i>Patient Birth Year:</i> 1988
	<i>Mail To Address:</i>	4720 NE 36TH ST. OKLAHOMA CITY OK 73121				

CARING HANDS HEALTH CARE

Office of State Finance VendorID: 0000256018

<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	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.	<i>Patient Initials:</i> L.L.
	<i>Approx Mail Date:</i>	6/21/2020				<i>Patient Birth Year:</i> 1957
	<i>Mail To Address:</i>	PO BOX 1992 MCALESTER OK 74501			Acceptance of payment may require a provider write-off. EOB will accompany payment.	

ST JOHN ANESTHESIA SERVICES

Office of State Finance VendorID: 0000263808

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/22/2021	108536128	\$117.46	02/24/20	ACCT: 13750112	
<i>Approx Mail Date:</i> 1/25/2021 <i>Mail To Address:</i> DEPT 2889 TULSA OK 74182-2889					Payment amount based on \$146.83 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment.
					<i>Patient Initials:</i> E.J. <i>Patient Birth Year:</i> 1977
12/17/2020	108521325	\$377.87	06/05/16 - 06/09/15	ACCT: 0084630071	
<i>Approx Mail Date:</i> 12/20/2020 <i>Mail To Address:</i> DEPT 2889 TULSA OK 74182-2889					Payment amount based on \$2,520.00 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.T. <i>Patient Birth Year:</i> 1995
11/19/2020	108507435	\$615.29	12/11/18	ACCT: 15488273	
<i>Approx Mail Date:</i> 11/22/2020 <i>Mail To Address:</i> DEPT 2889 TULSA OK 74182-2889					Payment amount based on \$900.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 85.45767% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment.
					<i>Patient Initials:</i> H.C. <i>Patient Birth Year:</i> 1986

OKLAHOMA SPORTS AND ORTHOPEDICS 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>
11/18/2020	108506322	\$26.88	11/27/18	ACCT: 70078337	
<i>Approx Mail Date:</i> 11/21/2020 <i>Mail To Address:</i> 3400 W. TECUMSEH RD SUITE 101 NORMAN OK 73070					Payment amount based on \$274.55 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.R. <i>Patient Birth Year:</i> 1999

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>Mail To Address:</i> PO BOX 504295 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.
					<i>Patient Initials:</i> W.E. <i>Patient Birth Year:</i> 1998

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>
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10/21/2020 108492717 \$186.40 06/13/19 ACCT: 14467046

Payment amount based on \$233.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/24/2020

Patient Initials: M.J.

Mail To Address: PO BOX 268919
OKLAHOMA CITY OK 73126-8919

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

Patient Birth Year: 1976

KAY COUNTY CLINIC COMPANY, LLC

Office of State Finance VendorID: 0000274060

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

Patient Identifiers

6/15/2020 108432740 \$874.47 12/14/20 AND 01/20/20 ACCT: 2388272

Payment amount based on \$2,970.00 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 9223
BELFAST ME 04915

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1998

ADVANCED IMAGING OF TULSA

Office of State Finance VendorID: 0000374309

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

Patient Identifiers

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.

Approx Mail Date: 5/22/2020

Patient Initials: B.P.

Mail To Address: 6757 S. YALE AVE.
TULSA OK 74136

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1943

TEXOMA MEDICAL CENTER

Office of State Finance VendorID: 0000282701

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

Patient Identifiers

11/19/2020 108507442 \$6,480.64 05/12/20 ACCT: 2950338

Payment amount based on \$8,100.80 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/22/2020

Patient Initials: C.B.

Mail To Address: PO BOX 31001-0827
PASADENA CA 91110-0827

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1969

Tulsa Sunshine Center

Office of State Finance VendorID: 0000307057

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

Patient Identifiers

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.

Approx Mail Date: 10/19/2020

Patient Initials: A.M.

Mail To Address: 2221 W. Detroit Street
Broken Arrow OK 74012

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 2007

JAMES L. WORKMAN, PA

Office of State Finance VendorID:

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

Patient Identifiers

\$140.72 09/09/18 ACCT: 14466-89452656

Approx Mail Date: Requested from OSF 12/8/20 Expected to be mailed by 12/22/20

Mail To Address: PO BOX 1210
PINE BLUFF AR 71613

Payment amount based on \$379.10 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 46.39968% among all providers. Patient Initials: J.R.

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

SOUTHWEST EMS INC

Office of State Finance VendorID: 0000259063

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

Patient Identifiers

12/17/2020 108521323 \$1,089.84 09/09/18 ACCT: 78827

Payment amount based on \$2,936.00 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 46.39968% among all providers. Patient Initials: J.R.

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

Approx Mail Date: 12/20/2020

Mail To Address: 1311 C HWY 71 N
MENA AR 71953

ST MARY'S REGIONAL MEDICAL CENTER

Office of State Finance VendorID: 0000078683

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

Patient Identifiers

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.

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

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

Approx Mail Date: 7/31/2020

Mail To Address: FILE 749344
LOS ANGELES CA 90074-9344

SAMARITAN COUNSELING AND GROWTH

Office of State Finance VendorID: 0000014912

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

Patient Identifiers

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.

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

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

Approx Mail Date: 8/29/2020

Mail To Address: 245 SE MADISON BLVD
BARTLESVILLE OK 74006

SELECT SPECIALTY HOSPITAL OKC WEST

Office of State Finance VendorID: 0000219749

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

Patient Identifiers

1/22/2021 108536124 \$245.96 12/27/19 - 02/10/20 ACCT: 13241A3057

Payment amount based on \$307.45 patient balance after insurance and insurance adjustments.

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

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1966

Approx Mail Date: 1/25/2021

Mail To Address: 3524 NW 56TH ST.
OKLAHOMA CITY OK 73112

CARE COMMUNICATIONS, LLC

Office of State Finance VendorID: 0000056512

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

Patient Identifiers

11/19/2020	108507427	\$560.97	05/10/20 - 05/12/20	ACCT: 3123629480 - \$288.91; 3123629470 - \$272.07	Payment amount based on \$833.00 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 84.17979% among all providers. Patient Initials: A.T.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1977	
11/19/2020	108507419	\$225.38	02/10/20 - 02/11/20	ACCT: 3115328340	Payment amount based on \$429.00 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 65.66922% among all providers. Patient Initials: J.E.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1997	
11/19/2020	108507420	\$2,498.85	03/17/20 AND 03/27/20	ACCT: 3117995060 - \$309.11; 3118133722 - \$95.95; 3118062330 - \$2,093.79	Payment amount based on \$4,818.00 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 64.8311% among all providers. Patient Initials: C.A.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1987	
10/21/2020	108492748	\$287.24	02/29/20	ACCT: 3127129520	Payment amount based on \$499.00 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 71.95409% among all providers. Patient Initials: E.A.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1981	
9/18/2020	108476190	\$208.80	01/22/20	ACCT: 3122300060	Payment amount based on \$261.00 patient balance after insurance and insurance adjustments.	
					Patient Initials: B.P.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1966	
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.	
					Patient Initials: J.B.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1987	
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.	
					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	

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.

Approx Mail Date: 6/18/2020
Mail To Address: 6600 S YALE AVE STE 1400
TULSA OK 74136-3331

Total Bills exceed maximum award. Payment is prorated at 99.47671% among all providers. *Patient Initials:* G.M.
Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 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.

Approx Mail Date: 5/22/2020
Mail To Address: 6600 S YALE AVE STE 1400
TULSA OK 74136-3331

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

Approx Mail Date: 5/22/2020
Mail To Address: 6600 S YALE AVE STE 1400
TULSA OK 74136-3331

Total Bills exceed maximum award. Payment is prorated at 39.7409% among all providers. *Patient Initials:* M.H.
Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1970

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>
		(\$1,008.89)	11/22/19	RESCIND PREVIOUS AWARD	
<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

Payment amount based on (\$1,008.89) patient balance after insurance and insurance adjustments.

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	\$962.01	9/2/19	ACCT: 41972	
<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

Payment amount based on \$1,202.51 patient balance after insurance and insurance adjustments.

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

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	\$262.96	10/26/19 - 11/07/19	ACCT: F00000095020 - \$221.13; W00000283619 - \$41.83	
<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

Payment amount based on \$987.00 patient balance after insurance and insurance adjustments.

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>
7/27/2020	108448995	\$14.21	9/23/2018	ACCT: 270870	
<i>Approx Mail Date:</i> 7/30/2020 <i>Mail To Address:</i> P O BOX 269065 OKLAHOMA CITY OK 73126-9065					<i>Patient Initials:</i> H.H. <i>Patient Birth Year:</i> 1989
5/19/2020	108421335	\$565.60	09/25/19	ACCT: 34609	
<i>Approx Mail Date:</i> 5/22/2020 <i>Mail To Address:</i> P O BOX 269065 OKLAHOMA CITY OK 73126-9065					<i>Patient Initials:</i> N.N. <i>Patient Birth Year:</i> 1979

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>
5/19/2020	108421211	\$24.16	01/17/19 AND 02/07/19	ACCT: 1079612	
<i>Approx Mail Date:</i> 5/22/2020 <i>Mail To Address:</i> PO BOX 108819 OKLAHOMA CITY OK 73101					<i>Patient Initials:</i> B.P. <i>Patient Birth Year:</i> 1943

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>
10/21/2020	108492721	\$5,098.33	06/12/19	ACCT: 2019321551	
<i>Approx Mail Date:</i> 10/24/2020 <i>Mail To Address:</i> PO BOX 248870 OKLAHOMA CITY OK 73124					<i>Patient Initials:</i> M.J. <i>Patient Birth Year:</i> 1976

FLORAL HAVEN MEMORIAL GARDENS

Office of State Finance VendorID: 0000286059

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/22/2021	108536095	\$7,500.00	07/21/20	ACCT: 040000217236 C.J.	
<i>Approx Mail Date:</i> 1/25/2021 <i>Mail To Address:</i> 6500 S. 129TH EAST AVENUE BROKEN ARROW OK 74012					<i>Patient Initials:</i> C.J. <i>Patient Birth Year:</i> N/A

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>
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1/22/2021	108536064	\$54.46	07/13/19	ACCT: 10591208A6385	Payment amount based on \$1,497.11 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 4.547349% among all providers. Patient Initials: T.J. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1977
<i>Approx Mail Date:</i> 1/25/2021					
<i>Mail To Address:</i> 6161 S YALE AVE TUSLA OK 74136-1902					
12/22/2020	108523888	\$776.10	8/25/2015	ACCT:12405071V6385	Payment amount based on \$970.13 patient balance after insurance and insurance adjustments. Patient Initials: C.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1994
<i>Approx Mail Date:</i> 12/25/2020					
<i>Mail To Address:</i> 6161 S YALE AVE TUSLA OK 74136-1902					
8/26/2020	108464026	\$1,237.24	10/06/19	ACCT: 11074936	Payment amount based on \$1,546.55 patient balance after insurance and insurance adjustments. Patient Initials: B.G. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1965
<i>Approx Mail Date:</i> 8/29/2020					
<i>Mail To Address:</i> 6161 S YALE AVE TUSLA OK 74136-1902					
5/19/2020	108421283	\$655.01	07/05/19 AND 07/19/19	ACCT: 10543859	Payment amount based on \$2,060.26 patient balance after insurance and insurance adjustments. Patient Initials: M.H. Total Bills exceed maximum award. Payment is prorated at 39.7409% among all providers. Patient Birth Year: 1970 Acceptance of payment may require a provider write-off. EOB will accompany payment.
<i>Approx Mail Date:</i> 5/22/2020					
<i>Mail To Address:</i> 6161 S YALE AVE TUSLA OK 74136-1902					

EMP OF TULSA COUNTY, PLLC

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>
1/12/2021	108530309	\$779.67	08/22/19	ACCT: 5591310	Payment amount based on \$974.59 patient balance after insurance and insurance adjustments. Patient Initials: V.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1998
<i>Approx Mail Date:</i> 1/15/2021					
<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084					
12/17/2020	108521230	\$470.34	07/11/19	ACCT: 10579176	Payment amount based on \$1,546.55 patient balance after insurance and insurance adjustments. Patient Initials: N.H. Total Bills exceed maximum award. Payment is prorated at 38.01526% among all providers. Patient Birth Year: 1960 Acceptance of payment may require a provider write-off. EOB will accompany payment.
<i>Approx Mail Date:</i> 12/20/2020					
<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084					
12/17/2020	108521231	\$151.46	06/18/20	ACCT: 2678-2724-3457	Payment amount based on \$985.00 patient balance after insurance and insurance adjustments. Patient Initials: W.F. Total Bills exceed maximum award. Payment is prorated at 19.22044% among all providers. Patient Birth Year: 1968 Acceptance of payment may require a provider write-off. EOB will accompany payment.
<i>Approx Mail Date:</i> 12/20/2020					
<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084					
11/19/2020	108507327	\$793.45	02/06/20	ACCT: 36152585V6385	Payment amount based on \$1,510.33 patient balance after insurance and insurance adjustments. Patient Initials: J.E. Total Bills exceed maximum award. Payment is prorated at 65.66922% among all providers. Patient Birth Year: 1997 Acceptance of payment may require a provider write-off. EOB will accompany payment.
<i>Approx Mail Date:</i> 11/22/2020					
<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084					

11/19/2020	108507328	\$1,346.05	03/17/20 AND 03/27/20	ACCT: 36953506V6385 - \$815.30; 36960022V6385 - \$530.76	Payment amount based on \$2,595.30 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 64.8311% 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> 1987
<i>Approx Mail Date:</i> 11/22/2020					
<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084					
11/19/2020	108507326	\$790.64	11/17/19	ACCT: 3914-5789-8519	Payment amount based on \$1,438.40 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 68.70795% among all providers. <i>Patient Initials:</i> W.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1989
<i>Approx Mail Date:</i> 11/22/2020					
<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084					
10/21/2020	108492664	\$967.14	02/29/20	ACCT: 36640462V6385	Payment amount based on \$1,680.13 patient balance after insurance and insurance adjustments. 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
<i>Approx Mail Date:</i> 10/24/2020					
<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084					
8/11/2020	108455894	\$739.67	11/9/19	ACCT: 11257705A6385	Payment amount based on \$924.59 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.C. <i>Patient Birth Year:</i> 1968
<i>Approx Mail Date:</i> 8/14/2020					
<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084					
7/28/2020	108449452	\$53.64	10/29/16- 05/13/17	ACCT: 47013148	Payment amount based on \$67.05 patient balance after insurance and insurance adjustments. 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
<i>Approx Mail Date:</i> 7/31/2020					
<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084					
6/15/2020	108432714	\$1,201.94	03/19/20	ACCT: 11985370	Payment amount based on patient balance after insurance and insurance adjustments. 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
<i>Approx Mail Date:</i> 6/18/2020					
<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084					
6/15/2020	108432713	\$2,458.09	10/03/19	ACCT: 33664297V6385 - \$1,207.10; 33664300V6385 - \$1,250.99	Payment amount based on \$5,121.99 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
<i>Approx Mail Date:</i> 6/18/2020					
<i>Mail To Address:</i> PO BOX 18921 BELFAST ME 04915-4084					

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	
Payment amount based on \$858.81 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					
<i>Mail To Address:</i> PO BOX 2054 LOWELL AR 72745					
Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> M.W. <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>Mail To Address:</i> 2424 E 21ST STE 320 TULSA OK 74114					Payment amount based on \$4,618.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 73.01783% among all providers. <i>Patient Initials:</i> D.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. <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>
1/22/2021	108536102	\$305.15	07/15/19 - 09/11/19	ACCT: 20330	
<i>Approx Mail Date:</i> 1/25/2021 <i>Mail To Address:</i> 5110 S YALE SUITE 525 TULSA OK 74135-7485					Payment amount based on \$8,388.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 4.547349% 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> 1977
1/12/2021	108530352	\$136.80	05/06/19 - 12/12/19	ACCT: 12819351	
<i>Approx Mail Date:</i> 1/15/2021 <i>Mail To Address:</i> 5110 S YALE SUITE 525 TULSA OK 74135-7485					Payment amount based on \$171.00 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> D.R. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1978
8/26/2020	108464135	\$7,720.00	08/02/19	ACCT: 20571	
<i>Approx Mail Date:</i> 8/29/2020 <i>Mail To Address:</i> 5110 S YALE SUITE 525 TULSA OK 74135-7485					Payment amount based on \$9,650.00 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
8/17/2020	108459254	\$1,036.80	03/01/20	ACCT: 22946	
<i>Approx Mail Date:</i> 8/20/2020 <i>Mail To Address:</i> 5110 S YALE SUITE 525 TULSA OK 74135-7485					Payment amount based on patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> E.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1983
6/15/2020	108432772	\$370.23	09/16/19	ACCT: 21014	
<i>Approx Mail Date:</i> 6/18/2020 <i>Mail To Address:</i> 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. <i>Patient Initials:</i> G.B. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1967

DRUMRIGHT DENTAL CENTER, PLLC

Office of State Finance VendorID: 0000390374

<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	108441703	\$2,023.00	08/11/16	ACCT: C.D.S.	
<i>Approx Mail Date:</i> 7/11/2020 <i>Mail To Address:</i> 1226 W. BROADWAY DRUMRIGHT OK 74030-5826					Payment amount based on \$2,528.75 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> C.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1979

MILLER & MILLER FUNERAL HOME*Office of State Finance VendorID:* 0000203266

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
12/21/2020	108523140	\$2,500.00	05/12/20	ACCT: R.F.P.	Payment amount based on \$2,500.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 12/24/2020					<i>Patient Initials:</i> R.F.
<i>Mail To Address:</i> 3151 E JACKSON ST HUGO OK 74743					<i>Patient Birth Year:</i> 1972

MOBILE MEDICAL SOLUTIONS*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>
		\$516.00	11/19/19 - 03/24/20	ACCT: 0000003652	Payment amount based on \$645.00 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> K.M.
<i>Mail To Address:</i> 2760 WASHINGTON DR. STE 110 NORMAN OK 73069					<i>Patient Birth Year:</i> 1969

CAH ACQUISITION COMPANY*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>
		\$1,503.10	02/08/20	ACCT: 512435	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 9/15/20 Expected to be mailed by 9/29/20					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> 1322 KLABZUBA AVE PRAGUE OK 74864-1090					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1989

INTEGRITY FUNERAL SERVICE*Office of State Finance VendorID:* 0000330975

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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.
<i>Approx Mail Date:</i> 6/6/2020					<i>Patient Initials:</i> D.G.
<i>Mail To Address:</i> 410 E. TRUDGEON HENRYETTA OK 74437					<i>Patient Birth Year:</i> 1991
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.
<i>Approx Mail Date:</i> 4/17/2020					<i>Patient Initials:</i> E.R.
<i>Mail To Address:</i> 410 E. TRUDGEON HENRYETTA OK 74437					<i>Patient Birth Year:</i> 1982

LIFE STRATEGY CENTER*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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\$16.00 6/12/20-9/22/20 ACCT: L.K.

Approx Mail Date: Requested from OSF 1/19/21 Expected to be mailed by 2/2/21

Mail To Address: 1949 SUGARLAND DR #218
SHERIDAN WY 82801

Payment amount based on \$20.00 patient balance after insurance and insurance adjustments.

Patient Initials: B.K.

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

Patient Birth Year: 1964

MELISSA D RATTERREE, MS LPC

Office of State Finance VendorID: 0000483924

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

Patient Identifiers

6/18/2020 108434697 \$260.00 10/7/19 - 12/11/2019 ACCT: J.G.

Payment amount based on \$325.00 patient balance after insurance and insurance adjustments.

Patient Initials: J.G.

Approx Mail Date: 6/21/2020

Mail To Address: 1133 N MAIN STREET
MUSKOGEE OK 74401-4441

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

Patient Birth Year: 1979

MERCY CLINIC OKLAHOMA COMMUNITIES INC

Office of State Finance VendorID: 0000334305

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

Patient Identifiers

12/11/2020 108517648 \$351.00 9-11-2019 ACCT: OK1242719

Payment amount based on \$438.75 patient balance after insurance and insurance adjustments.

Patient Initials: A.S.

Approx Mail Date: 12/14/2020

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: 1962

MERCY OKLAHOMA

Office of State Finance VendorID: 0000334305

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

Patient Identifiers

12/17/2020 108521265 \$9,042.89 07/07/20 - 07/08/20 ACCT: 53002223875

Payment amount based on \$11,303.61 patient balance after insurance and insurance adjustments.

Patient Initials: G.J.

Approx Mail Date: 12/20/2020

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: 2000

SUMMIT MEDICAL CENTER

Office of State Finance VendorID: 0000411039

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

Patient Identifiers

12/15/2020 108519554 \$2,462.45 07/25/19 - 07/31/19 ACCT: V000062246

Payment amount based on \$3,078.06 patient balance after insurance and insurance adjustments.

Patient Initials: M.D.

Approx Mail Date: 12/18/2020

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: 1970

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.

Patient Initials: R.J.

Approx Mail Date: 8/20/2020

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

<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	108441718	\$2,076.89	02/11/20	ACCT: C.P.	Payment amount based on \$2,076.89 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 7/11/2020					<i>Patient Initials:</i> C.P.
<i>Mail To Address:</i> CHANEY HARKINS FUNERAL HOME MCALESTER OK 74501					<i>Patient Birth Year:</i> 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.
<i>Approx Mail Date:</i> 6/6/2020					<i>Patient Initials:</i> J.N.
<i>Mail To Address:</i> CHANEY HARKINS FUNERAL HOME MCALESTER OK 74501					<i>Patient Birth Year:</i> 2002

FOCUS INSTITUTE

Office of State Finance VendorID: 0000318959

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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.
<i>Approx Mail Date:</i> 6/6/2020					<i>Patient Initials:</i> C.L.
<i>Mail To Address:</i> 920 S. MAIN STILLWATER OK 74074					<i>Patient Birth Year:</i> 1990

EMERGENCY SERVICES OF OKLAHOMA

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>
12/21/2020	108523089	\$863.20	11/20/18	ACCT: 22655946151	Payment amount based on \$1,079.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 12/24/2020					<i>Patient Initials:</i> C.A.
<i>Mail To Address:</i> PO BOX 636758 CINCINNATI OH 45263					<i>Patient Birth Year:</i> 1995
10/14/2020	108489540	\$755.20	10/03/18	ACCT: 601410980	Payment amount based on \$944.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 10/17/2020					<i>Patient Initials:</i> E.P.
<i>Mail To Address:</i> PO BOX 636758 CINCINNATI OH 45263					<i>Patient Birth Year:</i> 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.
<i>Approx Mail Date:</i> 10/4/2020					<i>Patient Initials:</i> J.N.
<i>Mail To Address:</i> PO BOX 636758 CINCINNATI OH 45263					<i>Patient Birth Year:</i> 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.
<i>Approx Mail Date:</i> 8/29/2020					<i>Patient Initials:</i> T.E.
<i>Mail To Address:</i> PO BOX 636758 CINCINNATI OH 45263					<i>Patient Birth Year:</i> 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

Approx Mail Date: 7/30/2020

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

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

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

Approx Mail Date: 10/19/2020

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

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

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

Approx Mail Date: 7/30/2020

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

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

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.

Approx Mail Date: 5/22/2020

Patient Initials: O.P.

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

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

Patient Birth Year: 1995

MERCY HOSPITAL ADA EMERGENCY PHYSICIANS

Office of State Finance VendorID: 0000325378

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

Patient Identifiers

10/21/2020 108492666 \$559.20 09/28/19 ACCT: 5000009523997

Payment amount based on \$699.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/24/2020

Patient Initials: B.S.

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

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

Patient Birth Year: 2002

ST MARY'S EMERGENCY PHYSICIANS

Office of State Finance VendorID: 0000325378

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

Patient Identifiers

1/22/2021 108536065 \$204.00 6/18/20 ACCT:m83182676
ACCT:314880493

Payment amount based on \$255.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/25/2021

Patient Initials: B.L.

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

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

Patient Birth Year: 2014

RADIOLOGY ASSOCIATES OF EASTERN OKLAHOMA

Office of State Finance VendorID: 0000334138

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

Patient Identifiers

10/16/2020 108490824 \$204.80 10/25/2018 ACCT: 62833

Payment amount based on \$256.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/19/2020

Patient Initials: M.G.

Mail To Address: 3433 NW 56TH ST #C40
OKLAHOMA CITY OK 73112-4455

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

Patient Birth Year: 1993

5/19/2020 108421365 \$8.58 01/14/19 ACCT: 56586

Payment amount based on \$22.95 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: 3330 NW 56TH ST SUITE 206
OKLAHOMA CITY OK 73112

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

Patient Birth Year: 1997

TEXARKANA EMERGENCY PHYSICIANS PLLC

Office of State Finance VendorID:

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

Patient Identifiers

\$1,777.60 06/23/19 ACCT: 03X59614462

Payment amount based on \$2,222.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 1/8/21 Expected to be mailed by 1/22/21

Patient Initials: R.R.

Mail To Address: PO BOX 731584
DALLAS TX 753736-1584

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

Patient Birth Year: 1960

ANGELA CASE

Office of State Finance VendorID: 0000506880

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
5/20/2020	108421968	\$172.00	01/09/20 - 02/26/20	ACCT: M.C.	
<i>Approx Mail Date:</i> 5/23/2020 <i>Mail To Address:</i> 8104 NW 32ND ST BETHANY OK 73008					<i>Patient Initials:</i> M.C. <i>Patient Birth Year:</i> 2000

DENTAL CARE OF NORMAN

Office of State Finance VendorID:

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		\$1,931.36	07/26/18 - 11/23/18	ACCT: 006809	
<i>Approx Mail Date:</i> Requested from OSF 12/10/20 Expected to be mailed by 12/24/20 <i>Mail To Address:</i> 1732 24TH NW C-107 NORMAN OK 7.069-6397					<i>Patient Initials:</i> A.I. <i>Patient Birth Year:</i> 1994

SOUTH CENTRAL EMERGENCY SERVICES

Office of State Finance VendorID: 0000332815

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
10/21/2020	108492755	\$560.00	08/08/20	ACCT: 270110333/47	
<i>Approx Mail Date:</i> 10/24/2020 <i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274					<i>Patient Initials:</i> E.Q. <i>Patient Birth Year:</i> 1989
10/21/2020	108492754	\$36.20	01/25/20	ACCT: 47223861-47-8108	
<i>Approx Mail Date:</i> 10/24/2020 <i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274					<i>Patient Initials:</i> J.F. <i>Patient Birth Year:</i> 1978
10/14/2020	108489586	\$1,448.80	04/18/20	ACCT: 263105346/47	
<i>Approx Mail Date:</i> 10/17/2020 <i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274					<i>Patient Initials:</i> T.C. <i>Patient Birth Year:</i> 2000
8/26/2020	108464197	\$307.99	11/06/19	ACCT: 251565442/47	
<i>Approx Mail Date:</i> 8/29/2020 <i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274					<i>Patient Initials:</i> S.H. <i>Patient Birth Year:</i> 1967
8/17/2020	108459276	\$383.20	08/25/19	ACCT: 78928043-47-8108	
<i>Approx Mail Date:</i> 8/20/2020 <i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274					<i>Patient Initials:</i> A.B. <i>Patient Birth Year:</i> 1999

8/12/2020	108456770	\$18.98	3/29/20	ACCT: 49726462-47-8108	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> R.S.
	<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Birth Year:</i> 1951
	<i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274					
6/3/2020	108427504	\$383.20	12/30/19	ACCT: 256278064/47	Payment amount based on \$479.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.L.
	<i>Approx Mail Date:</i> 6/6/2020					<i>Patient Birth Year:</i> 1990
	<i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
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.	<i>Patient Initials:</i> R.W.
	<i>Approx Mail Date:</i> 5/22/2020					<i>Patient Birth Year:</i> 1995
	<i>Mail To Address:</i> PO BOX 740022 CINCINNATI OH 45274				Total Bills exceed maximum award. Payment is prorated at 11.33645% among all providers.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	

STILLWATER EMERGENCY PHYSICIAN

Office of State Finance VendorID: 0000332815

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
11/18/2020	108506370	\$269.60	6/27/20	ACCT: 267175309/47	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> P.H.
	<i>Approx Mail Date:</i> 11/21/2020					<i>Patient Birth Year:</i> 1963
	<i>Mail To Address:</i> PO BOX 637113 CINCINNATI OH 45263-7113					

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>
		\$100.00	09/21/19	FUNERAL REIMBURSEMENT	Payment amount based on \$100.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> T.M.
	<i>Approx Mail Date:</i> Requested from OSF 6/30/20 Expected to be mailed by 7/14/20					<i>Patient Birth Year:</i> 1989
	<i>Mail To Address:</i> 118 1/2 S. MAIN ALTUS OK 73521					

NORTHSTAR ANESTHESIA OF OKLAHOMA, PLLC

Office of State Finance VendorID: 0000367028

<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	108421334	\$105.60	11/05/18	ACCT: 0001112574	Payment amount based on \$132.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> O.P.
	<i>Approx Mail Date:</i> 5/22/2020					<i>Patient Birth Year:</i> 1995
	<i>Mail To Address:</i> PO BOX 224747 DALLAS TX 75222-4747				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

CHARLES P. BOGIE III MD PHD INC PC

Office of State Finance VendorID: 0000361812

<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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6/15/2020 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

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 SUITE 420
BETHANY OK 73008

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

Patient Birth Year: 1972

THERAWEST

Office of State Finance VendorID: 0000380277

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

Patient Identifiers

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.

Approx Mail Date: 10/4/2020

Patient Initials: K.T.

Mail To Address: PO BOX 86
CLINTON OK 73601

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

Patient Birth Year: 1998

PARIS REGIONAL MEDICAL CENTER

Office of State Finance VendorID: 0000243703

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

Patient Identifiers

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.

Approx Mail Date: 9/21/2020

Patient Initials: J.A.

Mail To Address: 865 DESHONG DR.
PARIS TX 75460

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

Patient Birth Year: 1998

PARIS REGIONAL MED CENTER

Office of State Finance VendorID: 0000243703

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

Patient Identifiers

11/19/2020 108507391 \$2,142.98 03/28/18 ACCT: PR0001193892

Payment amount based on \$5,048.58 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/22/2020

Total Bills exceed maximum award. Payment is prorated at 53.05898% among all providers. Patient Initials: K.S.

Mail To Address: PO BOX 415000 MSC 410521
NASHVILLE OK 37241

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

Patient Birth Year: 1985

SAMARITAN EMS

Office of State Finance VendorID: 0000391090

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

Patient Identifiers

11/19/2020 108507428 \$162.09 10/25/18 ACCT: 1809838

Payment amount based on \$1,655.70 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/22/2020

Patient Initials: A.R.

Mail To Address: PO BOX 15764
DEL CITY OK 73155

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

Patient Birth Year: 1999

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.

Approx Mail Date: 5/22/2020

Total Bills exceed maximum award. Payment is prorated at 16.24235% among all providers. Patient Initials: J.W.

Mail To Address: PO BOX 15764
DEL CITY OK 73155

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

Patient Birth Year: 1988

INTEGRITY PATHWAYS

Office of State Finance VendorID: 0000327604

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

Patient Identifiers

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.

Approx Mail Date: 6/21/2020

Patient Initials: E.M.

Mail To Address: 814 WEST OKMULGEE
MUSKOGEE OK 74401

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

Patient Birth Year: 1996

\$860.00 6/3/18 - 7/24/18 Counseling \$860.00

Approx Mail Date: Requested from OSF 1/23/20 Expected to be mailed by 2/6/20

Mail To Address: 814 WEST OKMULGEE
MUSKOGEE OK 74401

Payment amount based on \$1,075.00 patient balance after insurance and insurance adjustments.

Patient Initials: E.M.

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

Patient Birth Year: 1996

WAGONER COMMUNITY HOSPITAL

Office of State Finance VendorID: 0000272747

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

Patient Identifiers

4/14/2020 108406915 \$644.80 07/19/19 ACCT: 4433525A14254

Payment amount based on \$806.00 patient balance after insurance and insurance adjustments.

Patient Initials: A.K.

Approx Mail Date: 4/17/2020

Mail To Address: PO BOX 18159
BELFAST ME 04915-4076

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

Patient Birth Year: 1980

WAGONER HOSPITAL AUTHORITY

Office of State Finance VendorID: 0000272747

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

Patient Identifiers

7/27/2020 108449028 \$120.00 5/10/2019 ACCT: 501230A14254

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

Patient Initials: H.K.

Approx Mail Date: 7/30/2020

Mail To Address: 1200 W. CHEROKEE ST.
WAGONER OK 74467

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

Patient Birth Year: 2008

INTEGRIS COMMUNITY HOSPITAL DEL CITY

Office of State Finance VendorID:

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

Patient Identifiers

\$1,293.60 8/8/19 ACCT:602176163

Payment amount based on \$1,617.00 patient balance after insurance and insurance adjustments.

Patient Initials: I.Y.

Approx Mail Date: Requested from OSF 1/19/21 Expected to be mailed by 2/2/21

Mail To Address: PO BOX 734476
DALLAS TX 75373-4476

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

Patient Birth Year: 1998

\$1,515.90 9/28/2019 ACCT: 602308885

Payment amount based on \$1,894.88 patient balance after insurance and insurance adjustments.

Patient Initials: C.F.

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

Mail To Address: PO BOX 734476
DALLAS TX 75373-4476

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

Patient Birth Year: 1983

ALLIANCE HEALTH CLINTON

Office of State Finance VendorID: 0000406751

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

Patient Identifiers

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.

Patient Initials: A.S.

Approx Mail Date: 9/21/2020

Mail To Address: 100 N. 30TH ST.
CLINTON OK 73601-1569

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

Patient Birth Year: 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.

Approx Mail Date: 5/2/2020

Patient Initials: P.W.

Mail To Address: 100 N. 30TH ST.
CLINTON OK 73601-1569

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

Patient Birth Year: 1991

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

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

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

Patient Identifiers

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.

Approx Mail Date: 9/26/2020

Patient Initials: T.E.

Mail To Address: 1200 E 25TH STREET
HIBBERING MN 55746-3897

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

Patient Birth Year: 1985

LINDA MORGAN

Office of State Finance VendorID: 0000510465

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
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>Mail To Address:</i> PO BOX 14554 KNOXVILLE TN 37914					<i>Patient Initials:</i> M.D. <i>Patient Birth Year:</i> 1957

VIRTUAL RADIOLOGIC PROF INC

Office of State Finance VendorID: 0000384420

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
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>Mail To Address:</i> PO BOX 4246 CAROL STREAM IL 60197-4246					<i>Patient Initials:</i> T.P. <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>Mail To Address:</i> PO BOX 4246 CAROL STREAM IL 60197-4246					<i>Patient Initials:</i> M.S. <i>Patient Birth Year:</i> 1999

PAFFORD MEDICAL SERVICES INC

Office of State Finance VendorID: 0000257242

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
1/22/2021	108536105	\$1,945.60	06/18/20	ACCT: 9182012371A	Payment amount based on \$2,432.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 1/25/2021 <i>Mail To Address:</i> P O BOX 1120 HOPE AR 71802					<i>Patient Initials:</i> A.H. <i>Patient Birth Year:</i> 1975
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.
<i>Approx Mail Date:</i> 9/21/2020 <i>Mail To Address:</i> P O BOX 1120 HOPE AR 71802					<i>Patient Initials:</i> M.I. <i>Patient Birth Year:</i> 1971
6/15/2020	108432779	\$1,235.20	01/28/20	ACCT: 114215	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 6/18/2020 <i>Mail To Address:</i> P O BOX 1120 HOPE AR 71802					<i>Patient Initials:</i> A.L. <i>Patient Birth Year:</i> 1978
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.
<i>Approx Mail Date:</i> 5/2/2020 <i>Mail To Address:</i> P O BOX 1120 HOPE AR 71802					<i>Patient Initials:</i> A.L. <i>Patient Birth Year:</i> 1978

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:		Patient Identifiers
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.	
		<i>Approx Mail Date:</i> 10/4/2020				<i>Patient Initials:</i> M.O.
		<i>Mail To Address:</i> HOSPITAL DENTISTRY INSTITUTE IOWA CITY IA 52242		105 JESSUP HALL	Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> N/A

AIR EVAC LIFETEAM

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:		Patient Identifiers
12/17/2020	108521169	\$13,273.17	07/11/19	ACCT: 0119006418AA	Payment amount based on \$43,644.23 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 12/20/2020			Total Bills exceed maximum award. Payment is prorated at 38.01526% among all providers.	<i>Patient Initials:</i> N.H.
		<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> 1960
12/17/2020	108521168	\$12,376.84	09/09/18	ACCT: 30018891058A	Payment amount based on \$33,343.03 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 12/20/2020			Total Bills exceed maximum award. Payment is prorated at 46.39968% 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> 1979
12/17/2020	108521167	\$651.91	07/13/18	ACCT: 30018869680A	Payment amount based on \$896.89 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 12/20/2020			Total Bills exceed maximum award. Payment is prorated at 90.85773% among all providers.	<i>Patient Initials:</i> E.A.
		<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> 1997
11/19/2020	108507272	\$17,927.13	07/13/20	ACCT: 0120062799A	Payment amount based on \$54,652.20 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 11/22/2020			Total Bills exceed maximum award. Payment is prorated at 41.00276% among all providers.	<i>Patient Initials:</i> D.D.
		<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> 1998
10/21/2020	108492609	\$16,085.11	09/08/19	ACCT: 0119028707A	Payment amount based on \$49,300.60 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 10/24/2020			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
6/15/2020	108432632	\$1,803.26	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
5/19/2020	108421212	\$4,670.89	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

4/22/2020 108410267 \$3,140.00 12/16/17 ACCT: 30017796764A

Payment amount based on \$3,925.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 4/25/2020

Patient Initials: K.B.

Mail To Address: PO BOX 106
WEST PLAINS MO 65775

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

Patient Birth Year: 2001

GAMMA HEALTHCARE

Office of State Finance VendorID:

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

Patient Identifiers

\$137.06 05/04/20 ACCT: 988691

Payment amount based on \$171.33 patient balance after insurance and insurance adjustments.

Patient Initials: L.H.

Approx Mail Date: Requested from OSF 1/12/21 Expected to be mailed by 1/26/21

Mail To Address: 1717 WEST MAUD
POPLAR BLUFF MO 63901-4003

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

Patient Birth Year: 1966

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

Mail To Address: PO BOX 958396
ST LOUIS MO 63195-8396

Patient Birth Year: 1984

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

Mail To Address: 14662 W BIG LAKE BLV
MT. VERNON WA 98274

Patient Birth Year: 1957

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.

Patient Initials: R.C.

Approx Mail Date: 6/28/2020

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

MICAH FORAKER

Office of State Finance VendorID: 0000517880

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

Patient Identifiers

12/22/2020 108523922 \$192.00 9/10/20-10/14/20 7586

Approx Mail Date: 12/25/2020

Mail To Address: 278871 E 1840
COMANCHE OK 73529

Payment amount based on \$240.00 patient balance after insurance and insurance adjustments.

Patient Initials: R.N.

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

Patient Birth Year: 1958

KEN HANEY, LPC

Office of State Finance VendorID: 0000467129

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

Patient Identifiers

10/22/2020 108493502 \$80.00 2/29/2020 ACCT: A.E.

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

Patient Initials: A.E.

Approx Mail Date: 10/25/2020

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

AMERICAN RADIOLOGY CONSULTANTS

Office of State Finance VendorID:

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

Patient Identifiers

\$49.66 03/28/18 ACCT: 901988

Payment amount based on \$117.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 11/10/20 Expected to be mailed by 11/24/20

Mail To Address: P O BOX 678253
DALLAS TX 75267

Total Bills exceed maximum award. Payment is prorated at 53.05898% among all providers.

Patient Initials: K.S.

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

Patient Birth Year: 1985

MIRAMAR GARCIA COHN, PHD

Office of State Finance VendorID: 0000318634

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

Patient Identifiers

12/2/2020 108511962 \$756.00 03/04/20 - 07/22/20 ACCT: R.H.

Payment amount based on \$945.00 patient balance after insurance and insurance adjustments.

Patient Initials: D.L.

Approx Mail Date: 12/5/2020

Mail To Address: 8908 S. YALE AVE, STE 403
TULSA OK 74137

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

Patient Birth Year: 1998

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.

Patient Initials: D.L.

Approx Mail Date: 4/25/2020

Mail To Address: 8908 S. YALE AVE, STE 403
TULSA OK 74137

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

Patient Birth Year: 1998

RED CANYON COUNSELING PLLC

Office of State Finance VendorID: 0000495706

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

Patient Identifiers

1/22/2021 108536117 \$432.00 6/16/20-9/16/20 ACCOUNT: R.B.

Payment amount based on \$540.00 patient balance after insurance and insurance adjustments.

Patient Initials: R.B.

Approx Mail Date: 1/25/2021

Mail To Address: PO BOX 64
FREEDOM OK 73842

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

Patient Birth Year: 2009

12/11/2020 108517665 \$388.00 ACCT:E.N. Payment amount based on patient balance after insurance and insurance adjustments.
Approx Mail Date: 12/14/2020 *Patient Initials:* E.N.
Mail To Address: PO BOX 64 *Patient Birth Year:* 2000
 FREEDOM OK 73842

FAMILY SOLUTIONS COUNSELING

Office of State Finance VendorID: 0000519946

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
12/30/2020	108526096	\$1,344.00	12/27/19-7/27/2020	ACCT: 835R626	
<i>Approx Mail Date:</i> 1/2/2021					<i>Patient Initials:</i> B.S.
<i>Mail To Address:</i> 10400 N. VINEYARD BLVD #A					<i>Patient Birth Year:</i> 2007
OKLAHOMA CITY OK 73120					

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	
<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Initials:</i> H.R.
<i>Mail To Address:</i> DEPT 2805					<i>Patient Birth Year:</i> 1992
TULSA OK 74182					
5/19/2020	108421305	\$1,411.02	03/03/18 - 01/06/20	ACCT: 1079612	
<i>Approx Mail Date:</i> 5/22/2020					<i>Patient Initials:</i> B.P.
<i>Mail To Address:</i> DEPT 2805					<i>Patient Birth Year:</i> 1943
TULSA OK 74182					

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>
10/1/2020	108482945	\$4,392.98	03/10/20	ACCT: 2189089	
<i>Approx Mail Date:</i> 10/4/2020					<i>Patient Initials:</i> D.E.
<i>Mail To Address:</i> 1202 N MUSKOGEE PL					<i>Patient Birth Year:</i> 1980
CLAREMORE OK 74017-3058					
9/18/2020	108476132	\$7,763.59	06/22/20	ACCT: 2266127	
<i>Approx Mail Date:</i> 9/21/2020					<i>Patient Initials:</i> M.I.
<i>Mail To Address:</i> 1202 N MUSKOGEE PL					<i>Patient Birth Year:</i> 1971
CLAREMORE OK 74017-3058					
6/15/2020	108432728	\$9,089.32	01/28/20 AND 01/30/20	ACCT: 956064	
<i>Approx Mail Date:</i> 6/18/2020					<i>Patient Initials:</i> A.L.
<i>Mail To Address:</i> 1202 N MUSKOGEE PL					<i>Patient Birth Year:</i> 1978
CLAREMORE OK 74017-3058					

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

CANNON ORAL & MAXILLOFACIAL SURGERY

Office of State Finance VendorID: 0000342407

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

Patient Identifiers

12/17/2020 108521202 \$26.36 09/17/15 ACCT: 412755

Payment amount based on \$175.76 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/20/2020

Patient Initials: M.T.

Mail To Address: 3345 S HARVARD AVE SUITE 103
TULSA OK 74135-4135

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

Patient Birth Year: 1995

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

OKLAHOMA SURGICAL GROUP

Office of State Finance VendorID: 0000341463

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

Patient Identifiers

12/11/2020 108517658 \$198.40 ACCT:125075

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

Approx Mail Date: 12/14/2020

Patient Initials: T.M.

Mail To Address: PO BOX 6370
EDMOND OK 73083-6370

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

Patient Birth Year: 1999

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

OKLAHOMA EM PHYS PART PLLC

Office of State Finance VendorID: 0000365680

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

Patient Identifiers

10/21/2020 108492720 \$2,152.00 05/05/20 ACCT: 14X67478091

Approx Mail Date: 10/24/2020

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

Payment amount based on \$2,690.00 patient balance after insurance and insurance adjustments.

Patient Initials: R.W.

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

Patient Birth Year: 2001

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

Approx Mail Date: 10/19/2020

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

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

Patient Initials: N.F.

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

Approx Mail Date: 8/15/2020

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

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

Patient Initials: G.G.

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.

Approx Mail Date: 6/21/2020

Mail To Address: 1600 SAYERS ST
LUFKIN TX 75904

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

Patient Initials: J.H.

Patient Birth Year: 1991

CELERITY PROSTHETICS LLC

Office of State Finance VendorID: 0000518182

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

Patient Identifiers

11/19/2020 108507302 \$4,183.96 04/30/20 ACCT: 157

Approx Mail Date: 11/22/2020

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

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

Total Bills exceed maximum award. Payment is prorated at 39.47931% among all providers.

Patient Initials: E.R.

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

10/21/2020 108492707 \$266.89 09/08/19 ACCT: 507000317465

Approx Mail Date: 10/24/2020

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

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

Total Bills exceed maximum award. Payment is prorated at 40.78328% among all providers.

Patient Initials: R.F.

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
12/11/2020	108517649	\$116.40	7/24/20	ACCT: 5000011684073	Payment amount based on patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> T.M. <i>Patient Birth Year:</i> 1999
<i>Approx Mail Date:</i> 12/14/2020					
<i>Mail To Address:</i> PO BOX 504292 ST LOUIS MO 63150-4292					
10/21/2020	108492708	\$8,676.22	09/28/19	ACCT: 507000322408	Payment amount based on \$10,845.28 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> B.S. <i>Patient Birth Year:</i> 2002
<i>Approx Mail Date:</i> 10/24/2020					
<i>Mail To Address:</i> PO BOX 504292 ST LOUIS MO 63150-4292					

R. JAY CHRISTENSEN, MD

Office of State Finance VendorID: 0000517090

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
12/11/2020		\$97.34	12/20/19	TGP18542	Payment amount based on \$121.68 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> D.J. <i>Patient Birth Year:</i> 1974
<i>Approx Mail Date:</i> 12/14/2020					
<i>Mail To Address:</i> 5415 MYSTIC PLACE OKLAHOMA CITY OK 73150					

ZOOM DIAGNOSTIC IMAGING ENID

Office of State Finance VendorID:

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		\$168.66		ACCT: 21353	Payment amount based on \$210.83 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> B.L. <i>Patient Birth Year:</i> 2014
<i>Approx Mail Date:</i> Requested from OSF 1/19/21 Expected to be mailed by 2/2/21					
<i>Mail To Address:</i> 1113 W CHERRY AVE ENID OK 73703-3321					

MERCY HOSPITAL KINGFISHER

Office of State Finance VendorID: 0000372693

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
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>Patient Initials:</i> R.C. <i>Patient Birth Year:</i> 2000
<i>Approx Mail Date:</i> 7/31/2020					
<i>Mail To Address:</i> 1000 HOSPITAL DRIVE KINGFISHER OK 73750					

ADAMS CREST FUNERAL HOME

Office of State Finance VendorID: 0000399896

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
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12/17/2020 108521164 \$7,500.00 06/13/20 ACCT: T.S.J. Payment amount based on \$8,437.46 patient balance after insurance and insurance adjustments.
Approx Mail Date: 12/20/2020 *Patient Initials:* T.J.
Mail To Address: 1916 S SHERIDAN *Patient Birth Year:* 1969
TULSA OK 74112

12/15/2020 108519507 \$7,092.35 09/20/19 ACCT: R.J. Payment amount based on \$7,092.35 patient balance after insurance and insurance adjustments.
Approx Mail Date: 12/18/2020 *Patient Initials:* R.J.
Mail To Address: 1916 S SHERIDAN *Patient Birth Year:* 1993
TULSA OK 74112

MICHELINE CHRISMAN

Office of State Finance VendorID: 0000519084

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

12/30/2020 108526141 \$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. *Patient Initials:* K.W.
Approx Mail Date: 1/2/2021
Mail To Address: 1225 W MAIN STREET, SUITE 102 *Patient Birth Year:* 1990
NORMAN OK 73069

CAVANAL HILL EMERG PHYS, LLC

Office of State Finance VendorID: 0000410665

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

10/1/2020 108482912 \$635.20 03/10/20 ACCT: 1000185043075LAR Payment amount based on \$794.00 patient balance after insurance and insurance adjustments. *Patient Initials:* D.E.
Approx Mail Date: 10/4/2020
Mail To Address: PO BOX 99009 *Patient Birth Year:* 1980
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. *Patient Initials:* A.L.
Approx Mail Date: 6/18/2020
Mail To Address: PO BOX 99009 *Patient Birth Year:* 1978
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. *Patient Initials:* A.L.
Approx Mail Date: 5/31/2020
Mail To Address: PO BOX 99009 *Patient Birth Year:* 1978
LAS VEGAS NV 89193

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. *Patient Initials:* A.L.
Approx Mail Date: 5/31/2020
Mail To Address: PO BOX 99009 *Patient Birth Year:* 1978
LAS VEGAS NV 89193

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.

Approx Mail Date: 5/2/2020

Patient Initials: A.L.

Mail To Address: PO BOX 99009
LAS VEGAS NV 89193

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

Patient Birth Year: 1978

THE CENTER FOR GRIEF RECOVERY & FAMILY SERVICES, LLC

Office of State Finance VendorID: 0000484837

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

Patient Identifiers

1/22/2021 108536044 \$644.00 9/8/20-11/16/20 ACCT:TERBRI001

Payment amount based on \$805.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/25/2021

Patient Initials: T.B.

Mail To Address: DESTINY WELLNESS CENTER 7226 E 41ST ST
TULSA OK 74145-4504

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

Patient Birth Year: 1964

CROSSWAY MEDICAL CLINIC W MEMORIAL PLLC

Office of State Finance VendorID: 0000404573

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

Patient Identifiers

9/18/2020 108476109 \$317.59 09/30/19 - 10/14/19 ACCT: 264692552

Payment amount based on \$1,766.61 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: 609 W MEMORIAL RD
OKLAHOMA CITY OK 73114

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

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

10/22/2020 108493475 \$660.00 5/18/20-8/18/20 ACCT:90837

Approx Mail Date: 10/25/2020

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

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

Patient Initials: M.W.

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.

Approx Mail Date: 8/29/2020

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

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

Patient Initials: I.F.

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

Approx Mail Date: 8/24/2020

Mail To Address: 3247 HIGHWAY 54
GUYMON OK 73942

Payment amount based on \$180.00 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: 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.

Approx Mail Date: 9/28/2020

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

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

Patient Initials: M.L.

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

Approx Mail Date: 8/15/2020

Mail To Address: PO BOX 638568
CINCINNATI OH 45263

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

Patient Initials: K.B.

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

1/12/2021 108530310 \$1,299.20 06/08/20 ACCT: 265638428/56

Approx Mail Date: 1/15/2021

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

Payment amount based on \$1,624.00 patient balance after insurance and insurance adjustments.

Patient Initials: A.R.

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

Patient Birth Year: 2001

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. 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
<i>Approx Mail Date:</i> 9/21/2020					
<i>Mail To Address:</i> PO BOX 638568 CINCINNATI OH 46263-8568					
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. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: B.L. Patient Birth Year: 1994
<i>Approx Mail Date:</i> 9/21/2020					
<i>Mail To Address:</i> PO BOX 638568 CINCINNATI OH 46263-8568					
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. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: J.N. Patient Birth Year: 1979
<i>Approx Mail Date:</i> 6/18/2020					
<i>Mail To Address:</i> PO BOX 638568 CINCINNATI OH 46263-8568					

INNOVATIONS DENTISTRY

Office of State Finance VendorID: 0000519951

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$763.20	1/30/20-3/5/20	ACCT: 5675	
<i>Approx Mail Date:</i> Requested from OSF 10/9/20 Expected to be mailed by 10/23/20					
<i>Mail To Address:</i> 14617 S MEMORIAL DR BIXBY OK 74008					
					Payment amount based on \$954.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: V.B. Patient Birth Year: 1998

WHINERY HUDDLESTON FUNERAL SERVICE

Office of State Finance VendorID: 0000427567

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/12/2021	108530386	\$7,480.84	06/25/20	ACCT: M.I.C.	
<i>Approx Mail Date:</i> 1/15/2021					
<i>Mail To Address:</i> 6210 NW CACHE RD LAWTON OK 73505					
					Payment amount based on \$7,480.84 patient balance after insurance and insurance adjustments. Patient Initials: M.C. Patient Birth Year: 1955

CHAMPION MINDS COUNSELING

Office of State Finance VendorID: 0000505907

<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	108410291	\$1,360.00	12/19/19 - 01/31/20	ACCT: CB09261986	
<i>Approx Mail Date:</i> 4/25/2020					
<i>Mail To Address:</i> 1622 SOUTH BOSTON TULSA OK 74119					
					Payment amount based on \$1,700.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: C.B. Patient Birth Year: 1986

DENTAL PARTNERS OF NORTH MAY LCC

Office of State Finance VendorID: 0000490344

<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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\$3,200.00

01/07/21

ACCT: G.C.

Payment amount based on \$4,000.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 1/22/21 Expected to be mailed by 2/5/21

Patient Initials: G.C.

Mail To Address: COMFORT DENTAL - NORTH MAY 5920 N. MAY AVE
OKLAHOMA CITY OK 73112

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

Patient Birth Year: 1992

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.

Patient Initials: L.C.

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

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

Patient Birth Year: N/A

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

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.

Patient Initials: A.G.

Approx Mail Date: 6/6/2020

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

Patient Birth Year: 1998

Mail To Address: 2105 E. 21ST ST.
TULSA OK 74114

TOM JUSTUS

Office of State Finance VendorID: 0000519062

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

Patient Identifiers

12/30/2020 108526189 \$633.93 2/8/19 FUNERAL REIMBURSEMENT

Payment amount based on \$633.93 patient balance after insurance and insurance adjustments.

Patient Initials: R.M.

Approx Mail Date: 1/2/2021

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

Patient Birth Year: 1979

Mail To Address: 2008 SW C. AVE
LAWTON OK 73501

FAMILY CHRISTIAN COUNSELING

Office of State Finance VendorID:

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

Patient Identifiers

\$624.00 1/13/20-6/1/20 ACCOUNT: C.B.

Payment amount based on \$780.00 patient balance after insurance and insurance adjustments.

Patient Initials: C.B.

Approx Mail Date: Requested from OSF 1/19/21 Expected to be mailed by 2/2/21

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

Patient Birth Year: 2000

Mail To Address: 3035 NW 63RD ST. SUITE 202
OKC OK 73116

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

Approx Mail Date: 6/18/2020

Mail To Address: PO BOX 515471
LOS ANGELES CA 90051-6771

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

Total Bills exceed maximum award. Payment is prorated at 36.80409% among all providers. Patient Initials: W.E.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1998

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.

Patient Initials: G.M.

Approx Mail Date: 10/19/2020

Mail To Address: 1430 DECISION ST.
VISTA CA 92081-8553

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

GIBSON COUNSELING SRVS INC

Office of State Finance VendorID: 0000227766

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

Patient Identifiers

12/15/2020 108519529 \$2,216.00 10/30/19 - 07/28/20 ACOUNT: J.S.

Payment amount based on \$2,770.00 patient balance after insurance and insurance adjustments.

Patient Initials: J.S.

Approx Mail Date: 12/18/2020

Mail To Address: LFS COUNSELING/MYRIA GIBSON 333 W MAIN ST
ARDMORE OK 73401

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 2005

DONNIE SMITH

Office of State Finance VendorID: 0000510265

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

Patient Identifiers

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.

Patient Initials: K.P.

Approx Mail Date: 8/14/2020

Mail To Address: 10766e. 14TH PL
TULSA OK 74128

Patient Birth Year: 2002

VEOLA IVAN WADE

Office of State Finance VendorID: 0000508694

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

Patient Identifiers

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.

Patient Initials: S.M.

Approx Mail Date: 7/30/2020

Mail To Address: 114516 PORTSIDE DR
EUFALA OK 74432

Patient Birth Year: 1980

DURANT HMA LLC

Office of State Finance VendorID: 0000054038

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

Patient Identifiers

1/22/2021 108536017 \$11,751.40 08/25/18 ACCT: 6511834 Payment amount based on \$16,920.19 patient balance after insurance and insurance adjustments.
Approx Mail Date: 1/25/2021 Total Bills exceed maximum award. Payment is prorated at 86.81496% among all providers. *Patient Initials:* A.S.
Mail To Address: ALLIANCEHEALTH DURANT PO BOX 281463 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1992
 ATLANTA GA 30384

10/21/2020 108492610 \$2,754.43 05/05/20 ACCT: 6553870 Payment amount based on \$3,443.04 patient balance after insurance and insurance adjustments. *Patient Initials:* R.W.
Approx Mail Date: 10/24/2020 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 2001
Mail To Address: ALLIANCEHEALTH DURANT PO BOX 281463
 ATLANTA GA 30384

SARFARAZ ANWAR MD

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>
		\$141.26	03/11/20 - 07/06/20	ACCT: 968674952	
<i>Approx Mail Date:</i> Requested from OSF 1/12/21 Expected to be mailed by 1/26/21					<i>Patient Initials:</i> L.H.
<i>Mail To Address:</i> 3008 NW 168 CT					<i>Patient Birth Year:</i> 1966
EDMOND OK 73012					

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	
<i>Approx Mail Date:</i> 7/30/2020					<i>Patient Initials:</i> S.W.
<i>Mail To Address:</i> 900 17TH ST.					<i>Patient Birth Year:</i> 1988
WOODWARD OK 73801					
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	
<i>Approx Mail Date:</i> 5/22/2020					<i>Patient Initials:</i> O.P.
<i>Mail To Address:</i> 900 17TH ST.					<i>Patient Birth Year:</i> 1995
WOODWARD OK 73801					

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>
8/12/2020	108456760	\$1,296.71	2/12/20	ACCT:100511808C	
<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Initials:</i> M.S.
<i>Mail To Address:</i> PO BOX 740782					<i>Patient Birth Year:</i> 1999
CINCINNATI OH 45274-0782					

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:		Patient Identifiers
1/22/2021	108536103	\$800.00	02/10/20 - 02/14/20	ACCT: 668899960	Payment amount based on \$1,000.00 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 1/25/2021				<i>Patient Initials:</i> L.H.
		<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1966
1/22/2021	108536104	\$16,000.00	03/12/20 - 03/16/20	ACCT: 99900543462	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 1/25/2021				<i>Patient Initials:</i> J.W.
		<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1980
1/12/2021	108530354	\$734.57	10/07/18	ACCT: 663680520	Payment amount based on \$918.21 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 1/15/2021				<i>Patient Initials:</i> T.W.
		<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1986
12/21/2020	108523155	\$4,689.52	02/17/20 - 02/22/20	ACCT: 99900540163	Payment amount based on \$5,861.90 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 12/24/2020				<i>Patient Initials:</i> T.G.
		<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1971
12/21/2020	108523156	\$280.00	12/16/19	ACCT: 668316651	Payment amount based on \$350.00 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 12/24/2020				<i>Patient Initials:</i> L.J.
		<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1977
12/17/2020	108521287	\$13,176.29	01/27/20 - 02/03/20	ACCT: 99900537685	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 12/20/2020			Total Bills exceed maximum award. Payment is prorated at 82.35184% among all providers.	<i>Patient Initials:</i> K.O.
		<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1979
12/17/2020	108521288	\$19,406.87	01/01/20 - 03/23/20	ACT: 99900534324 - \$19,374.87; 669305180 - \$12.04; 669020338 - \$14.44; 669025592 - \$4.89; 669062374 - \$0.63	Payment amount based on \$614,323.83 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 12/20/2020			Total Bills exceed maximum award. Payment is prorated at 3.94883% among all providers.	<i>Patient Initials:</i> K.J.
		<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1981
12/17/2020	108521289	\$1,026.51	09/09/20	ACCT: 99900569149	Payment amount based on \$1,283.14 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 12/20/2020				<i>Patient Initials:</i> K.A.
		<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 2003

12/17/2020	108521286	\$14,358.65	11/16/19 - 11/19/19	ACCT: 668097770 - \$20.71; 99900527747 - \$14,337.94	Payment amount based on \$17,948.31 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> B.M.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1997
12/17/2020	108521285	\$8,518.29	05/04/19 - 05/09/19	ACCT: 99900502024	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 53.23933% among all providers.	<i>Patient Initials:</i> J.R.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1984
12/17/2020	108521284	\$19,168.06	01/28/20 - 02/26/20	ACCT: 99900537902 - \$19,135.75; 668841806 - \$1.50; 669007568 - \$3.46; 669016618 - \$27.35	Payment amount based on \$256,086.73 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 9.35623% 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> 1974
12/15/2020	108519542	\$564.48	04/05/19	ACCT: 665590949	Payment amount based on \$705.60 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.D.
						<i>Patient Birth Year:</i> 1970
11/18/2020	108506323	\$15,727.11	10/25/18 - 12/11/18	ACCT: 99900479718 - \$15,704.87; 664325226 - \$22.24	Payment amount based on \$160,646.01 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.R.
						<i>Patient Birth Year:</i> 1999
11/19/2020	108507389	\$12,525.44	06/16/19 - 06/18/19	ACCT: 99900507113	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 78.28401% among all providers.	<i>Patient Initials:</i> M.D.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1980
11/19/2020	108507390	\$6,110.71	07/03/19 - 07/05/19 AND 08/03/19	ACCT: 99900509650 - \$3,291.48; 99900513964 - \$2,819.23	Payment amount based on \$7,638.39 patient balance after insurance and insurance adjustments.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Initials:</i> O.S.
						<i>Patient Birth Year:</i> 1976
10/21/2020	108492729	\$18,731.67	05/10/19 - 05/17/19	ACCT: 99900502555	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.	<i>Patient Initials:</i> A.M.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1977

10/21/2020	108492730	\$16,901.84	05/28/20 - 07/27/20	ACCT: 99900704717 - \$15,946.58; 669896472 - \$312.15; 669978402 - \$312.15; 670389343 - \$330.95	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. Patient Initials: J.B.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 2007	
10/21/2020	108492731	\$17,987.97	07/23/20 - 07/25/20 AND 08/06/20	ACCT: 99900561155 - \$2,462.21; 670548149 - \$15,525.76	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. Patient Initials: M.V.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1975	
10/21/2020	108492728	\$13,804.52	02/22/20 - 02/23/20	ACCT: 99900540909	Payment amount based on \$47,769.75 patient balance after insurance and insurance adjustments.	
						Patient Initials: K.P.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1971	
10/21/2020	108492725	\$3,883.28	01/25/20	ACCT: 99900537368 - \$396.54; 668722335 - \$3,486.74	Payment amount based on \$4,854.10 patient balance after insurance and insurance adjustments.	
						Patient Initials: J.F.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1978	
10/21/2020	108492727	\$2,134.13	05/25/19	ACCT: 99900504371	Payment amount based on \$2,667.66 patient balance after insurance and insurance adjustments.	
						Patient Initials: T.J.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1973	
10/21/2020	108492726	\$1,688.18	06/30/19 - 07/03/19	ACCT: 99900509357	Payment amount based on \$2,110.23 patient balance after insurance and insurance adjustments.	
						Patient Initials: A.A.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 2004	
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. Patient Initials: K.C.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1989	
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. Patient Initials: C.C.	
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1987	
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.	
						Patient Initials: C.J.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1963	

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. Patient Initials: P.C. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1987
					<i>Approx Mail Date:</i> 9/21/2020 <i>Mail To Address:</i> 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. Patient Initials: S.G. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1983
					<i>Approx Mail Date:</i> 9/21/2020 <i>Mail To Address:</i> 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. Patient Initials: C.F. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1983
					<i>Approx Mail Date:</i> 9/21/2020 <i>Mail To Address:</i> 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. Patient Initials: D.M. Patient Birth Year: 1992
					<i>Approx Mail Date:</i> 9/21/2020 <i>Mail To Address:</i> 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. Patient Initials: J.C. Patient Birth Year: 1989
					<i>Approx Mail Date:</i> 9/21/2020 <i>Mail To Address:</i> 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. Patient Initials: S.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1975
					<i>Approx Mail Date:</i> 8/29/2020 <i>Mail To Address:</i> 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. Patient Initials: J.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1987
					<i>Approx Mail Date:</i> 8/29/2020 <i>Mail To Address:</i> 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. Patient Initials: S.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1996
					<i>Approx Mail Date:</i> 8/29/2020 <i>Mail To Address:</i> 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. Patient Initials: J.N. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1962
					<i>Approx Mail Date:</i> 8/29/2020 <i>Mail To Address:</i> 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.	<i>Patient Initials:</i>	A.K.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i>	1997
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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.		
						<i>Patient Initials:</i>	S.W.
						<i>Patient Birth Year:</i>	1996
<hr/>							
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.	<i>Patient Initials:</i>	D.M.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i>	1984
<hr/>							
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.	<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
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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.	<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
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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.	<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
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		\$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.		
					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
<hr/>							
7/28/2020	108449525	\$18,259.23	02/22/20	ACCT: 99900540911	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

7/28/2020	108449524	\$539.52	04/27/19	ACCT: 665788342	Payment amount based on \$674.40 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.N.
	<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> 1992
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					
7/28/2020	108449523	\$12,456.60	09/14/18 - 09/18/18	ACCT: 99900475102	Payment amount based on \$20,000.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> D.R.
	<i>Approx Mail Date:</i> 7/31/2020				Total Bills exceed maximum award. Payment is prorated at 77.85373% among all providers.	<i>Patient Birth Year:</i> 1977
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
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	Payment amount based on \$23,822.74 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.J.
	<i>Approx Mail Date:</i> 7/31/2020				Total Bills exceed maximum award. Payment is prorated at 46.62222% among all providers.	<i>Patient Birth Year:</i> 1986
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
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	Payment amount based on \$64,194.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.S.
	<i>Approx Mail Date:</i> 7/31/2020				Total Bills exceed maximum award. Payment is prorated at 32.75809% among all providers.	<i>Patient Birth Year:</i> 1958
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
7/28/2020	108449519	\$16,000.00	01/27/20 - 01/28/20	ACCT: 99900537712	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> S.H.
	<i>Approx Mail Date:</i> 7/31/2020					<i>Patient Birth Year:</i> 2000
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					
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.
	<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> 1991
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					
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.
	<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> 1969
	<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					

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. Patient Initials: B.D. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1999
<i>Approx Mail Date:</i> 6/18/2020					
<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					
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. Patient Initials: C.A. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1998
<i>Approx Mail Date:</i> 6/18/2020					
<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					
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. Patient Initials: D.R. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1989
<i>Approx Mail Date:</i> 6/18/2020					
<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					
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. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: R.B. Patient Birth Year: 1996
<i>Approx Mail Date:</i> 6/6/2020					
<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					
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. Patient Initials: D.F. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1991
<i>Approx Mail Date:</i> 5/22/2020					
<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					
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. Patient Initials: J.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1988
<i>Approx Mail Date:</i> 5/22/2020					
<i>Mail To Address:</i> PO BOX 277362 ATLANTA GA 30384-7362					
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. Patient Initials: R.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 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. Patient Initials: B.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 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.	<i>Patient Initials:</i> T.W.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<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.	<i>Patient Initials:</i> K.T.
					Total Bills exceed maximum award. Payment is prorated at 76.69417% among all providers.	<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.	<i>Patient Initials:</i> J.W.
					Total Bills exceed maximum award. Payment is prorated at 16.24235% among all providers.	<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.	<i>Patient Initials:</i> B.S.
					Total Bills exceed maximum award. Payment is prorated at 64.27231% among all providers.	<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						

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.	<i>Patient Initials:</i> C.A.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1989
<i>Approx Mail Date:</i> 8/29/2020						
<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048						

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.	<i>Patient Initials:</i> D.J.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1974
<i>Approx Mail Date:</i> 8/15/2020						
<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>Patient Initials:</i> K.C.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1996
<i>Approx Mail Date:</i> 8/15/2020						
<i>Mail To Address:</i> 201 EXECUTIVE COURT LITTLE ROCK AR 72205 SUITE A						

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>
10/21/2020	108492704	\$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> 10/24/2020					<i>Patient Initials:</i> J.B.
<i>Mail To Address:</i> PO BOX 740782 CINCINNATI OH 45274-0782					<i>Patient Birth Year:</i> 1994

SOUTHCREST HOSPITAL*Office of State Finance VendorID:* 0000055086

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
11/18/2020	108506371	\$965.65	2/1/2020	ACCT: 20004163465	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 11/21/2020					<i>Patient Initials:</i> D.S.
<i>Mail To Address:</i> 8801 S. 101st EAST AVE TULSA OK 74133-5716					<i>Patient Birth Year:</i> 1970

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>
6/3/2020	108427351	\$4,315.40	02/16/20	ACCT: 255034901	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 6/6/2020					<i>Patient Initials:</i> B.E.
<i>Mail To Address:</i> PO BOX 849110 DALLAS TX 75284					<i>Patient Birth Year:</i> 1973
5/20/2020	108421934	\$587.60	03/26/20	ACCT:255599401	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 5/23/2020					<i>Patient Initials:</i> J.O.
<i>Mail To Address:</i> PO BOX 849110 DALLAS TX 75284					<i>Patient Birth Year:</i> 1996

TAHLEQUAH ORTHOPEDIC SURGERY*Office of State Finance VendorID:* 0000522183

<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	Payment amount based on \$3,995.18 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> T.F.
<i>Mail To Address:</i> 1373 E. BOONE ST. #3401 TAHLEQUAH OK 74464					<i>Patient Birth Year:</i> 1974

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>
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\$96.00 5/12/2017-5/16/2017 ACCT:343066

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

Mail To Address: PO BOX 17025
FORT SMITH AR 72917

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

Patient Initials: K.C.

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

Patient Birth Year: 1996

LIFENET

Office of State Finance VendorID: 0000055753

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

Patient Identifiers

11/18/2020 108506301 \$644.49 6/26/20 ACCT: 20-43918

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

Approx Mail Date: 11/21/2020

Patient Initials: P.H.

Mail To Address: 6225 ST. MICHAEL DR.
TEXARKANA TX 75503

Patient Birth Year: 1963

10/21/2020 108492697 \$1,282.30 08/08/20 ACCT: 20-55565

Payment amount based on \$1,602.88 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/24/2020

Patient Initials: E.Q.

Mail To Address: 6225 ST. MICHAEL DR.
TEXARKANA TX 75503

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

Patient Birth Year: 1989

10/21/2020 108492696 \$850.80 01/25/20 ACCT: 20-6358

Payment amount based on \$1,063.50 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/24/2020

Patient Initials: J.F.

Mail To Address: 6225 ST. MICHAEL DR.
TEXARKANA TX 75503

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

Patient Birth Year: 1978

PAFFORD MEDICAL SVS

Office of State Finance VendorID: 0000257242

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

Patient Identifiers

11/18/2020 108506340 \$977.60 11/2/2019 ACCT:9181923311

Payment amount based on \$1,222.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/21/2020

Patient Initials: B.V.

Mail To Address: PO BOX 1120
HOPE AR 71802-1120

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

Patient Birth Year: 1963

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.

Approx Mail Date: 6/18/2020

Patient Initials: Z.V.

Mail To Address: PO BOX 1120
HOPE AR 71802-1120

Total Bills exceed maximum award. Payment is prorated at 59.98875% among all providers.

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

Patient Birth Year: 1992

DEQUEEN REGIONAL MED CTR

Office of State Finance VendorID:

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

Patient Identifiers

\$2,083.04 09/09/18 ACCT: 4054842

Payment amount based on \$5,611.68 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 12/8/20 Expected to be mailed by 12/22/20

Patient Initials: J.R.

Mail To Address: 1306 W COLLIN RAYE DR
DE QUEEN AR 71832-2502

Total Bills exceed maximum award. Payment is prorated at 46.39968% among all providers.

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

Patient Birth Year: 1979

UAMS BILLING OFFICE

Office of State Finance VendorID:

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

Patient Identifiers

\$2,714.69 09/09/18 - 01/15/19 ACCT: 856939

Payment amount based on \$7,313.34 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 12/8/20 Expected to be mailed by 12/22/20

Total Bills exceed maximum award. Payment is prorated at 46.39968% among all providers. **Patient Initials:** J.R.

Mail To Address: PO BOX 251508
LITTLE ROCK AR 72225

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

UAMS BILLING SERVICES

Office of State Finance VendorID:

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

Patient Identifiers

\$1,155.17 ACCT: 005002693485

Payment amount based on \$3,112.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 12/8/20 Expected to be mailed by 12/22/20

Total Bills exceed maximum award. Payment is prorated at 46.39968% among all providers. **Patient Initials:** J.R.

Mail To Address: PO BOX 504962
ST LOUIS MO 63150-4962

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

FAIRVIEW PHARMACY SERVICES

Office of State Finance VendorID:

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

Patient Identifiers

\$93.48 04/22/20 ACCT: 00000212535

Payment amount based on \$116.85 patient balance after insurance and insurance adjustments.

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

Patient Initials: T.E.

Mail To Address: NW 6184 PO BOX 1450
MINNEAPOLIS MN 55485-6184

Acceptance of payment may require a provider write-off. EOB will accompany payment. **Patient Birth Year:** 1985

HILLCREST MEDICAL CENTER

Office of State Finance VendorID: 0000056219

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

Patient Identifiers

10/21/2020 108492683 \$2,196.80 04/09/20 ACCT: 200045748661

Payment amount based on \$2,746.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/24/2020

Patient Initials: J.S.

Mail To Address: DEPT 572
TULSA OK 74182

Acceptance of payment may require a provider write-off. EOB will accompany payment. **Patient Birth Year:** 1976

10/16/2020 108490780 \$1,622.41 6/22/20 ACCT: 20004962050

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

Approx Mail Date: 10/19/2020

Patient Initials: G.F.

Mail To Address: DEPT 572
TULSA OK 74182

Patient Birth Year: 1992

6/15/2020 108432727 \$20,000.00 12/18/19 - 02/13/20 ACCT: 20003933849

Payment amount based on \$483,228.91 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/18/2020

Total Bills exceed maximum award. Payment is prorated at 5.17353% among all providers. **Patient Initials:** R.H.

Mail To Address: DEPT 572
TULSA OK 74182

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

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>
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.
<i>Approx Mail Date:</i> 4/17/2020					<i>Patient Initials:</i> M.Y.
<i>Mail To Address:</i> 3400 N MIDWEST BLVD OKLAHOMA CITY OK 73141					<i>Patient Birth Year:</i> 1988

MOORE'S SOUTHLAWN CHAPEL*Office of State Finance VendorID:* 0000056132

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
10/14/2020	108489569	\$3,181.42	08/03/20	ACCT: D.M.	Payment amount based on \$3,181.42 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 10/17/2020					<i>Patient Initials:</i> D.M.
<i>Mail To Address:</i> 9350 E 51ST ST TULSA OK 74145-9031					<i>Patient Birth Year:</i> 1977

MOORE'S ROSEWOOD CHAPEL*Office of State Finance VendorID:* 0000056132

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
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.
<i>Approx Mail Date:</i> 6/6/2020					<i>Patient Initials:</i> J.S.
<i>Mail To Address:</i> 2570 S HARVARD TULSA OK 74114-4661					<i>Patient Birth Year:</i> 1954
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.
<i>Approx Mail Date:</i> 6/6/2020					<i>Patient Initials:</i> B.S.
<i>Mail To Address:</i> 2570 S HARVARD TULSA OK 74114-4661					<i>Patient Birth Year:</i> 1954

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>
10/14/2020	108489583	\$7,500.00	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> 10/17/2020					<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

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>
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1/22/2021 108536126 \$2,688.22 12/07/20 ACCT: A.T. Payment amount based on \$2,688.22 patient balance after insurance and insurance adjustments.
Approx Mail Date: 1/25/2021 *Patient Initials:* A.T.
Mail To Address: 14624 N. MAY AVE *Patient Birth Year:* 1988
 OKLAHOMA CITY OK 73134

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	\$45.26	10/28/19	ACCT: 2193060000OR	Payment amount based on \$56.58 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> K.T.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1998

Approx Mail Date: 7/11/2020
Mail To Address: 1200 E PECAN
 ALTUS OK 73521

HILLCREST HEALTHCARE SYSTEM

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>
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>Patient Initials:</i> J.C.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1977

Approx Mail Date: 5/22/2020
Mail To Address: DEPT 572
 TULSA OK 74182
 110 W 7th SUITE 2400

MERCY HEALTH CENTER

Office of State Finance VendorID: 0000056220

<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	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>Patient Initials:</i> L.T.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1961

Approx Mail Date: 8/15/2020
Mail To Address: P O BOX 504292
 ST LOUIS MO 63150-4292

Office of State Finance VendorID: 0000056220

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
12/11/2020	108517651	\$520.67	4/16/20-4/17/20	ACCT: 59000236663	Payment amount based on patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> V.M.
						<i>Patient Birth Year:</i> 2006

Approx Mail Date: 12/14/2020
Mail To Address: PO BOX 505393
 ST LOUIS MO 63150

12/11/2020	108517650	\$173.60	9/11/2019	ACCT:5400047423000	Payment amount based on \$217.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.S.
	<i>Approx Mail Date:</i>	12/14/2020				<i>Patient Birth Year:</i> 1962
	<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.	
10/21/2020	108492709	\$324.66	09/08/19	ACCT: 112542144	Payment amount based on \$995.08 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> R.F.
	<i>Approx Mail Date:</i>	10/24/2020			Total Bills exceed maximum award. Payment is prorated at 40.78328% among all providers.	<i>Patient Birth Year:</i> 1968
	<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.	
10/11/2020	108482957	\$197.60	03/01/20	ACCT: 59000230806	Payment amount based on \$247.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.R.
	<i>Approx Mail Date:</i>	10/4/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1989
	<i>Mail To Address:</i>	PO BOX 505393 ST LOUIS MO 63150				
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>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 505393 ST LOUIS MO 63150				
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.
	<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> 1979
	<i>Mail To Address:</i>	PO BOX 505393 ST LOUIS MO 63150				
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.	<i>Patient Initials:</i> S.L.
	<i>Approx Mail Date:</i>	7/31/2020			Total Bills exceed maximum award. Payment is prorated at 48.54606% among all providers.	<i>Patient Birth Year:</i> 1996
	<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.	
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.
	<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> 1993
	<i>Mail To Address:</i>	PO BOX 505393 ST LOUIS MO 63150				

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>
12/17/2020	108521326	\$56.01	08/23/15 - 08/24/15	ACCT: W0022294326	<i>Patient Initials:</i> M.T.
	<i>Approx Mail Date:</i>	12/20/2020			<i>Patient Birth Year:</i> 1995
	<i>Mail To Address:</i>	1923 S. UTICA AVE TULSA OK 74182-0606		DEPT. 606	

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
1/22/2021	108536131	\$5,769.95	06/18/20	ACCT: J0078641665	
	<i>Approx Mail Date:</i> 1/25/2021				<i>Patient Initials:</i> A.H.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		<i>Patient Birth Year:</i> 1975
1/22/2021	108536132	\$9,830.11	03/11/20 - 03/13/20	ACCT: J0078245115	
	<i>Approx Mail Date:</i> 1/25/2021				<i>Patient Initials:</i> K.B.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		<i>Patient Birth Year:</i> 1978
1/22/2021	108536133	\$18,723.71	05/31/20 - 06/02/20 AND 07/12/20 - 07/13/20	ACCT: J0078786051 - \$567.53; J0078550171 - \$18,156.19	
	<i>Approx Mail Date:</i> 1/25/2021				<i>Patient Initials:</i> J.H.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		<i>Patient Birth Year:</i> 1991
1/22/2021	108536129	\$5,071.18	08/27/19 - 02/24/20	ACCT: J0077930086 - \$3,479.98; J0077916881 - \$23.34; J0077626557 - \$481.28; J0077028994 - \$1,086.58	
	<i>Approx Mail Date:</i> 1/25/2021				<i>Patient Initials:</i> E.J.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		<i>Patient Birth Year:</i> 1977
12/15/2020	108519551	\$80.00	12/09/19 - 12/10/19	ACCT: J0077631127	
	<i>Approx Mail Date:</i> 12/18/2020				<i>Patient Initials:</i> D.E.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		<i>Patient Birth Year:</i> 1974
12/11/2020	108517667	\$80.00	4/19/20	ACCT:20-20066649	
	<i>Approx Mail Date:</i> 12/14/2020				<i>Patient Initials:</i> D.C.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		<i>Patient Birth Year:</i> 1962
11/19/2020	108507437	\$15,494.43	05/10/20	ACCT: J0078455411	
	<i>Approx Mail Date:</i> 11/22/2020				<i>Patient Initials:</i> R.L.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		<i>Patient Birth Year:</i> 1978
11/19/2020	108507436	\$15,638.96	12/11/18 - 12/12/18	ACCT: J0075507437	
	<i>Approx Mail Date:</i> 11/22/2020				<i>Patient Initials:</i> H.C.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		<i>Patient Birth Year:</i> 1986

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.
	<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> 1964
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182			
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.	
	<i>Approx Mail Date:</i> 10/4/2020				Total Bills exceed maximum award. Payment is prorated at 1.572509% among all providers.	<i>Patient Initials:</i> D.B.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1973
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.	
	<i>Approx Mail Date:</i> 9/21/2020				Total Bills exceed maximum award. Payment is prorated at 46.13764% among all providers.	<i>Patient Initials:</i> L.M.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1961
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>Approx Mail Date:</i> 9/21/2020					<i>Patient Initials:</i> J.S.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		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>Approx Mail Date:</i> 8/29/2020					<i>Patient Initials:</i> B.T.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		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>Approx Mail Date:</i> 8/29/2020				Total Bills exceed maximum award. Payment is prorated at 36.78649% among all providers.	<i>Patient Initials:</i> D.B.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1974
8/17/2020	108459278	\$80.00	03/01/20	ACCT: J0078181010	Payment amount based on patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> 8/20/2020					<i>Patient Initials:</i> E.T.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182			<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>Approx Mail Date:</i> 7/31/2020				Total Bills exceed maximum award. Payment is prorated at 74.12385% among all providers.	<i>Patient Initials:</i> T.A.
	<i>Mail To Address:</i> DEPT 606 TULSA		OK 74182		Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1969

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.	Patient Initials: L.P.
	<i>Approx Mail Date:</i>	7/31/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1949
	<i>Mail To Address:</i>	DEPT 606 TULSA	OK 74182			

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.	Patient Initials: G.B.
	<i>Approx Mail Date:</i>	6/18/2020			Total Bills exceed maximum award. Payment is prorated at 4.779422% among all providers.	Patient Birth Year: 1967
	<i>Mail To Address:</i>	DEPT 606 TULSA	OK 74182		Acceptance of payment may require a provider write-off. EOB will accompany payment.	

ST JOHN OWASSO

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>
1/22/2021	108536130	\$723.84	01/13/20	ACCT: W0024305571	Payment amount based on \$904.80 patient balance after insurance and insurance adjustments.	Patient Initials: E.J.
	<i>Approx Mail Date:</i>	1/25/2021			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1977
	<i>Mail To Address:</i>	DEPT 2334 TULSA	OK 74182-0001			

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.	Patient Initials: A.D.
	<i>Approx Mail Date:</i>	4/25/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1980
	<i>Mail To Address:</i>	DEPT 2334 TULSA	OK 74182-0001			

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.	Patient Initials: S.S.
	<i>Approx Mail Date:</i>	8/29/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1997
	<i>Mail To Address:</i>	PO BOX 2339 ELK CITY	OK 73648-2339			

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.	Patient Initials: R.C.
	<i>Approx Mail Date:</i>	7/31/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 2000
	<i>Mail To Address:</i>	PO BOX 960239 OKLAHOMA CITY	OK 73196-0239			

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>Patient Initials:</i> B.B.
					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>
1/12/2021	108530371	\$845.82	06/08/20	ACCT: 40201606267	Payment amount based on \$1,057.28 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> A.R.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 2001
12/17/2020	108521324	\$7,204.70	07/03/20	ACCT: 40201850643	Payment amount based on \$9,005.88 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> D.G.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 2000
12/15/2020	108519550	\$32.80	03/21/19	ACCT: 40190803289	Payment amount based on \$41.00 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> E.F.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1988
10/14/2020	108489588	\$564.50	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.	
						<i>Patient Initials:</i> R.P.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1975
10/22/2020	108493533	\$1,474.14	2/15/2019	ACCT: 40190462234	Payment amount based on \$1,842.68 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> K.B.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1968
9/18/2020	108476196	\$2,162.02	01/23/20	ACCT: 40200233540	Payment amount based on \$12,026.58 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 22.47133% among all providers.	<i>Patient Initials:</i> S.G.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1983

9/18/2020	108476195	\$4,973.21	06/20/19	ACCT: 40191710267	Payment amount based on \$6,216.51 patient balance after insurance and insurance adjustments.	Patient Initials: B.L.
	Approx Mail Date: 9/21/2020					Patient Birth Year: 1994
	Mail To Address: ST ANTHONY HOSPITAL CHICAGO IL 60677-6323			PO BOX 776323	Acceptance of payment may require a provider write-off. EOB will accompany payment.	
7/28/2020	108449564	\$160.00	04/24/18	ACCT: 4018114093101	Payment amount based on \$200.00 patient balance after insurance and insurance adjustments.	Patient Initials: J.W.
	Approx Mail Date: 7/31/2020					Patient Birth Year: 1981
	Mail To Address: ST ANTHONY HOSPITAL CHICAGO IL 60677-6323			PO BOX 776323	Acceptance of payment may require a provider write-off. EOB will accompany payment.	
6/15/2020	108432809	\$7,272.32	12/12/19	ACCT:40193460134	Payment amount based on \$9,090.40 patient balance after insurance and insurance adjustments.	Patient Initials: J.N.
	Approx Mail Date: 6/18/2020					Patient Birth Year: 1979
	Mail To Address: ST ANTHONY HOSPITAL CHICAGO IL 60677-6323			PO BOX 776323	Acceptance of payment may require a provider write-off. EOB will accompany payment.	
5/19/2020	108421386	\$717.20	04/27/19	ACCT: 150459	Payment amount based on \$896.50 patient balance after insurance and insurance adjustments.	Patient Initials: T.W.
	Approx Mail Date: 5/22/2020					Patient Birth Year: 1961
	Mail To Address: ST ANTHONY HOSPITAL CHICAGO IL 60677-6323			PO BOX 776323	Acceptance of payment may require a provider write-off. EOB will accompany payment.	
5/19/2020	108421384	\$16,061.49	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.	Patient Initials: V.M.
	Approx Mail Date: 5/22/2020				Total Bills exceed maximum award. Payment is prorated at 73.87926% among all providers.	Patient Birth Year: 1958
	Mail To Address: ST ANTHONY HOSPITAL CHICAGO IL 60677-6323			PO BOX 776323	Acceptance of payment may require a provider write-off. EOB will accompany payment.	

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 OKLAHOMA CITY OK 73124-8849				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1958

ST. JOHN SAPULPA

Office of State Finance VendorID: 0000056348

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:		Patient Identifiers
10/21/2020	108492756	\$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: 10/24/2020					Patient Initials: C.B.
	Mail To Address: DEPT 2594 TULSA OK 74182				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1978

ST. FRANCIS HOSPITAL

Office of State Finance VendorID: 0000056512

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:		Patient Identifiers
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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.
<i>Approx Mail Date:</i> 7/31/2020					Total Bills exceed maximum award. Payment is prorated at 74.12385% among all providers. <i>Patient Initials:</i> T.A.
<i>Mail To Address:</i> 6600 S YALE AVE SUITE 500					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1969
TULSA OK 74136-3319					

ST FRANCIS HEALTH SYSTEM

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>
1/22/2021	108536122	\$1,840.70	4/1/20	ACCT: 206003130	Payment amount based on \$2,300.88 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 1/25/2021					<i>Patient Initials:</i> T.C.
<i>Mail To Address:</i> PO BOX 707001					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1998
TULSA OK 74170					
12/22/2020	108523966	\$334.06	5/10/19-5/14/19	ACCT: 60575488702	Payment amount based on \$417.58 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 12/25/2020					<i>Patient Initials:</i> C.P.
<i>Mail To Address:</i> PO BOX 707001					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1951
TULSA OK 74170					
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>Approx Mail Date:</i> 8/29/2020					<i>Patient Initials:</i> J.B.
<i>Mail To Address:</i> PO BOX 707001					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1977
TULSA OK 74170					
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>Approx Mail Date:</i> 8/29/2020					<i>Patient Initials:</i> C.W.
<i>Mail To Address:</i> PO BOX 707001					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1994
TULSA OK 74170					
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>Approx Mail Date:</i> 8/14/2020					<i>Patient Initials:</i> C.C.
<i>Mail To Address:</i> PO BOX 707001					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1968
TULSA OK 74170					
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>Approx Mail Date:</i> 7/31/2020					<i>Patient Initials:</i> A.C.
<i>Mail To Address:</i> PO BOX 707001					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1974
TULSA OK 74170					
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>Approx Mail Date:</i> 7/31/2020					<i>Patient Initials:</i> W.G.
<i>Mail To Address:</i> PO BOX 707001					<i>Patient Birth Year:</i> 1963
TULSA OK 74170					

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>Approx Mail Date:</i> 6/28/2020				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 707001 TULSA OK 74170					
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>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 707001 TULSA OK 74170				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
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>Approx Mail Date:</i> 4/25/2020				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 707001 TULSA OK 74170					

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>
1/22/2021	108536121	\$19,266.42	07/13/19 - 10/23/19	ACCT: 113284667 - \$4.11; 605983582 - \$2.76; 606157678 - \$29.39; 605904745 - \$484.75; 482690191 - \$17.75; 605924855 - \$2.76; 605997950- \$16.01; 605924858 - \$2.76; 605995829 -\$1,953.68; 605904730 - \$16,752.44	Payment amount based on \$529,606.11 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> 1/25/2021				Total Bills exceed maximum award. Payment is prorated at 4.547349% among all providers.	<i>Patient Initials:</i> T.J.
	<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> 1977
1/12/2021	108530367	\$5,675.04	08/22/19	ACCT: 606001759	Payment amount based on \$7,093.80 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> V.M.
	<i>Approx Mail Date:</i> 1/15/2021				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 706161 TULSA OK 74170-6161					
12/17/2020	108521312	\$6,256.49	07/11/19 - 07/31/19	ACCT: 605901168 - \$5,947.74; 575018423 - \$34.55; 605901195 - \$239.65; 575018197 - \$34.55	Payment amount based on \$20,572.30 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> N.H.
	<i>Approx Mail Date:</i> 12/20/2020				Total Bills exceed maximum award. Payment is prorated at 38.01525% among all providers.	<i>Patient Birth Year:</i> 1960
	<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.	
12/17/2020	108521313	\$9,861.48	06/18/20 - 06/20/20	ACCT: 606986385	Payment amount based on \$64,134.05 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> W.F.
	<i>Approx Mail Date:</i> 12/20/2020				Total Bills exceed maximum award. Payment is prorated at 19.22044% among all providers.	<i>Patient Birth Year:</i> 1968
	<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.	

12/17/2020	108521311	\$16.64	05/03/19	ACCT: 3685692	Payment amount based on \$20.80 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	M.M.
12/15/2020	108519548	\$3,981.02	02/02/20	ACCT: 860266668	Payment amount based on \$4,976.28 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	C.W.
12/15/2020	108519549	\$4,032.06	06/23/20	ACCT: 138681	Payment amount based on \$5,040.08 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	E.F.
12/2/2020	108511993	\$16,494.40	12/24/19 - 12/30/19	ACCT: 60633646400	Payment amount based on \$79,515.73 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	B.P.
11/19/2020	108507426	\$4,996.59	05/10/20 - 05/12/20	ACCT: 606843673 - \$4,547.81; 913137 - \$448.78	Payment amount based on \$7,419.53 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	A.T.
11/19/2020	108507418	\$18,201.29	02/06/20 - 02/11/20	ACCT: 60651767002	Payment amount based on \$34,645.78 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.E.
11/19/2020	108507421	\$15,182.11	03/17/20 AND 03/23/20	ACCT: 60668382301 - \$14,859.08; 60670420501 - \$323.03	Payment amount based on \$29,272.45 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	C.A.
11/19/2020	108507422	\$19,987.67	02/16/20	ACCT: 60655451801	Payment amount based on \$103,710.76 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.M.
11/19/2020	108507423	\$6,098.00	11/07/19 - 11/08/19	ACCT: 600198074	Payment amount based on \$7,622.50 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	S.P.

11/19/2020	108507424	\$20,000.00	09/07/19	ACCT: 20406700	Payment amount based on \$28,964.03 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 86.31399% 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> 1986
11/19/2020	108507425	\$103.26	07/13/20	ACCT: 3773989	Payment amount based on \$314.80 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 41.00276% among all providers. <i>Patient Initials:</i> D.D. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1998
11/19/2020	108507417	\$19,001.49	11/17/19 - 11/19/19	ACCT: 606221172 - \$457.87; 860218009 - \$12,760.69; 606220725 - \$5,782.94	Payment amount based on \$34,569.31 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 68.70795% among all providers. <i>Patient Initials:</i> W.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1989
10/21/2020	108492747	\$110.08	02/11/20 AND 02/19/20	ACCT: 1658149	Payment amount based on \$137.60 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> D.S. <i>Patient Birth Year:</i> 1962
10/21/2020	108492746	\$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. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> D.S. <i>Patient Birth Year:</i> 1962
10/21/2020	108492749	\$17,016.71	02/29/20	ACCT: 606613045	Payment amount based on \$29,561.76 patient balance after insurance and insurance adjustments. 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
10/21/2020	108492745	\$15,233.84	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. <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
10/1/2020	108482975	\$711.69	05/22/17 - 06/01/17	ACCT: 3526343	Payment amount based on \$889.61 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> O.L. <i>Patient Birth Year:</i> 1974

8/26/2020	108464182	\$6,563.35	10/06/19	ACCT: 606114119	Payment amount based on \$8,204.19 patient balance after insurance and insurance adjustments.	Patient Initials:	B.G.
8/26/2020	108464181	\$13,256.06	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.	Patient Initials:	J.B.
8/26/2020	108464179	\$12,577.39	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.	Patient Initials:	I.M.
7/28/2020	108449550	\$1,627.39	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.	Patient Initials:	L.C.
7/28/2020	108449553	\$7,975.02	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.	Patient Initials:	M.S.
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.	Patient Initials:	J.C.
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.	Patient Initials:	Z.V.
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.	Patient Initials:	D.T.

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. Total Bills exceed maximum award. Payment is prorated at 39.7409% among all providers. Patient Initials: M.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1970
<i>Approx Mail Date:</i> 5/22/2020					
<i>Mail To Address:</i> PO BOX 706161 TULSA OK 74170-6161					
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. Total Bills exceed maximum award. Payment is prorated at 46.74856% among all providers. Patient Initials: J.E. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1997
<i>Approx Mail Date:</i> 5/22/2020					
<i>Mail To Address:</i> PO BOX 706161 TULSA OK 74170-6161					

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>
11/19/2020	108507279	\$972.99	03/17/20 AND 06/03/20	ACCT: 369828 - \$522.28; 369829 - \$450.71	Payment amount based on \$1,876.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 64.8311% among all providers. Patient Initials: C.A. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1987
<i>Approx Mail Date:</i> 11/22/2020					
<i>Mail To Address:</i> 6839 S CANTON AVE TULSA OK 74136-3402					
10/21/2020	108492614	\$1,559.49	09/25/18 - 03/20/20	ACCT: 72461	Payment amount based on \$5,875.00 patient balance after insurance and insurance adjustments. 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
<i>Approx Mail Date:</i> 10/24/2020					
<i>Mail To Address:</i> 6839 S CANTON AVE TULSA OK 74136-3402					
10/1/2020	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. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: O.L. Patient Birth Year: 1974
<i>Approx Mail Date:</i> 10/4/2020					
<i>Mail To Address:</i> 6839 S CANTON AVE TULSA OK 74136-3402					
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. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: B.P. Patient Birth Year: 1966
<i>Approx Mail Date:</i> 9/21/2020					
<i>Mail To Address:</i> 6839 S CANTON AVE TULSA OK 74136-3402					
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. Patient Initials: I.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1996
<i>Approx Mail Date:</i> 8/29/2020					
<i>Mail To Address:</i> 6839 S CANTON AVE TULSA OK 74136-3402					

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>Approx Mail Date:</i> 7/31/2020					<i>Patient Birth Year:</i> 1963
	<i>Mail To Address:</i> 6839 S CANTON AVE TULSA OK 74136-3402					
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.	<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> 6839 S CANTON AVE TULSA OK 74136-3402				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
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.
	<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> 1964
	<i>Mail To Address:</i> 6839 S CANTON AVE TULSA OK 74136-3402					
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.	<i>Patient Initials:</i> M.H.
	<i>Approx Mail Date:</i> 5/22/2020				Total Bills exceed maximum award. Payment is prorated at 39.7409% among all providers.	<i>Patient Birth Year:</i> 1970
	<i>Mail To Address:</i> 6839 S CANTON AVE TULSA OK 74136-3402				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
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.	<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> 6839 S CANTON AVE TULSA OK 74136-3402				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

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.
	<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> 1979
	<i>Mail To Address:</i> PO BOX 1387 ARDMORE OK 73402-1387					
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.	<i>Patient Initials:</i> S.L.
	<i>Approx Mail Date:</i> 7/31/2020				Total Bills exceed maximum award. Payment is prorated at 48.54606% among all providers.	<i>Patient Birth Year:</i> 1996
	<i>Mail To Address:</i> PO BOX 1387 ARDMORE OK 73402-1387				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

CHOCTAW NATION HOSPITAL

Office of State Finance VendorID: 0000072529

<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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12/17/2020 108521208 \$2,437.04 05/03/19 ACCT: CH200302615

Payment amount based on \$3,046.30 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/20/2020

Patient Initials: M.M.

Mail To Address: 1 CHOCTAW WAY
TALIHINA OK 74571-2022

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

Patient Birth Year: 1985

MEMORIAL HOSPITAL OF TEXAS COUNTY

Office of State Finance VendorID: 0000056492

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

Patient Identifiers

8/12/2020 108456749 \$362.37 09/13/2019 ACCT:741718

Payment amount based on \$452.96 patient balance after insurance and insurance adjustments.

Patient Initials: L.C.

Approx Mail Date: 8/15/2020

Mail To Address: 520 MEDICAL DR
GUYMON OK 73942-4438

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

Patient Birth Year: 1998

OKLAHOMA RADIOLOGY GROUP

Office of State Finance VendorID: 0000056502

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

Patient Identifiers

1/22/2021 108536100 \$32.00 08/15/18 ACCT: 402936

Payment amount based on \$40.00 patient balance after insurance and insurance adjustments.

Patient Initials: F.E.

Approx Mail Date: 1/25/2021

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

DEPT 146

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

Patient Birth Year: 1977

12/17/2020 108521280 \$48.00 07/03/20 ACCT: 509279

Payment amount based on \$60.00 patient balance after insurance and insurance adjustments.

Patient Initials: D.G.

Approx Mail Date: 12/20/2020

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

DEPT 146

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

Patient Birth Year: 2000

6/15/2020 108432765 \$532.00 12/12/19 ACCT: 485375

Payment amount based on \$665.00 patient balance after insurance and insurance adjustments.

Patient Initials: J.N.

Approx Mail Date: 6/18/2020

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

DEPT 146

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

Patient Birth Year: 1979

OK RADIOLOGY GROUP

Office of State Finance VendorID: 0000056502

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

Patient Identifiers

12/11/2020 108517656 \$252.00 10-6-18 ACCT:411353

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

Patient Initials: B.S.

Approx Mail Date: 12/14/2020

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: 1986

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

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

Patient Initials: S.G.

Approx Mail Date: 9/21/2020

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

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

9/18/2020	108476154	\$83.84	06/20/19	ACCT: 363683	Payment amount based on \$104.80 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> B.L.
	<i>Approx Mail Date:</i> 9/21/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1994
	<i>Mail To Address:</i> PO BOX 21228 DEPT 146 TULSA OK 74121-1228					
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.	<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 21228 DEPT 146 TULSA OK 74121-1228					
5/19/2020	108421338	\$218.69	08/16/18	ACCT: 403118	Payment amount based on \$370.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> V.M.
	<i>Approx Mail Date:</i> 5/22/2020				Total Bills exceed maximum award. Payment is prorated at 73.87926% among all providers.	<i>Patient Birth Year:</i> 1958
	<i>Mail To Address:</i> PO BOX 21228 DEPT 146 TULSA OK 74121-1228					

GIFFORD MONUMENT

Office of State Finance VendorID: 0000056537

<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	108449462	\$690.46	06/02/20	ACCT: L.D.	Payment amount based on \$690.46 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> L.D.
	<i>Approx Mail Date:</i> 7/31/2020					<i>Patient Birth Year:</i> 1982
	<i>Mail To Address:</i> 900 N BROADWAY AVE ADA OK 74820-2035					

SURGERY, INC

Office of State Finance VendorID: 0000192709

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
1/22/2021	108536138	\$267.20	03/11/20	ACCT: 205128	Payment amount based on \$334.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.B.
	<i>Approx Mail Date:</i> 1/25/2021				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1978
	<i>Mail To Address:</i> P.O. BOX 35307 TULSA OK 74153-0307					
10/22/2020	108493538	\$573.66	4/26/2019	ACCT: 2004560	Payment amount based on \$717.08 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.B.
	<i>Approx Mail Date:</i> 10/25/2020				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 35307 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.	<i>Patient Initials:</i> E.T.
	<i>Approx Mail Date:</i> 8/20/2020					<i>Patient Birth Year:</i> 1983
	<i>Mail To Address:</i> P.O. BOX 35307 TULSA OK 74153-0307					

TULSA RADIOLOGY ASSOCIATES

Office of State Finance VendorID: 0000056693

<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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1/22/2021	108536146	\$308.00	06/18/20	ACCT: 3616262C	Payment amount based on \$385.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	A.H.
	<i>Approx Mail Date:</i>	1/25/2021				<i>Patient Birth Year:</i>	1975
	<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.		
1/22/2021	108536145	\$16.66	01/13/20	ACCT: 1123906	Payment amount based on \$20.83 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	E.J.
	<i>Approx Mail Date:</i>	1/25/2021				<i>Patient Birth Year:</i>	1977
	<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.		
12/15/2020	108519555	\$142.40	12/09/19	ACCT: 1123649	Payment amount based on \$178.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	D.E.
	<i>Approx Mail Date:</i>	12/18/2020				<i>Patient Birth Year:</i>	1974
	<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.		
11/19/2020	108507446	\$667.20	05/10/20	ACCT: TRA227936	Payment amount based on \$834.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	R.L.
	<i>Approx Mail Date:</i>	11/22/2020				<i>Patient Birth Year:</i>	1978
	<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.		
11/19/2020	108507445	\$12.33	03/14/20	ACCT: TRA149646	Payment amount based on \$64.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.M.
	<i>Approx Mail Date:</i>	11/22/2020			Total Bills exceed maximum award. Payment is prorated at 24.09064% among all providers.	<i>Patient Birth Year:</i>	1989
	<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.		
10/21/2020	108492767	\$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.	<i>Patient Initials:</i>	C.B.
	<i>Approx Mail Date:</i>	10/24/2020				<i>Patient Birth Year:</i>	1978
	<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.		
10/16/2020	108490843	\$89.63	8/29/2019	ACCT: 1106557	Payment amount based on \$112.04 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	R.B.
	<i>Approx Mail Date:</i>	10/19/2020				<i>Patient Birth Year:</i>	1964
	<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.		
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.	<i>Patient Initials:</i>	D.B.
	<i>Approx Mail Date:</i>	10/4/2020			Total Bills exceed maximum award. Payment is prorated at 1.572509% among all providers.	<i>Patient Birth Year:</i>	1973
	<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.		
9/18/2020	108476205	\$20.00	03/10/20	ACCT: TRA447499	Payment amount based on \$25.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.S.
	<i>Approx Mail Date:</i>	9/21/2020				<i>Patient Birth Year:</i>	1988
	<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.		

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.	<i>Patient Initials:</i>	B.P.
						<i>Patient Birth Year:</i>	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.	<i>Patient Initials:</i>	B.T.
						<i>Patient Birth Year:</i>	1988
8/12/2020	108456726	\$277.60	03/01/20	ACCT: 1139113	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	108449580	\$43.69	01/02/19 - 01/04/19	ACCT: 1066388	Payment amount based on \$54.61 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	L.P.
						<i>Patient Birth Year:</i>	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.	<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.		

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>Patient Birth Year:</i> 1992
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.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> N/A
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>Patient Birth Year:</i> 1978

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.

Approx Mail Date: 6/21/2020

Patient Initials: C.S.

Mail To Address: P.O. BOX 54760
TULSA OK 74155-0760

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

Patient Birth Year: 1985

PURCELL MUNICIPAL

Office of State Finance VendorID: 0000056820

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

Patient Identifiers

6/18/2020 108434721 \$100.00 5/28/18 ACCT:907181480003

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

Approx Mail Date: 6/21/2020

Patient Initials: M.A.

Mail To Address: 1500 N. GREEN AVENUE
PURCELL OK 73080

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

Patient Birth Year: 1999

DIAGNOSTIC IMAGING ASSOC INC

Office of State Finance VendorID: 0000072917

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

Patient Identifiers

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.

Approx Mail Date: 8/15/2020

Patient Initials: K.B.

Mail To Address: PO BOX 973038
DALLAS TX 75397

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

Patient Birth Year: 1968

DIAGNOSTIC IMAGING ASSOCIATES

Office of State Finance VendorID: 0000072917

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

Patient Identifiers

10/21/2020 108492653 \$56.00 01/03/19 ACCT: Z4Z3VPV

Payment amount based on \$70.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/24/2020

Patient Initials: L.J.

Mail To Address: P.O. BOX 973038
DALLAS TX 75397-3038

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

Patient Birth Year: 1988

10/1/2020 108482932 \$276.00 07/23/20 ACCT: Z6XPI99

Payment amount based on \$345.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/4/2020

Patient Initials: K.R.

Mail To Address: P.O. BOX 973038
DALLAS TX 75397-3038

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

Patient Birth Year: 1989

8/26/2020 108464013 \$411.40 04/10/19 ACCT: 1871863712

Payment amount based on \$523.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2020

Total Bills exceed maximum award. Payment is prorated at 98.32726% among all providers.

Patient Initials: J.S.

Mail To Address: P.O. BOX 973038
DALLAS TX 75397-3038

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

Patient Birth Year: 1979

8/26/2020 108464014 \$399.36 08/22/19 ACCT: 1688005

Payment amount based on \$544.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2020

Total Bills exceed maximum award. Payment is prorated at 91.76457% among all providers.

Patient Initials: J.S.

Mail To Address: P.O. BOX 973038
DALLAS TX 75397-3038

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

Patient Birth Year: 1979

7/28/2020 108449448 \$464.80 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.

Approx Mail Date: 7/31/2020

Mail To Address: P.O. BOX 973038
DALLAS TX 75397-3038

Patient Initials: H.M.

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

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>
1/22/2021	108536060	\$20.80	4/3/20	ACCT: 730793134	
<i>Approx Mail Date:</i> 1/25/2021					<i>Patient Initials:</i> A.L.
<i>Mail To Address:</i> PO BOX 3205 INDIANAPOLIS IN 46206-3205					<i>Patient Birth Year:</i> 1968
1/12/2021	108530304	\$395.20	12/29/19	ACCT: 2650563-QDIA1	
<i>Approx Mail Date:</i> 1/15/2021					<i>Patient Initials:</i> R.F.
<i>Mail To Address:</i> PO BOX 3205 INDIANAPOLIS IN 46206-3205					<i>Patient Birth Year:</i> 1959
12/17/2020	108521224	\$376.80	07/03/20	ACCT: 2765171-QDIA1	
<i>Approx Mail Date:</i> 12/20/2020					<i>Patient Initials:</i> D.G.
<i>Mail To Address:</i> PO BOX 3205 INDIANAPOLIS IN 46206-3205					<i>Patient Birth Year:</i> 2000
12/11/2020	108517635	\$88.80	1/17/20	ACCT:128443QDIA1	
<i>Approx Mail Date:</i> 12/14/2020					<i>Patient Initials:</i> S.P.
<i>Mail To Address:</i> PO BOX 3205 INDIANAPOLIS IN 46206-3205					<i>Patient Birth Year:</i> 1999
11/18/2020	108506234	\$29.60	11/2/2019	ACCT:1059081-DIA1	
<i>Approx Mail Date:</i> 11/21/2020					<i>Patient Initials:</i> B.V.
<i>Mail To Address:</i> PO BOX 3205 INDIANAPOLIS IN 46206-3205					<i>Patient Birth Year:</i> 1963
8/12/2020	108456704	\$51.16	5/11/20	ACCT:2704741-QDIA1	
<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

DIAGNOSTIC IMAGING ASSOCIATES

Office of State Finance VendorID: 0000072917

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

9/18/2020 108476113 \$23.51 02/08/20 ACCT: 2006987-QDIA1
Approx Mail Date: 9/21/2020
Mail To Address: PO BOX 973038
 DALLAS TX 75397-3038

Payment amount based on \$31.00 patient balance after insurance and insurance adjustments.
 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

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>
7/8/2020	108441742	\$7,500.00	03/30/17	ACCT: S.M.	
<i>Approx Mail Date:</i> 7/11/2020					<i>Patient Initials:</i> S.M.
<i>Mail To Address:</i> 102 W 5TH ST CLAREMORE OK 74017-7079					<i>Patient Birth Year:</i> 1964

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>
12/17/2020	108521300	\$156.80	07/07/20	ACCT: 472609	
<i>Approx Mail Date:</i> 12/20/2020					<i>Patient Initials:</i> G.J.
<i>Mail To Address:</i> PO BOX 95818 OKLAHOMA CITY OK 73143-5818					<i>Patient Birth Year:</i> 2000
10/1/2020	108482971	\$40.80	03/01/20	ACCT: 429068	
<i>Approx Mail Date:</i> 10/4/2020					<i>Patient Initials:</i> K.R.
<i>Mail To Address:</i> PO BOX 95818 OKLAHOMA CITY OK 73143-5818					<i>Patient Birth Year:</i> 1989

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>
8/26/2020	108464109	\$203.20	03/01/20	ACCT: 513375	
<i>Approx Mail Date:</i> 8/29/2020					<i>Patient Initials:</i> T.E.
<i>Mail To Address:</i> PO BOX 269083 OKLAHOMA CITY OK 73126-9083					<i>Patient Birth Year:</i> 1985
7/28/2020	108449508	\$37.48	10/07/17	ACCT: 462667	
<i>Approx Mail Date:</i> 7/31/2020					<i>Patient Initials:</i> M.S.
<i>Mail To Address:</i> PO BOX 269083 OKLAHOMA CITY OK 73126-9083					<i>Patient Birth Year:</i> 1958

KINCANNON-LEE FUNERAL HOME

Office of State Finance VendorID: 0000056907

<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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\$2,994.06

06/17/20

ACCT: V.G. HEADSTONE PAYMENT

Payment amount based on \$2,994.06 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 1/22/21 Expected to be mailed by 2/5/21

Patient Initials: V.G.

Mail To Address: 3020 N MAIN ST
ALTUS OK 73521-1303

Patient Birth Year: 2007

STILLWATER MEDICAL CENTER

Office of State Finance VendorID: 0000175255

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:		Patient Identifiers
12/11/2020	108517668	\$190.76	1/14/20	ACCT: V00003080851	Payment amount based on patient balance after insurance and insurance adjustments.	
Approx Mail Date: 12/14/2020 Mail To Address: P.O. BOX 2468 STILLWATER OK 74074						Patient Initials: V.M. Patient Birth Year: 2006
11/18/2020	108506380	\$649.12	6/27/20	ACCT: V00003154313	Payment amount based on patient balance after insurance and insurance adjustments.	
Approx Mail Date: 11/21/2020 Mail To Address: P.O. BOX 2468 STILLWATER OK 74074						Patient Initials: P.H. Patient Birth Year: 1963
11/18/2020	108506379	\$694.13	12/19/19	ACCT: V00003069231	Payment amount based on \$867.66 patient balance after insurance and insurance adjustments.	
Approx Mail Date: 11/21/2020 Mail To Address: P.O. BOX 2468 STILLWATER OK 74074						Patient Initials: B.M. Patient Birth Year: 1996

STILLWATER MEDICAL CENTER

Office of State Finance VendorID: 0000175255

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:		Patient Identifiers
1/12/2021	108530374	\$1,984.38	09/30/19 - 03/11/20	ACCT: V00002999732 - \$280.12; V00003029584 - \$285.78; V00003045348 - \$224.08; 31283 - \$1,194.40	Payment amount based on \$2,480.48 patient balance after insurance and insurance adjustments.	
Approx Mail Date: 1/15/2021 Mail To Address: 1323 W 6TH AVE STILLWATER OK 74074-4306						Patient Initials: D.R. Patient Birth Year: 1978
10/21/2020	108492759	\$8,558.40	08/08/20	ACCT: V00003177191	Payment amount based on \$10,698.00 patient balance after insurance and insurance adjustments.	
Approx Mail Date: 10/24/2020 Mail To Address: 1323 W 6TH AVE STILLWATER OK 74074-4306						Patient Initials: E.Q. Patient Birth Year: 1989
10/21/2020	108492758	\$1,198.87	01/25/20	ACCT: V00003086776	Payment amount based on \$1,498.59 patient balance after insurance and insurance adjustments.	
Approx Mail Date: 10/24/2020 Mail To Address: 1323 W 6TH AVE STILLWATER OK 74074-4306						Patient Initials: J.F. Patient Birth Year: 1978

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.	<i>Patient Initials:</i> A.B.
	<i>Approx Mail Date:</i> 8/20/2020					
	<i>Mail To Address:</i> 1323 W 6TH AVE				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1999
			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.	<i>Patient Initials:</i> C.L.
	<i>Approx Mail Date:</i> 6/6/2020					
	<i>Mail To Address:</i> 1323 W 6TH AVE				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1990
			STILLWATER OK 74074-4306			

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.
	<i>Approx Mail Date:</i> 8/29/2020					
	<i>Mail To Address:</i> PO BOX 518				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> N/A
			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.
	<i>Approx Mail Date:</i> 7/31/2020					
	<i>Mail To Address:</i> PO BOX 518				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1979
			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.	<i>Patient Initials:</i> S.L.
	<i>Approx Mail Date:</i> 7/31/2020				Total Bills exceed maximum award. Payment is prorated at 48.54606% among all providers.	
	<i>Mail To Address:</i> PO BOX 518				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1996
			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>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					<i>Patient Birth Year:</i> 1989
			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.	<i>Patient Initials:</i> S.L.
	<i>Approx Mail Date:</i> 7/31/2020				Total Bills exceed maximum award. Payment is prorated at 48.54606% among all providers.	
	<i>Mail To Address:</i> PO BOX 550				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1996
			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.

Approx Mail Date: 6/6/2020

Patient Initials: S.D.

Mail To Address: PO BOX 550
NORMAN OK 73070-0550

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

Patient Birth Year: 1959

RADIOLOGY CONSULTANTS OF TULSA, INC.

Office of State Finance VendorID: 0000057079

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
1/22/2021	108536116	\$151.92	07/13/19 - 10/23/19	ACCT: 746553	
Approx Mail Date: 1/25/2021 Mail To Address: PO BOX 4975 TULSA OK 74159-0975					Payment amount based on \$4,176.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 4.547349% among all providers. Patient Initials: T.J. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1977
1/12/2021	108530362	\$225.00	08/22/19	ACCT: RCT325456	
Approx Mail Date: 1/15/2021 Mail To Address: PO BOX 4975 TULSA OK 74159-0975					Payment amount based on \$281.25 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: V.M. Patient Birth Year: 1998
12/17/2020	108521302	\$220.49	06/18/20 - 06/20/20	ACCT: 4559770C - \$165.53; 4559769C - \$4.11; 4559768C - \$4.11; 4559771C - \$4.11; 4559774C - \$19.18; 4559773C - \$19.34; 4559772C - \$4.11;	
Approx Mail Date: 12/20/2020 Mail To Address: PO BOX 4975 TULSA OK 74159-0975					Payment amount based on \$1,434.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 19.22044% among all providers. Patient Initials: W.F. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1968
12/17/2020	108521301	\$3.20	04/28/19	ACCT: 734939	
Approx Mail Date: 12/20/2020 Mail To Address: PO BOX 4975 TULSA OK 74159-0975					Payment amount based on \$4.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: M.M. Patient Birth Year: 1985
12/15/2020	108519544	\$161.60	06/23/20	ACCT: RCT591987	
Approx Mail Date: 12/18/2020 Mail To Address: PO BOX 4975 TULSA OK 74159-0975					Payment amount based on \$202.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: E.F. Patient Birth Year: 1992
11/19/2020	108507409	\$15.99	05/10/20	ACCT: 318029	
Approx Mail Date: 11/22/2020 Mail To Address: PO BOX 4975 TULSA OK 74159-0975					Payment amount based on \$23.75 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 84.17979% among all providers. Patient Initials: A.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1977
11/19/2020	108507408	\$347.46	07/13/20	ACCT: 4511929	
Approx Mail Date: 11/22/2020 Mail To Address: PO BOX 4975 TULSA OK 74159-0975					Payment amount based on \$1,059.25 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 41.00276% among all providers. Patient Initials: D.D. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1998

11/19/2020	108507406	\$779.88	02/06/20	ACCT: 4572230C - \$76.83; 4572229C - \$134.22; 4572228C - \$14.06; 4572227C - \$554.77	Payment amount based on \$1,484.50 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 11/22/2020					Total Bills exceed maximum award. Payment is prorated at 65.66922% among all providers. <i>Patient Initials:</i> J.E.	
<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> 1997	
11/19/2020	108507407	\$325.60	01/07/20	ACCT: 347991	Payment amount based on \$407.00 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 11/22/2020					<i>Patient Initials:</i> S.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> 1991	
10/21/2020	108492740	\$338.80	02/11/20	ACCT: 535832	Payment amount based on \$423.50 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 10/24/2020					<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	
10/21/2020	108492741	\$756.09	03/01/20	ACCT: RCT781061	Payment amount based on \$1,313.50 patient balance after insurance and insurance adjustments.	
<i>Approx Mail Date:</i> 10/24/2020					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	
9/18/2020	108476181	\$357.60		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	
8/26/2020	108464169	\$251.40	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	
8/26/2020	108464170	\$89.80	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					<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	
8/12/2020	108456736	\$854.40	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	

7/28/2020	108449539	\$1,289.00	01/14/20 - 02/10/20	ACCT: 774329	Payment amount based on patient balance after insurance and insurance adjustments.	Patient Initials: W.G.
<i>Approx Mail Date:</i> 7/31/2020						Patient Birth Year: 1963
<i>Mail To Address:</i> PO BOX 4975 TULSA OK 74159-0975						
7/28/2020	108449538	\$3.65	11/14/19 - 12/06/19	ACCT: RCT400721	Payment amount based on \$4.56 patient balance after insurance and insurance adjustments.	Patient Initials: M.S.
<i>Approx Mail Date:</i> 7/31/2020						Patient Birth Year: 1964
<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.						
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.	Patient Initials: J.C.
<i>Approx Mail Date:</i> 7/31/2020						Patient Birth Year: 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.	Patient Initials: G.M.
<i>Approx Mail Date:</i> 6/18/2020						Patient Birth Year: 1999
<i>Mail To Address:</i> PO BOX 4975 TULSA OK 74159-0975						
Total Bills exceed maximum award. Payment is prorated at 99.47671% among all providers.						
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.	Patient Initials: Z.V.
<i>Approx Mail Date:</i> 6/18/2020						Patient Birth Year: 1992
<i>Mail To Address:</i> PO BOX 4975 TULSA OK 74159-0975						
Total Bills exceed maximum award. Payment is prorated at 59.98875% among all providers.						
Acceptance of payment may require a provider write-off. EOB will accompany payment.						

NEUROSURGERY SPECIALISTS

Office of State Finance VendorID: 0000057111

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>	
11/19/2020	108507371	\$207.87	11/17/19 - 11/18/19	ACCT: 760289	Payment amount based on \$378.18 patient balance after insurance and insurance adjustments.	Patient Initials: W.T.
<i>Approx Mail Date:</i> 11/22/2020						Patient Birth Year: 1989
<i>Mail To Address:</i> 6767 S YALE AVE # A TULSA OK 74136-3302						
Total Bills exceed maximum award. Payment is prorated at 68.70795% among all providers.						
Acceptance of payment may require a provider write-off. EOB will accompany payment.						

EMERGENCY MEDICAL SERVICES

Office of State Finance VendorID: 0000057115

<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	108432710	\$36.90	09/16/19	ACCT: 2584	Payment amount based on \$965.00 patient balance after insurance and insurance adjustments.	Patient Initials: G.B.
<i>Approx Mail Date:</i> 6/18/2020						Patient Birth Year: 1967
<i>Mail To Address:</i> PO BOX 1056 OKMULGEE OK 74447-1056						
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.						

CRISWELL FUNERAL HOME, INC.

Office of State Finance VendorID: 0000057122

<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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1/12/2021	108530301	\$5,221.36	10/17/19	ACCT: T.M.	Payment amount based on \$5,221.36 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> T.M.
	<i>Approx Mail Date:</i> 1/15/2021					<i>Patient Birth Year:</i> 1995
	<i>Mail To Address:</i> PO BOX 1300 ADA OK 74821-1300					
9/18/2020	108476108	\$7,499.26	10/31/19	ACCT: C.J.	Payment amount based on \$7,499.26 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> 1998
	<i>Mail To Address:</i> PO BOX 1300 ADA OK 74821-1300					
8/11/2020	108455887	\$6,954.85	1/24/20	ACCT: B.P.	Payment amount based on \$6,954.85 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> B.P.
	<i>Approx Mail Date:</i> 8/14/2020					<i>Patient Birth Year:</i> 1988
	<i>Mail To Address:</i> PO BOX 1300 ADA OK 74821-1300					

BARTLESVILLE AMBULANCE

Office of State Finance VendorID: 0000057150

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
8/17/2020	108459152	\$1,764.00	03/01/20	ACCT: 39094	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> E.T.
	<i>Approx Mail Date:</i> 8/20/2020					<i>Patient Birth Year:</i> 1983
	<i>Mail To Address:</i> PO BOX 468 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.	<i>Patient Initials:</i> A.G.
	<i>Approx Mail Date:</i> 6/6/2020					<i>Patient Birth Year:</i> 1998
	<i>Mail To Address:</i> PO BOX 468 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

<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	108476082	\$7,500.00	03/10/20	ACCT: G.J.	Payment amount based on \$7,940.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> G.J.
	<i>Approx Mail Date:</i> 9/21/2020					<i>Patient Birth Year:</i> 1993
	<i>Mail To Address:</i> 1616 NE 36TH ST. OKLAHOMA CITY OK 73117					

MEMORIAL HOSPITAL

Office of State Finance VendorID: 0000057172

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
12/11/2020	108517624	\$1,051.00		ACCT: 21997	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> S.P.
	<i>Approx Mail Date:</i> 12/14/2020					<i>Patient Birth Year:</i> 1999
	<i>Mail To Address:</i> PO BOX 272 STILWELL OK 74960-0272					

11/18/2020	108506127	\$291.00	11-19-19	ACCT: 102726	Payment amount based on \$363.75 patient balance after insurance and insurance adjustments.	Patient Initials: A.G.
	<i>Approx Mail Date:</i> 11/21/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 2000
	<i>Mail To Address:</i> PO BOX 272 STILWELL OK 74960-0272					

11/18/2020	108506126	\$627.82	11/2/2019	ACCT: 102659	Payment amount based on \$784.78 patient balance after insurance and insurance adjustments.	Patient Initials: B.V.
	<i>Approx Mail Date:</i> 11/21/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1963
	<i>Mail To Address:</i> PO BOX 272 STILWELL OK 74960-0272					

EASTERN OKLAHOMA EAR, NOSE & THROAT INC

Office of State Finance VendorID: 0000073220

<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	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.	Patient Initials: D.S.
	<i>Approx Mail Date:</i> 4/25/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1988
	<i>Mail To Address:</i> PO BOX 2244 OKLAHOMA CITY OK 73101					

MCALESTER REGIONAL HLTH CTR

Office of State Finance VendorID: 0000057252

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
11/19/2020	108507368	\$1,409.92	07/12/20	ACCT: HV0020263984-2	Payment amount based on \$4,298.25 patient balance after insurance and insurance adjustments.	Patient Initials: D.D.
	<i>Approx Mail Date:</i> 11/22/2020				Total Bills exceed maximum award. Payment is prorated at 41.00276% among all providers.	Patient Birth Year: 1998
	<i>Mail To Address:</i> PO BOX 1228 MCALESTER OK 74502-1228				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
11/18/2020	108506313	\$1,021.62	4/18/20	ACCT:HV00201023249	Payment amount based on patient balance after insurance and insurance adjustments.	Patient Initials: A.M.
	<i>Approx Mail Date:</i> 11/21/2020					Patient Birth Year: 1994
	<i>Mail To Address:</i> PO BOX 1228 MCALESTER OK 74502-1228					

MCALESTER REGIONAL HEALTH CENTER

Office of State Finance VendorID: 0000057252

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
12/15/2020	108519533	\$722.78	12/08/19	ACCT: V00017902479	Payment amount based on \$903.48 patient balance after insurance and insurance adjustments.	Patient Initials: D.E.
	<i>Approx Mail Date:</i> 12/18/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1974
	<i>Mail To Address:</i> 1 E CLARK BASS BLVD MCALESTER OK 74501					

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
Mail To Address: 1 E CLARK BASS BLVD
MCALESTER OK 74501

Total Bills exceed maximum award. Payment is prorated at 46.74856% among all providers. *Patient Initials:* J.E.
Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1997

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
Mail To Address: 1 E CLARK BASS BLVD
MCALESTER OK 74501

Patient Initials: B.M.
Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1981

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
Mail To Address: 1 E CLARK BASS BLVD
MCALESTER OK 74501

Patient Initials: D.S.
Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1956

MCALESTER REGIONAL HEALTH CENTER

Office of State Finance VendorID: 0000057252

<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	108490802	\$875.01	10/25/2018	ACCT: V00016947939	
<i>Approx Mail Date:</i> 10/19/2020					<i>Patient Initials:</i> M.G.
<i>Mail To Address:</i> PAYMENT PROCESSING CENTER - AVADYN PO BOX 219714 KANSAS CITY MO 64121					<i>Patient Birth Year:</i> 1993

TEMPLE & SON FUNERAL HOME, INC.

Office of State Finance VendorID: 0000057298

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
10/14/2020	108489593	\$5,127.59	04/18/20	ACCT: S.M.	
<i>Approx Mail Date:</i> 10/17/2020					<i>Patient Initials:</i> S.M.
<i>Mail To Address:</i> PO BOX 11301 OKLAHOMA CITY OK 73136-0301					<i>Patient Birth Year:</i> 1987
10/14/2020	108489592	\$5,117.67	040/10/20	ACCT: L.F.	
<i>Approx Mail Date:</i> 10/17/2020					<i>Patient Initials:</i> L.F.
<i>Mail To Address:</i> PO BOX 11301 OKLAHOMA CITY OK 73136-0301					<i>Patient Birth Year:</i> 1971
10/1/2020	108482983	\$5,020.88	11/22/19	ACCT: A.P.	
<i>Approx Mail Date:</i> 10/4/2020					<i>Patient Initials:</i> A.P.
<i>Mail To Address:</i> PO BOX 11301 OKLAHOMA CITY OK 73136-0301					<i>Patient Birth Year:</i> 1992

DUNCAN REGIONAL HOSPITAL

Office of State Finance VendorID: 0000057308

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
10/14/2020	108489537	\$560.00	04/18/20	ACCT: D00040225492	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 10/17/2020 <i>Mail To Address:</i> PO BOX 100 DUNCAN OK 73534					<i>Patient Initials:</i> T.C. <i>Patient Birth Year:</i> 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.
<i>Approx Mail Date:</i> 8/29/2020 <i>Mail To Address:</i> PO BOX 100 DUNCAN OK 73534					Total Bills exceed maximum award. Payment is prorated at 33.30311% among all providers. <i>Patient Initials:</i> S.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1967

DUNCAN REGIONAL HOSPITAL

Office of State Finance VendorID: 0000057308

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
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 <i>Mail To Address:</i> P.O. BOX 248821 OKLAHOMA CITY OK 73124-8821					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

CLEVELAND AREA HOSPITAL

Office of State Finance VendorID: 0000176138

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
1/22/2021	108536082	\$820.80	4/3/20	ACCT: 60044852	Payment amount based on \$1,026.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 1/25/2021 <i>Mail To Address:</i> 1401 W PAWNEE ST CLEVELAND OK 74020-3033					<i>Patient Initials:</i> A.L. <i>Patient Birth Year:</i> 1968

INTEGRIS BAPTIST MEDICAL CENTER

Office of State Finance VendorID: 0000057438

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
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 <i>Mail To Address:</i> PO BOX 268907 OKLAHOMA CITY OK 73126					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

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	
<i>Approx Mail Date:</i> 7/31/2020 <i>Mail To Address:</i> PAYMENT PROCESSING CENTER KANSAS CITY MO 64121-9714					Payment amount based on \$2,499.51 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 32.75809% among all providers. <i>Patient Initials:</i> M.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1958

EMSA - EASTERN DIVISION

Office of State Finance VendorID: 0000057454

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/22/2021	108536062	\$1,146.40	03/11/20	ACCT: 20-20045482	
<i>Approx Mail Date:</i> 1/25/2021 <i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505					Payment amount based on \$1,433.00 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.B. <i>Patient Birth Year:</i> 1978
1/22/2021	108536063	\$343.59	05/31/20	ACCT: 20-20090681	
<i>Approx Mail Date:</i> 1/25/2021 <i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505					Payment amount based on \$1,433.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 29.9709% among all providers. <i>Patient Initials:</i> J.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1991
11/19/2020	108507325	\$939.45	05/10/20	ACCT: 20-20078352	
<i>Approx Mail Date:</i> 11/22/2020 <i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505					Payment amount based on \$1,395.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 84.17979% among all providers. <i>Patient Initials:</i> A.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1977
10/21/2020	108492661	\$846.76	02/29/20	ACCT: 20-20038463	
<i>Approx Mail Date:</i> 10/24/2020 <i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505					Payment amount based on \$1,471.00 patient balance after insurance and insurance adjustments. 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
10/21/2020	108492659	\$40.00	06/15/19	ACCT: 19-19101985	
<i>Approx Mail Date:</i> 10/24/2020 <i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505					Payment amount based on \$50.00 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.E. <i>Patient Birth Year:</i> 1985
10/16/2020	108490762	\$702.99	8/29/2019	ACCT:19-19151301	
<i>Approx Mail Date:</i> 10/19/2020 <i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505					Payment amount based on \$878.74 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.B. <i>Patient Birth Year:</i> 1964
8/26/2020	108464018	\$414.36	09/24/16	ACCT: 16-16156879	
<i>Approx Mail Date:</i> 8/29/2020 <i>Mail To Address:</i> PO BOX 392505 PITTSBURG PA 15251-9505					Payment amount based on \$1,408.00 patient balance after insurance and insurance adjustments. 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	\$1,232.00	08/31/15	ACCT:15-15139520	Payment amount based on \$1,540.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> T.C.
	<i>Approx Mail Date:</i>	8/15/2020				<i>Patient Birth Year:</i> 1980
	<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.	
<hr/>						
8/11/2020	108455893	\$1,176.80	11/9/19	ACCT: 19-19197853	Payment amount based on \$1,471.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.C.
	<i>Approx Mail Date:</i>	8/14/2020				<i>Patient Birth Year:</i> 1968
	<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.	
<hr/>						
6/15/2020	108432712	\$471.36	03/01/20	ACCT: 20038595	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.A.
	<i>Approx Mail Date:</i>	6/18/2020			Total Bills exceed maximum award. Payment is prorated at 44.03599% among all providers.	<i>Patient Birth Year:</i> 1998
	<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.	
<hr/>						
5/19/2020	108421280	\$1,078.40	05/17/19	ACCT: 1919084359	Payment amount based on \$1,348.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> T.P.
	<i>Approx Mail Date:</i>	5/22/2020				<i>Patient Birth Year:</i> 1964
	<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.	
<hr/>						
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.	<i>Patient Initials:</i> M.H.
	<i>Approx Mail Date:</i>	5/22/2020			Total Bills exceed maximum award. Payment is prorated at 39.7409% among all providers.	<i>Patient Birth Year:</i> 1970
	<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.	
<hr/>						
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.	<i>Patient Initials:</i> J.C.
	<i>Approx Mail Date:</i>	5/22/2020				<i>Patient Birth Year:</i> 1977
	<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.	

EMSA - WESTERN DIVISION - OKC

Office of State Finance VendorID: 0000057454

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>	
<hr/>						
12/17/2020	108521228	\$919.05	01/27/20	ACCT: 20-20025722	Payment amount based on \$1,395.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.O.
	<i>Approx Mail Date:</i>	12/20/2020			Total Bills exceed maximum award. Payment is prorated at 82.35184% among all providers.	<i>Patient Birth Year:</i> 1979
	<i>Mail To Address:</i>	PO BOX 392519 PITTSBURG PA 152519519			Acceptance of payment may require a provider write-off. EOB will accompany payment.	
<hr/>						
12/17/2020	108521229	\$1,176.80	07/03/20	ACCT: 20-20111684	Payment amount based on \$1,471.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> D.G.
	<i>Approx Mail Date:</i>	12/20/2020				<i>Patient Birth Year:</i> 2000
	<i>Mail To Address:</i>	PO BOX 392519 PITTSBURG PA 152519519			Acceptance of payment may require a provider write-off. EOB will accompany payment.	

12/17/2020	108521227	\$100.15	01/28/20	ACCT: 20-20025731	Payment amount based on \$1,338.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 9.35623% among all providers. Patient Initials: R.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1974
	Approx Mail Date:	12/20/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			
12/22/2020	108523887	\$1,145.60	3/31/2017	ACCT: 1717052730	Payment amount based on \$1,432.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: R.R. Patient Birth Year: 1986
	Approx Mail Date:	12/25/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			
11/19/2020	108507324	\$874.28	06/13/19	ACCT: 19-19101256	Payment amount based on \$1,396.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 78.28401% among all providers. Patient Initials: M.D. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1980
	Approx Mail Date:	11/22/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			
10/21/2020	108492660	\$86.25	05/10/19	ACCT: 19-19079222	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. Patient Initials: A.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1977
	Approx Mail Date:	10/24/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			
10/21/2020	108492662	\$1,157.72	05/28/20	ACCT: 20-20089352	Payment amount based on \$1,452.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 99.66612% among all providers. Patient Initials: J.B. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 2007
	Approx Mail Date:	10/24/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			
10/21/2020	108492663	\$609.81	07/23/20	ACCT: 20-20124895	Payment amount based on \$1,471.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 51.81909% among all providers. Patient Initials: M.V. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1975
	Approx Mail Date:	10/24/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			
10/21/2020	108492658	\$1,059.20	05/25/19	ACCT: 19-19089268	Payment amount based on \$1,324.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: T.J. Patient Birth Year: 1973
	Approx Mail Date:	10/24/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			
10/14/2020	108489539	\$1,068.80	10/03/18	ACCT: 18-18166788	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. Patient Initials: E.P. Patient Birth Year: 1974
	Approx Mail Date:	10/17/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			
9/18/2020	108476117	\$1,088.00	06/17/18	ACCT: 18-18099801	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. Patient Initials: C.J. Patient Birth Year: 1963
	Approx Mail Date:	9/21/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			

9/18/2020	108476118	\$240.53	09/19/19	ACCT: 19-19165866	Payment amount based on \$1,338.00 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
	Approx Mail Date:	9/21/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			
9/18/2020	108476119	\$243.99	01/23/20	ACCT: 20-200144440	Payment amount based on \$1,357.25 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
	Approx Mail Date:	9/21/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			
9/25/2020	108480173	\$1,088.00	1/7/20-1/8/20	ACCT:1919001422	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. Patient Initials: C.B. Patient Birth Year: 1970
	Approx Mail Date:	9/28/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			
8/26/2020	108464024	\$1,085.60	03/01/20	ACCT: 20-20039095	Payment amount based on \$1,357.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: T.E. Patient Birth Year: 1985
	Approx Mail Date:	8/29/2020			
	Mail To Address:	PO BOX 392519 PITTSBURG PA 152519519			
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. Patient Initials: S.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1996
	Approx Mail Date:	8/29/2020			
	Mail To Address:	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. Patient Initials: A.K. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1997
	Approx Mail Date:	8/29/2020			
	Mail To Address:	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. Patient Initials: S.W. Patient Birth Year: 1996
	Approx Mail Date:	8/29/2020			
	Mail To Address:	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. Patient Initials: D.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1984
	Approx Mail Date:	8/29/2020			
	Mail To Address:	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. Patient Initials: C.K. Patient Birth Year: 1996
	Approx Mail Date:	8/29/2020			
	Mail To Address:	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. Patient Initials: E.R. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1974
			Approx Mail Date: 8/29/2020		
			Mail To Address: PO BOX 392519 PITTSBURG PA 152519519		
			\$48.87		
			11/06/16 ACCT: 16-16181893		
			Approx Mail Date: Requested from OSF 1/9/18 Expected to be mailed by 1/23/18		
			Mail To Address: 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. Patient Initials: J.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1981
			Approx Mail Date: 7/31/2020		
			Mail To Address: 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. Patient Initials: N.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1994
			Approx Mail Date: 6/28/2020		
			Mail To Address: 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. Patient Initials: B.D. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1999
			Approx Mail Date: 6/18/2020		
			Mail To Address: 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. Patient Initials: B.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1995
			Approx Mail Date: 5/22/2020		
			Mail To Address: 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. Patient Initials: T.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1961
			Approx Mail Date: 5/22/2020		
			Mail To Address: 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. Patient Initials: K.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1988
			Approx Mail Date: 5/22/2020		
			Mail To Address: 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. Patient Initials: V.M. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1958
			Approx Mail Date: 5/22/2020		
			Mail To Address: PO BOX 392519 PITTSBURG PA 152519519		

SEQUOYAH MEMORIAL HOSPITAL

Office of State Finance VendorID: 0000057609

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		\$65.26	8/13/2019	ACCT: 1023954	
<i>Approx Mail Date:</i> Requested from OSF 7/16/20 Expected to be mailed by 7/30/20					<i>Patient Initials:</i> G.H.
<i>Mail To Address:</i> 213 E. REDWOOD SALLISAW OK 74955					<i>Patient Birth Year:</i> 1950

Payment amount based on \$81.58 patient balance after insurance and insurance adjustments.
Acceptance of payment may require a provider write-off. EOB will accompany payment.

MCCURTAIN COUNTY EMS

Office of State Finance VendorID: 0000057681

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
1/22/2021	108536087	\$108.52	9/5/20	ACCT: 204254	
<i>Approx Mail Date:</i> 1/25/2021					<i>Patient Initials:</i> L.R.
<i>Mail To Address:</i> 827 EAST LINCOLN ROAD IDABEL OK 74745					<i>Patient Birth Year:</i> 1990
10/21/2020	108492701	\$2,856.95	05/16/20	ACCT: 20-1910	
<i>Approx Mail Date:</i> 10/24/2020					<i>Patient Initials:</i> J.B.
<i>Mail To Address:</i> 827 EAST LINCOLN ROAD IDABEL OK 74745					<i>Patient Birth Year:</i> 1994
10/21/2020	108492700	\$468.70	09/02/18	ACCT: 18-3361	
<i>Approx Mail Date:</i> 10/24/2020					<i>Patient Initials:</i> J.C.
<i>Mail To Address:</i> 827 EAST LINCOLN ROAD IDABEL OK 74745					<i>Patient Birth Year:</i> 1980

Payment amount based on \$135.65 patient balance after insurance and insurance adjustments.
Acceptance of payment may require a provider write-off. EOB will accompany payment.

Payment amount based on \$3,571.19 patient balance after insurance and insurance adjustments.
Acceptance of payment may require a provider write-off. EOB will accompany payment.

Payment amount based on \$585.88 patient balance after insurance and insurance adjustments.
Acceptance of payment may require a provider write-off. EOB will accompany payment.

PATHOLOGY LABORATORY ASSOCIATES

Office of State Finance VendorID: 0000057719

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
1/22/2021	108536106	\$9.34	02/24/20	ACC: 7069343	
<i>Approx Mail Date:</i> 1/25/2021					<i>Patient Initials:</i> E.J.
<i>Mail To Address:</i> PO BOX 21228, DEPT. 184 TULSA OK 74121-1228					<i>Patient Birth Year:</i> 1977

Payment amount based on \$11.68 patient balance after insurance and insurance adjustments.
Acceptance of payment may require a provider write-off. EOB will accompany payment.

INTEGRIS SOUTHWEST MEDICAL CTR

Office of State Finance VendorID: 0000057735

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
12/11/2020	108517641	\$670.94	3/25/20	ACCT: 602769284	
<i>Approx Mail Date:</i> 12/14/2020					<i>Patient Initials:</i> J.H.
<i>Mail To Address:</i> PO BOX 268908 OKLAHOMA CITY OK 73126-8908					<i>Patient Birth Year:</i> 1989

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

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

Payment amount based on \$779.40 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/2/2020*Patient Initials:* P.W.*Mail To Address:* PO BOX 1072
CLINTON OK 73601-1072

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.

Approx Mail Date: 8/29/2020*Patient Initials:* B.P.*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****1/22/2021 108536118 \$153.76** 02/24/20 ACCT: 3028894

Payment amount based on \$192.20 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/25/2021*Patient Initials:* E.J.*Mail To Address:* DEPT 2803
TULSA OK 74182

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

Patient Birth Year: 1977**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.

Approx Mail Date: 7/31/2020*Patient Initials:* W.G.*Mail To Address:* 200 CALLAHAN ST
MUSKOGEE OK 74403-5126*Patient Birth Year:* 1963

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

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

CENTRAL OKLAHOMA FAMILY MEDICINE*Office of State Finance VendorID:* 0000058478

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
12/11/2020	108517632	\$24.00	6/22/20	ACCT:53371	Payment amount based on patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 12/14/2020					<i>Patient Initials:</i> T.M.
<i>Mail To Address:</i> 527 W. 3RD KONOWA OK 74849					<i>Patient Birth Year:</i> 1999

MARY HURLEY HOSP. dba COAL CO. GENERAL HOSP.*Office of State Finance VendorID:* 0000178608

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
6/3/2020	108427390	\$40.00	09/16/19	ACCT: 2010	Payment amount based on \$50.00 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> 6 N COVINGTON COALGATE OK 74538					<i>Patient Birth Year:</i> 1996

CHOCTAW CO. AMBULANCE*Office of State Finance VendorID:* 0000058623

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
11/19/2020	108507306	\$379.69	03/28/18	ACCT: 227-2271800674:1	Payment amount based on \$894.50 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 11/22/2020					<i>Patient Initials:</i> K.S.
<i>Mail To Address:</i> PO BOX 567 HUGO OK 74743-0567					<i>Patient Birth Year:</i> 1985

9/18/2020 108476096 \$765.52 08/07/18 ACCT: 227-2271801569:1
Approx Mail Date: 9/21/2020
Mail To Address: PO BOX 567
 HUGO OK 74743-0567

Payment amount based on \$956.90 patient balance after insurance and insurance adjustments.

Patient Initials: J.A.

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

Patient Birth Year: 1998

KUHN, JOHN R. MD

Office of State Finance VendorID: 0000179060

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

Patient Identifiers

11/19/2020 108507354 \$3.43 11/26/18 ACCT: 6366283

Payment amount based on \$35.04 patient balance after insurance and insurance adjustments.

Patient Initials: A.R.

Approx Mail Date: 11/22/2020

Mail To Address: 1024 SW 44TH ST
 OKLAHOMA CITY OK 73109-3608

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

Patient Birth Year: 1999

RADIOLOGY ASSOC. OF EASTERN OKLAHOMA

Office of State Finance VendorID:

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

Patient Identifiers

\$268.00 12/08/19 ACCT: 130729

Payment amount based on \$335.00 patient balance after insurance and insurance adjustments.

Patient Initials: D.E.

Approx Mail Date: Requested from OSF 12/10/20 Expected to be mailed by 12/24/20

Mail To Address: 1 E. CLARK BASS BLVD
 MCALESTER OK 74501

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

Patient Birth Year: 1974

WILLIAMSON FUNERAL HOME

Office of State Finance VendorID: 0000208275

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

Patient Identifiers

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.

Patient Initials: P.W.

Approx Mail Date: 8/29/2020

Mail To Address: 221 SOUTH MAIN
 WETUMKA OK 74883

Patient Birth Year: 1937

WARREN CLINIC

Office of State Finance VendorID: 0000074753

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

Patient Identifiers

10/21/2020 108492776 \$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.

Patient Initials: M.M.

Approx Mail Date: 10/24/2020

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.

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.
<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 74136-3348				Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 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.
<i>Approx Mail Date:</i> 7/31/2020				Total Bills exceed maximum award. Payment is prorated at 74.12385% among all providers. <i>Patient Initials:</i> T.A.	
<i>Mail To Address:</i> 6600 S YALE AVE STE 1400 TULSA OK 74136-3348				Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 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.
<i>Approx Mail Date:</i> 4/25/2020				<i>Patient Initials:</i> G.S.	
<i>Mail To Address:</i> 6600 S YALE AVE STE 1400 TULSA OK 74136-3348				Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1966	

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>
1/22/2021	108536136	\$185.60	03/12/20 - 03/13/20	ACCT: 3390194A7661	Payment amount based on \$232.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 1/25/2021				<i>Patient Initials:</i> K.B.	
<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> 1978	
1/22/2021	108536134	\$789.59	12/06/19 AND 08/27/19 - 02/24/20	ACCT: 3616146A7661 - \$41.20; 2682192A7661 - \$748.39	Payment amount based on \$986.99 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 1/25/2021				<i>Patient Initials:</i> E.J.	
<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	
12/17/2020	108521327	\$90.00	06/06/15 - 08/23/15	ACCT: 2383362A7661	Payment amount based on \$600.20 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 12/20/2020				<i>Patient Initials:</i> M.T.	
<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> 1995	
12/15/2020	108519552	\$1,192.00	12/09/19	ACCT: 3606824A7661	Payment amount based on \$1,490.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 12/18/2020				<i>Patient Initials:</i> D.E.	
<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> 1974	

11/19/2020	108507438	\$3,724.25	12/11/18	ACCT: 3401970A7661	Payment amount based on \$5,447.50 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 85.45767% among all providers. Patient Initials: H.C. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1986
<i>Approx Mail Date:</i> 11/22/2020					
<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023					
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. Patient Initials: B.P. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1998
<i>Approx Mail Date:</i> 8/29/2020					
<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023					
8/26/2020	108464202	\$4,003.60	08/06/19 - 08/12/19	ACCT: 3541197	Payment amount based on \$5,004.50 patient balance after insurance and insurance adjustments. Patient Initials: B.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1988
<i>Approx Mail Date:</i> 8/29/2020					
<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023					
7/28/2020	108449567	\$411.34	01/02/19 - 01/05/19	ACCT: 3417364A7661 - \$27.64; 341268A7661 - \$383.70	Payment amount based on \$514.18 patient balance after insurance and insurance adjustments. Patient Initials: L.P. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1949
<i>Approx Mail Date:</i> 7/31/2020					
<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023					

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. Patient Initials: R.B. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1964
<i>Approx Mail Date:</i> 10/19/2020					
<i>Mail To Address:</i> 1920 S. UTICA AVE. TULSA OK 74104					

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>
1/22/2021	108536135	\$83.16	06/18/20	ACCT: 3714391A7661	Payment amount based on \$103.95 patient balance after insurance and insurance adjustments. Patient Initials: A.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1975
<i>Approx Mail Date:</i> 1/25/2021					
<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023					
11/19/2020	108507439	\$1,941.60	05/10/20	ACCT: 7439485V7661	Payment amount based on \$2,427.00 patient balance after insurance and insurance adjustments. Patient Initials: R.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1978
<i>Approx Mail Date:</i> 11/22/2020					
<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023					

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>Patient Initials:</i> J.S.
	<i>Approx Mail Date:</i> 9/21/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1988
	<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023					
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>Patient Initials:</i> C.S.
	<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> 1977
	<i>Mail To Address:</i> PO BOX 13292 BELFAST ME 04915-4023					

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>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 960119 OKLAHOMA CITY OK 73196-0119					

MAYES EMERGENCY SERVICES TRUST AUTHORITY

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>
		\$121.06	07/13/19	ACCT: 53556967	Payment amount based on \$3,327.69 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> Requested from OSF 1/12/21 Expected to be mailed by 1/26/21				Total Bills exceed maximum award. Payment is prorated at 4.547349% among all providers.	<i>Patient Initials:</i> T.J.
	<i>Mail To Address:</i> 4 REDDEN PRYOR OK 74361-8800				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1977
		\$474.52	06/18/20	ACCT: 57501889	Payment amount based on \$3,086.03 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> Requested from OSF 12/8/20 Expected to be mailed by 12/22/20				Total Bills exceed maximum award. Payment is prorated at 19.22044% among all providers.	<i>Patient Initials:</i> W.F.
	<i>Mail To Address:</i> 4 REDDEN PRYOR OK 74361-8800				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1968

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>Patient Initials:</i> D.T.
	<i>Approx Mail Date:</i> 10/19/2020					<i>Patient Birth Year:</i> 1982
	<i>Mail To Address:</i> 603 N. MISSION SAPULPA OK 74066					
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>Patient Initials:</i> S.H.
	<i>Approx Mail Date:</i> 4/17/2020					<i>Patient Birth Year:</i> 1982
	<i>Mail To Address:</i> 603 N. MISSION SAPULPA OK 74066					

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>
1/22/2021	108536068	\$140.00	06/22/20	ACCT: 1250230	Payment amount based on \$175.00 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> A.H.
<i>Approx Mail Date:</i> 1/25/2021					<i>Patient Birth Year:</i> 1975
<i>Mail To Address:</i> PO BOX 21228 TULSA OK 74121-1228					Acceptance of payment may require a provider write-off. EOB will accompany payment.
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>Patient Initials:</i> T.H.
<i>Approx Mail Date:</i> 6/28/2020					<i>Patient Birth Year:</i> 1979
<i>Mail To Address:</i> PO BOX 21228 TULSA OK 74121-1228					Acceptance of payment may require a provider write-off. EOB will accompany payment.

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>
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. <i>Patient Initials:</i> N.C.
<i>Approx Mail Date:</i> 7/11/2020					<i>Patient Birth Year:</i> 1981
<i>Mail To Address:</i> 6613 N MERIDIAN AVE OKLAHOMA CITY OK 73116					Acceptance of payment may require a provider write-off. EOB will accompany payment.

ALAN CONGER, PSYD

Office of State Finance VendorID: 0000266065

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
		\$312.00	8/16/18-02/28/2019	ACCT:3266OAC	Payment amount based on \$390.00 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> A.M.
<i>Approx Mail Date:</i> Requested from OSF 10/9/20 Expected to be mailed by 10/23/20					<i>Patient Birth Year:</i> 2007
<i>Mail To Address:</i> 5512 S LEWIS TULSA OK 74105-7116					Acceptance of payment may require a provider write-off. EOB will accompany payment.

LOCKSTONE FUNERAL HOME OF THOMAS

Office of State Finance VendorID: 0000254344

<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	108449491	\$1,034.35	4/24/19	ACCT: H.B.	Payment amount based on \$1,034.35 patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> H.B.
<i>Approx Mail Date:</i> 7/31/2020					<i>Patient Birth Year:</i> 1973
<i>Mail To Address:</i> PO BOX 663 THOMAS OK 73669-0663					Acceptance of payment may require a provider write-off. EOB will accompany payment.

GRIFFITH MEMORIAL FUNERAL HOME

Office of State Finance VendorID: 0000060054

<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 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 *Patient Birth Year:* 1975
 TULSA OK 74107-6400

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				<i>Patient Birth Year:</i> 1992
		GUYMON OK 73942				

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>
12/17/2020	108521254	\$1,340.94	05/02/20	ACCT: D.O.	Payment amount based on \$1,340.94 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 12/20/2020				<i>Patient Initials:</i> D.O.
		<i>Mail To Address:</i> PO BOX 2411				<i>Patient Birth Year:</i> 1974
		MUSKOGEE OK 74402-2411				
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				<i>Patient Birth Year:</i> 1974
		MUSKOGEE OK 74402-2411				

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				<i>Patient Birth Year:</i> 2000
		TULSA OK 74106				

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			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1999
		TULSA OK 74105				

NORTHWEST ANESTHESIA

Office of State Finance VendorID: 0000060573

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
12/15/2020	108519539	\$82.34	07/25/19	ACCT: 54076577	
<i>Approx Mail Date:</i> 12/18/2020 <i>Mail To Address:</i> PO BOX 26168 OKLAHOMA CITY OK 73126-0168					Patient Initials: M.D. Patient Birth Year: 1970
Payment amount based on \$102.93 patient balance after insurance and insurance adjustments.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					
8/17/2020	108459252	\$93.60	12/03/19	ACCT: 54639926	
<i>Approx Mail Date:</i> 8/20/2020 <i>Mail To Address:</i> PO BOX 26168 OKLAHOMA CITY OK 73126-0168					Patient Initials: R.J. Patient Birth Year: 2000
Payment amount based on \$117.00 patient balance after insurance and insurance adjustments.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

CENTRAL STATES ORTHOPEDIC SPECIALISTS, INC.

Office of State Finance VendorID: 0000060771

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
12/17/2020	108521207	\$448.94	06/09/15 - 08/18/15	ACCT: 634443	
<i>Approx Mail Date:</i> 12/20/2020 <i>Mail To Address:</i> DEPT 100 PO BOX 22063 TULSA OK 74121-2063					Patient Initials: M.T. Patient Birth Year: 1995
Payment amount based on \$2,994.00 patient balance after insurance and insurance adjustments.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

OU PHYSICIANS GROUP

Office of State Finance VendorID: 0000061010

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
1/22/2021	108536038	\$83.18	12/17/19 - 03/05/20	ACCT: 3017266	
<i>Approx Mail Date:</i> 1/25/2021 <i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026					Patient Initials: L.H. Patient Birth Year: 1966
Payment amount based on \$103.98 patient balance after insurance and insurance adjustments.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					
1/22/2021	108536039	\$3,363.20	03/12/20 - 03/16/20	ACCT: 569495	
<i>Approx Mail Date:</i> 1/25/2021 <i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026					Patient Initials: J.W. Patient Birth Year: 1980
Payment amount based on \$4,204.00 patient balance after insurance and insurance adjustments.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					
1/22/2021	108536036	\$7,988.00	03/17/18 - 07/23/18	ACCT: 2428591	
<i>Approx Mail Date:</i> 1/25/2021 <i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026					Patient Initials: F.E. Patient Birth Year: 1977
Payment amount based on \$9,985.00 patient balance after insurance and insurance adjustments.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					
1/22/2021	108536037	\$20,000.00	10/13/19 - 12/23/19	ACCT: 1542571	
<i>Approx Mail Date:</i> 1/25/2021 <i>Mail To Address:</i> PO BOX 269026 OKLAHOMA CITY OK 73126-9026					Patient Initials: D.M. Patient Birth Year: 2000
Payment amount based on \$36,461.00 patient balance after insurance and insurance adjustments.					
Total Bills exceed maximum award. Payment is prorated at 68.56641% among all providers.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

1/22/2021	108536040	\$286.00	6/25/20	ACCT: 3049485	Payment amount based on \$357.50 patient balance after insurance and insurance adjustments.	Patient Initials: B.L.
	Approx Mail Date:	1/25/2021			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 2014
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
12/21/2020	108523064	\$980.56	02/17/20 - 02/27/20	ACCT: 3029671	Payment amount based on \$1,225.70 patient balance after insurance and insurance adjustments.	Patient Initials: T.G.
	Approx Mail Date:	12/24/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1971
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
12/21/2020	108523065	\$1,359.32	07/18/19 - 08/22/20	ACCT: 2980320	Payment amount based on \$1,699.16 patient balance after insurance and insurance adjustments.	Patient Initials: L.J.
	Approx Mail Date:	12/24/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1977
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
12/17/2020	108521197	\$4,559.00	01/27/20 - 02/03/20	ACCT: 3025419	Payment amount based on \$6,920.00 patient balance after insurance and insurance adjustments.	Patient Initials: K.O.
	Approx Mail Date:	12/20/2020			Total Bills exceed maximum award. Payment is prorated at 82.35184% among all providers.	Patient Birth Year: 1979
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.	
12/17/2020	108521198	\$11,227.20	01/23/20 - 03/04/20	ACCT: 1271617	Payment amount based on \$14,034.00 patient balance after insurance and insurance adjustments.	Patient Initials: R.W.
	Approx Mail Date:	12/20/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1978
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
12/17/2020	108521199	\$593.13	01/01/20 - 02/04/20	ACCT: 3007395	Payment amount based on \$18,775.35 patient balance after insurance and insurance adjustments.	Patient Initials: K.J.
	Approx Mail Date:	12/20/2020			Total Bills exceed maximum award. Payment is prorated at 3.94883% among all providers.	Patient Birth Year: 1981
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.	
12/17/2020	108521196	\$5,087.60	11/16/19 - 12/04/19	ACCT: 3010905	Payment amount based on \$6,359.50 patient balance after insurance and insurance adjustments.	Patient Initials: B.M.
	Approx Mail Date:	12/20/2020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1997
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
12/17/2020	108521195	\$10,371.66	05/04/19 - 07/09/19	ACCT: 1254274	Payment amount based on \$24,351.50 patient balance after insurance and insurance adjustments.	Patient Initials: J.R.
	Approx Mail Date:	12/20/2020			Total Bills exceed maximum award. Payment is prorated at 53.23933% among all providers.	Patient Birth Year: 1984
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.	
12/17/2020	108521194	\$539.99	01/28/20 - 02/18/20	ACCT: 128132	Payment amount based on \$7,214.35 patient balance after insurance and insurance adjustments.	Patient Initials: R.S.
	Approx Mail Date:	12/20/2020			Total Bills exceed maximum award. Payment is prorated at 9.35623% among all providers.	Patient Birth Year: 1974
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.	

12/17/2020	108521193	\$6.40	07/13/20	ACCT: 2137085	Payment amount based on \$8.00 patient balance after insurance and insurance adjustments.	Patient Initials:	L.B.
			<i>Approx Mail Date:</i>	12/20/2020			
			<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.	Patient Birth Year:	1980
12/15/2020	108519517	\$3,801.60	05/11/19 - 05/12/19	ACCT: 2590063	Payment amount based on \$4,752.00 patient balance after insurance and insurance adjustments.	Patient Initials:	S.C.
			<i>Approx Mail Date:</i>	12/18/2020			
			<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.	Patient Birth Year:	1987
12/15/2020	108519518	\$221.93	04/15/19	ACCT: 2734256	Payment amount based on \$277.41 patient balance after insurance and insurance adjustments.	Patient Initials:	M.D.
			<i>Approx Mail Date:</i>	12/18/2020			
			<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.	Patient Birth Year:	1970
12/22/2020	108523857	\$222.89	2/21/2018-11/5/2019	ACCT:154461	Payment amount based on \$278.61 patient balance after insurance and insurance adjustments.	Patient Initials:	B.D.
			<i>Approx Mail Date:</i>	12/25/2020			
			<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.	Patient Birth Year:	1971
11/19/2020	108507296	\$1,314.06	10/25/18 - 12/10/18	ACCT: 2297522	Payment amount based on \$13,422.55 patient balance after insurance and insurance adjustments.	Patient Initials:	A.R.
			<i>Approx Mail Date:</i>	11/22/2020			
			<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.	Patient Birth Year:	1999
11/19/2020	108507297	\$6,600.28	06/13/19 - 07/02/19	ACCT: 2976473	Payment amount based on \$10,539.00 patient balance after insurance and insurance adjustments.	Patient Initials:	M.D.
			<i>Approx Mail Date:</i>	11/22/2020	Total Bills exceed maximum award. Payment is prorated at 78.28401% among all providers.		
			<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.	Patient Birth Year:	1980
11/19/2020	108507298	\$1,503.20	07/03/19- 08/02/19	ACCT: 284099	Payment amount based on \$1,879.00 patient balance after insurance and insurance adjustments.	Patient Initials:	O.S.
			<i>Approx Mail Date:</i>	11/22/2020			
			<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.	Patient Birth Year:	1976
10/21/2020	108492639	\$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.	Patient Initials:	A.M.
			<i>Approx Mail Date:</i>	10/24/2020	Total Bills exceed maximum award. Payment is prorated at 7.92745% among all providers.		
			<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.	Patient Birth Year:	1977
10/21/2020	108492641	\$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.	Patient Initials:	J.B.
			<i>Approx Mail Date:</i>	10/24/2020	Total Bills exceed maximum award. Payment is prorated at 99.66612% among all providers.		
			<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.	Patient Birth Year:	2007

10/21/2020	108492642	\$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. Total Bills exceed maximum award. Payment is prorated at 51.81909% among all providers. Patient Initials: M.V. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1975
			Approx Mail Date: 10/24/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
10/21/2020	108492640	\$828.72	09/08/19	ACCT: 2995061	Payment amount based on \$2,540.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 40.78328% among all providers. Patient Initials: R.F. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1968
			Approx Mail Date: 10/24/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
10/21/2020	108492638	\$49.43	02/22/20	ACCT: 309907	Payment amount based on \$171.05 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: K.P. Patient Birth Year: 1971
			Approx Mail Date: 10/24/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
10/21/2020	108492636	\$108.59	01/25/20	ACCT: 3025014	Payment amount based on \$135.74 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: J.F. Patient Birth Year: 1978
			Approx Mail Date: 10/24/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
10/21/2020	108492637	\$1,680.00	05/25/19	ACCT: 289808	Payment amount based on \$2,100.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: T.J. Patient Birth Year: 1973
			Approx Mail Date: 10/24/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
9/18/2020	108476089	\$538.42	02/08/20 - 02/10/20	ACCT: 2979526	Payment amount based on \$710.05 patient balance after insurance and insurance adjustments. 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
			Approx Mail Date: 9/21/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
9/18/2020	108476084	\$10,174.11	03/22/20 - 04/21/20	ACCT: 3036540	Payment amount based on \$23,981.80 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 53.03037% among all providers. Patient Initials: C.C. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1987
			Approx Mail Date: 9/21/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
9/18/2020	108476085	\$1,832.80	06/17/18 - 07/03/18	ACCT: 273696	Payment amount based on \$2,291.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: C.J. Patient Birth Year: 1963
			Approx Mail Date: 9/21/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
9/18/2020	108476086	\$455.25	07/13/19 - 02/24/20	ACCT: 2982573	Payment amount based on \$27,706.50 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 2.053886% among all providers. Patient Initials: P.C. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1987
			Approx Mail Date: 9/21/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		

9/18/2020	108476087	\$4,457.70	09/19/19 - 02/14/20	ACCT: 1174810	Payment amount based on \$24,796.65 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
			Approx Mail Date: 9/21/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
9/18/2020	108476088	\$3,177.92	12/21/19 - 12/23/19	ACCT: 3018169	Payment amount based on \$3,972.40 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: D.M. Patient Birth Year: 1992
			Approx Mail Date: 9/21/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
9/18/2020	108476083	\$10.53	10/19/18	ACCT: 216064	Payment amount based on \$26.33 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: J.C. Patient Birth Year: 1989
			Approx Mail Date: 9/21/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
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. Total Bills exceed maximum award. Payment is prorated at 80.49522% among all providers. Patient Initials: S.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1975
			Approx Mail Date: 8/29/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
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. Total Bills exceed maximum award. Payment is prorated at 64.04706% among all providers. Patient Initials: J.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1987
			Approx Mail Date: 8/29/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
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. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: C.A. Patient Birth Year: 1989
			Approx Mail Date: 8/29/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
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. Total Bills exceed maximum award. Payment is prorated at 13.64039% among all providers. Patient Initials: S.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1996
			Approx Mail Date: 8/29/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
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. Total Bills exceed maximum award. Payment is prorated at 30.14325% among all providers. Patient Initials: J.N. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1962
			Approx Mail Date: 8/29/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
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. Total Bills exceed maximum award. Payment is prorated at 6.329409% among all providers. Patient Initials: A.K. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1997
			Approx Mail Date: 8/29/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		

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.
						<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.	<i>Patient Initials:</i>	F.R.
						<i>Patient Birth Year:</i>	1976
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.	<i>Patient Initials:</i>	C.K.
						<i>Patient Birth Year:</i>	1996
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.	<i>Patient Initials:</i>	E.R.
						<i>Patient Birth Year:</i>	1974
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.	<i>Patient Initials:</i>	R.S.
						<i>Patient Birth Year:</i>	1964
8/26/2020	108463975	\$12.80	6/18/19	ACCT: 2977436	Payment amount based on \$16.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.W.
						<i>Patient Birth Year:</i>	N/A
		\$570.49	11/06/16 - 02/19/19	ACCT: 446537	Payment amount based on \$15,876.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	R.L.
						<i>Patient Birth Year:</i>	1963
8/12/2020	108456664	\$7.50	2-12-20	ACCT:1491544	Payment amount based on \$9.38 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	M.S.
						<i>Patient Birth Year:</i>	1999

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. Patient Initials: T.J. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1968
	Approx Mail Date: 7/31/2020				
	Mail To Address: 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. Patient Initials: A.Q. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1993
	Approx Mail Date: 7/31/2020				
	Mail To Address: 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. Patient Initials: T.D. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1964
	Approx Mail Date: 7/30/2020				
	Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
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. 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
	Approx Mail Date: 7/31/2020				
	Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
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. 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
	Approx Mail Date: 7/31/2020				
	Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
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. 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
	Approx Mail Date: 7/31/2020				
	Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
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. Patient Initials: L.N. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1991
	Approx Mail Date: 7/31/2020				
	Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
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. Total Bills exceed maximum award. Payment is prorated at 30.18452% among all providers. Patient Initials: B.D. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1999
	Approx Mail Date: 6/18/2020				
	Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026				
6/15/2020	108432663	\$158.53	03/01/20	ACCT: 2861754	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. Patient Initials: C.A. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1998
	Approx Mail Date: 6/18/2020				
	Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026				

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. Total Bills exceed maximum award. Payment is prorated at 41.82931% among all providers. Patient Initials: D.R. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1989
			Approx Mail Date: 6/18/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
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. Total Bills exceed maximum award. Payment is prorated at 92.70327% among all providers. Patient Initials: D.F. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1991
			Approx Mail Date: 5/22/2020		
			Mail To Address: PO BOX 269026 OKLAHOMA CITY OK 73126-9026		
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. Patient Initials: J.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1988
			Approx Mail Date: 5/22/2020		
			Mail To Address: 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. Patient Initials: R.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1995
			Approx Mail Date: 5/22/2020		
			Mail To Address: 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. Patient Initials: B.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1995
			Approx Mail Date: 5/22/2020		
			Mail To Address: 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. Patient Initials: T.W. Patient Birth Year: 1961
			Approx Mail Date: 5/22/2020		
			Mail To Address: 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. Patient Initials: K.T. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1988
			Approx Mail Date: 5/22/2020		
			Mail To Address: 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. Patient Initials: J.W. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1988
			Approx Mail Date: 5/22/2020		
			Mail To Address: 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. Patient Initials: B.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1988
			Approx Mail Date: 5/22/2020		
			Mail To Address: 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.

Approx Mail Date: 4/25/2020

Patient Initials: S.G.

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: 1984

WESTERN MEDICAL EQUIPMENT #1

Office of State Finance VendorID:

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

Patient Identifiers

\$68.69 05/09/18 ACCT: 33898

Payment amount based on \$184.18 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 46.62222% among all providers. Patient Initials: C.J.

Mail To Address: P O BOX 236
TALOGA OK 73667-0236

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

N.R.H. EMSSTAT AMBULANCE SERVICES.

Office of State Finance VendorID: 0000061102

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

Patient Identifiers

6/18/2020 108434702 \$976.00 12/8/18 ACCT: N00885973

Payment amount based on \$1,220.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/21/2020

Patient Initials: C.C.

Mail To Address: PO BOX 268961
OKLAHOMA CITY OK 73126

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1997

SOUTHWEST ORTHOPAEDIC

Office of State Finance VendorID: 0000061138

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

Patient Identifiers

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.

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 269049
OKLAHOMA CITY OK 73126-9049

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

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.

Approx Mail Date: 5/22/2020

Patient Initials: M.W.

Mail To Address: PO BOX 269049
OKLAHOMA CITY OK 73126-9049

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

GILBERT MEDICAL CENTER

Office of State Finance VendorID: 0000176079

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

Patient Identifiers

12/21/2020 108523099 \$153.33 08/07/19 ACCT: 241204

Payment amount based on \$191.66 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/24/2020

Patient Initials: L.J.

Mail To Address: PO BOX 1998
OKLAHOMA CITY OK 73101

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

Patient Birth Year: 1977

THE PHYSICIANS GROUP

Office of State Finance VendorID: 0000061214

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

Patient Identifiers

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.

Approx Mail Date: 9/7/2020

Patient Initials: T.G.

Mail To Address: P O BOX 1998
OKLAHOMA CITY OK 73101-1998

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

Patient Birth Year: 1969

LOWELL-TIMS FUNERAL HOME

Office of State Finance VendorID: 0000239539

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

Patient Identifiers

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.

Approx Mail Date: 7/11/2020

Patient Initials: T.M.

Mail To Address: 1100 E TAMARACK RD
ALTUS OK 73521-1232

Patient Birth Year: 1989

REACT-EMS

Office of State Finance VendorID: 0000061247

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

Patient Identifiers

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.

Approx Mail Date: 9/21/2020

Patient Initials: K.C.

Mail To Address: 2316 N AIRPORT DR
SHAWNEE OK 74802-3700

Total Bills exceed maximum award. Payment is prorated at 94.78569% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1989

MMS OF OKLAHOMA CITY, INC

Office of State Finance VendorID: 0000183678

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

Patient Identifiers

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.

Approx Mail Date: 9/21/2020

Patient Initials: J.H.

Mail To Address: MAJORS MEDICAL SUPPLY 415 W WILSHIRE, SUITE A
OKLAHOMA CITY OK 73116

Total Bills exceed maximum award. Payment is prorated at 83.37431% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment.

Patient Birth Year: 1978

ALLIANCE HEALTH MIDWEST

Office of State Finance VendorID: 0000061360

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

Patient Identifiers

10/21/2020	108492712	\$3,859.38	01/03/19	ACCT: 844972501	Payment amount based on \$4,824.23 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> L.J.
	<i>Approx Mail Date:</i> 10/24/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1988
	<i>Mail To Address:</i> PO BOX 405970 ATLANTA GA 30384					
9/25/2020	108480200	\$2,601.46	3/4/2019	ACCT: 846095401	Payment amount based on \$3,251.83 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.Z.
	<i>Approx Mail Date:</i> 9/28/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1979
	<i>Mail To Address:</i> PO BOX 405970 ATLANTA GA 30384					
9/4/2020	108468982	\$16,240.96	2/16/2018 -2/17/2018	ACCT: 8384187	Payment amount based on \$21,576.51 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.J.
	<i>Approx Mail Date:</i> 9/7/2020				Total Bills exceed maximum award. Payment is prorated at 94.08936% among all providers.	<i>Patient Birth Year:</i> 1974
	<i>Mail To Address:</i> PO BOX 405970 ATLANTA GA 30384				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
8/26/2020	108464100	\$19,588.60	04/10/19	ACCT: 8467710-01	Payment amount based on \$24,902.30 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.S.
	<i>Approx Mail Date:</i> 8/29/2020				Total Bills exceed maximum award. Payment is prorated at 98.32726% among all providers.	<i>Patient Birth Year:</i> 1979
	<i>Mail To Address:</i> PO BOX 405970 ATLANTA GA 30384				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
8/26/2020	108464101	\$18,279.23	08/22/19	ACCT: 549263901	Payment amount based on \$24,899.63 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.S.
	<i>Approx Mail Date:</i> 8/29/2020				Total Bills exceed maximum award. Payment is prorated at 91.76457% among all providers.	<i>Patient Birth Year:</i> 1979
	<i>Mail To Address:</i> PO BOX 405970 ATLANTA GA 30384				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
8/12/2020	108456753	\$389.63	2/14/2019	ACCT:845761701	Payment amount based on \$487.04 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 405970 ATLANTA GA 30384					
6/3/2020	108427451	\$3,178.88	04/23/19	ACCT: 010181050 - \$2,199.08; 8470097 - \$979.80	Payment amount based on \$3,973.60 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> S.D.
	<i>Approx Mail Date:</i> 6/6/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1959
	<i>Mail To Address:</i> PO BOX 405970 ATLANTA GA 30384					
5/19/2020	108421327	\$13,637.24	02/02/19	ACCT: 845537101	Payment amount based on \$17,046.55 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> S.G.
	<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> 1985
	<i>Mail To Address:</i> PO BOX 405970 ATLANTA GA 30384					

MIDWEST REGIONAL HOSPITAL

Office of State Finance VendorID: 0000061360

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

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.	
						<i>Patient Initials:</i> H.K.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1993

Approx Mail Date: 9/28/2020

Mail To Address: PO BOX 405970
ATLANTA GA 30384-5970

PULMONARY SPECIALISTS, LLC

Office of State Finance VendorID: 0000076059

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
1/22/2021	108536113	\$187.34	01/01/20 - 02/07/20	ACCT: 66074V3057	Payment amount based on \$234.18 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> L.H.
				ATTN #8340J	Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1966

Approx Mail Date: 1/25/2021

Mail To Address: PO BOX 14000
BELFAST ME 04915-4033

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>
1/22/2021	108536090	\$8,248.59	08/29/18	ACCT: 5400307451	Payment amount based on \$11,876.69 patient balance after insurance and insurance adjustments.	
					Total Bills exceed maximum award. Payment is prorated at 86.81496% among all providers.	<i>Patient Initials:</i> A.S.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1992
7/28/2020	108449499	\$418.95	10/24/18 AND 10/31/18	ACCT: 54000331360 - \$298.95; 54000334512 - \$120.00	Payment amount based on \$523.69 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

Approx Mail Date: 1/25/2021

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

Approx Mail Date: 7/31/2020

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

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	Payment amount based on \$4,316.00 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> B.B.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1969

Approx Mail Date: 10/4/2020

Mail To Address: ONE PLAZA SOUTH PMB 149
TAHLEQUAH OK 74464

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>
1/22/2021	108536092	\$164.19	03/06/20 - 03/20/20	ACCT: 20526	Payment amount based on \$205.24 patient balance after insurance and insurance adjustments.	
						<i>Patient Initials:</i> L.H.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1966

Approx Mail Date: 1/25/2021

Mail To Address: 4120 W MEMORIAL RD STE 118
OKLAHOMA CITY OK 73120-9322

5/19/2020 108421284 \$2,032.00 02/02/19 ACCT: 0079392872

Payment amount based on \$2,540.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/22/2020

Patient Initials: S.G.

Mail To Address: PO BOX 96408
OKLAHOMA CITY OK 73143

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

Patient Birth Year: 1985

JUSTIN LIVELY, DDS

Office of State Finance VendorID: 0000522188

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

Patient Identifiers

\$6,235.20 12/02/20 - 01/12/21 ACCT: GR0090

Payment amount based on \$7,794.00 patient balance after insurance and insurance adjustments.

Patient Initials: J.G.

Approx Mail Date: Requested from OSF 1/22/21 Expected to be mailed by 2/5/21

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

Patient Birth Year: 2000

Mail To Address: 230 E JEFFERSON
MANGUM OK 73554

RICK J. KRAUSE

Office of State Finance VendorID:

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

Patient Identifiers

\$170.37 5/8/20-5/29/20 ACCT: B.S.

Payment amount based on \$212.96 patient balance after insurance and insurance adjustments.

Patient Initials: B.S.

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

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

Patient Birth Year: 1972

Mail To Address: 4435 NW 36TH ST
OKC OK 73112

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.

Patient Initials: J.N.

Approx Mail Date: 8/29/2020

Total Bills exceed maximum award. Payment is prorated at 30.14325% among all providers.

Patient Birth Year: 1962

Mail To Address: PO BOX 108818
OKLAHOMA CITY OK 73101

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.

Patient Initials: S.L.

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

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

Patient Birth Year: 1996

Mail To Address: PO BOX 6405
NORMAN OK 73070-6405

TULSA BONE AND JOINT ASSOCIATES

Office of State Finance VendorID: 0000062557

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

Patient Identifiers

1/22/2021	108536144	\$887.62	06/12/20 - 09/28/20	ACCT: 276329	Payment amount based on \$3,702.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 29.9709% among all providers. Patient Initials: J.H. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1991
<i>Approx Mail Date:</i> 1/25/2021					
<i>Mail To Address:</i> PO BOX 258813 OKLAHOMA CITY OK 73125-8813					
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. Total Bills exceed maximum award. Payment is prorated at 1.572509% among all providers. Patient Initials: D.B. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1973
<i>Approx Mail Date:</i> 10/4/2020					
<i>Mail To Address:</i> PO BOX 258813 OKLAHOMA CITY OK 73125-8813					
9/18/2020	108476203	\$1,224.00	03/10/20 - 04/23/20	ACCT: 272381	Payment amount based on \$1,530.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: J.S. Patient Birth Year: 1988
<i>Approx Mail Date:</i> 9/21/2020					
<i>Mail To Address:</i> PO BOX 258813 OKLAHOMA CITY OK 73125-8813					
7/28/2020	108449579	\$27.46	11/26/19 - 12/24/19	ACCT: 264487	Payment amount based on \$34.33 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: M.S. Patient Birth Year: 1964
<i>Approx Mail Date:</i> 7/31/2020					
<i>Mail To Address:</i> PO BOX 258813 OKLAHOMA CITY OK 73125-8813					

G-EAGLE CORP.

Office of State Finance VendorID: 0000291138

<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	108482942	\$1,362.50	09/02/20	ACCT: U.A.	Payment amount based on \$1,362.50 patient balance after insurance and insurance adjustments. Patient Initials: U.A. Patient Birth Year: 1968
<i>Approx Mail Date:</i> 10/4/2020					
<i>Mail To Address:</i> 502 SW SHERIDAN LAWTON OK 73505-1525					

ANADARKO MONUMENT CO.

Office of State Finance VendorID: 0000291138

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/22/2021	108536019	\$1,415.29	9/20/2018	FUNERAL REIMBURSEMENT	Payment amount based on \$1,415.29 patient balance after insurance and insurance adjustments. Patient Initials: B.T. Patient Birth Year: 1986
<i>Approx Mail Date:</i> 1/25/2021					
<i>Mail To Address:</i> PO BOX 112 ANADARKO OK 73005					
4/14/2020	108406799	\$1,346.85	3/20/20	ACCT: F.N.M.	Payment amount based on \$1,346.85 patient balance after insurance and insurance adjustments. Patient Initials: F.M. Patient Birth Year: 1982
<i>Approx Mail Date:</i> 4/17/2020					
<i>Mail To Address:</i> PO BOX 112 ANADARKO OK 73005					
4/14/2020	108406798	\$1,346.85	3/20/20	ACCT: M.C.M.	Payment amount based on \$1,346.85 patient balance after insurance and insurance adjustments. Patient Initials: M.M. Patient Birth Year: 1995
<i>Approx Mail Date:</i> 4/17/2020					
<i>Mail To Address:</i> PO BOX 112 ANADARKO OK 73005					

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

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>
12/28/2020	108525438	\$2,000.00	05/21/20	ACCT: D.O.	Payment amount based on \$2,818.12 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 12/31/2020					<i>Patient Initials:</i> D.O.
<i>Mail To Address:</i> PO BOX 1528 MUSKOGEE OK 74402-1528					<i>Patient Birth Year:</i> 1974
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

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>
8/26/2020	108464103	\$120.00	11/19/19	ACCT: COLLA005	Payment amount based on \$150.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 8/29/2020					<i>Patient Initials:</i> L.C.
<i>Mail To Address:</i> P O BOX 700930 TULSA OK 74170					<i>Patient Birth Year:</i> 1959
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

SOUTHEAST OK ORAL & MAXILLOFACIAL SURGERY*Office of State Finance VendorID:* 0000063038

<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 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 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1968
 ADA OK 74820

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 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1990
 TULSA OK 74137-4230

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 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1943
 TULSA OK 74137-4230

MALLORY FUNERAL HOME

Office of State Finance VendorID: 0000063080

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

1/12/2021 108530340 \$2,925.00 10/04/19 ACCT: G.L.D. Payment amount based on \$2,925.00 patient balance after insurance and insurance adjustments.
Approx Mail Date: 1/15/2021 *Patient Initials:* G.D.
Mail To Address: PO BOX 717 STIGLER OK 74462-0717 *Patient Birth Year:* 1952

OU PATHOLOGY

Office of State Finance VendorID: 0000185546

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

1/22/2021 108536101 \$567.52 05/29/18 AND 07/10/18 - 07/17/18 ACCT: 5062*6622678114 - \$36.80; 5062*662722404 - \$530.72 Payment amount based on \$709.40 patient balance after insurance and insurance adjustments.
Approx Mail Date: 1/25/2021 *Patient Initials:* F.E.
Mail To Address: PO BOX 269048 OKLAHOMA CITY OK 73126-9048 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1977

12/17/2020 108521281 \$346.90 01/27/20 ACCT: 997000228658 Payment amount based on \$526.55 patient balance after insurance and insurance adjustments.
Approx Mail Date: 12/20/2020 Total Bills exceed maximum award. Payment is prorated at 82.35184% among all providers. *Patient Initials:* K.O.
Mail To Address: PO BOX 269048 OKLAHOMA CITY OK 73126-9048 Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1979

12/15/2020	108519541	\$48.00	05/22/19	ACCT: 5062*665580949	Payment amount based on \$60.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	M.D.
	<i>Approx Mail Date:</i>	12/18/2020				<i>Patient Birth Year:</i>	1970
	<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.		
11/19/2020	108507384	\$28.15	10/25/18 - 10/30/18	ACCT: 5062*99900479718	Payment amount based on \$287.56 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	A.R.
	<i>Approx Mail Date:</i>	11/22/2020				<i>Patient Birth Year:</i>	1999
	<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.		
10/21/2020	108492724	\$65.80	05/28/20	ACCT: 5062*99900704717	Payment amount based on \$82.53 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.B.
	<i>Approx Mail Date:</i>	10/24/2020			Total Bills exceed maximum award. Payment is prorated at 99.66612% among all providers.	<i>Patient Birth Year:</i>	2007
	<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.		
10/21/2020	108492723	\$14.97	02/22/20	ACCT: 5062*99900540909.1	Payment amount based on \$51.75 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	K.P.
	<i>Approx Mail Date:</i>	10/24/2020				<i>Patient Birth Year:</i>	1971
	<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.		
9/18/2020	108476159	\$184.53	02/08/20 - 02/10/20	ACCT: 5062*99900539235	Payment amount based on \$243.35 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 269048 OKLAHOMA CITY OK 73126-9048			Acceptance of payment may require a provider write-off. EOB will accompany payment.		
9/18/2020	108476156	\$1,341.03	03/22/20 - 04/21/20	ACCT: 5062*99900544565	Payment amount based on \$3,161.00 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 269048 OKLAHOMA CITY OK 73126-9048			Acceptance of payment may require a provider write-off. EOB will accompany payment.		
9/18/2020	108476157	\$22.92	07/12/19 - 08/20/19	ACT: 5062*999000218579	Payment amount based on \$1,395.10 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 269048 OKLAHOMA CITY OK 73126-9048			Acceptance of payment may require a provider write-off. EOB will accompany payment.		
9/18/2020	108476158	\$370.11	09/19/19 - 09/30/19	ACCT: 5062*9990520628	Payment amount based on \$2,058.80 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 269048 OKLAHOMA CITY OK 73126-9048			Acceptance of payment may require a provider write-off. EOB will accompany payment.		
8/26/2020	108464130	\$281.96	03/02/20 - 03/07/20	ACCT: 5062*99900542131	Payment amount based on \$437.85 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	S.S.
	<i>Approx Mail Date:</i>	8/29/2020			Total Bills exceed maximum award. Payment is prorated at 80.49522% among all providers.	<i>Patient Birth Year:</i>	1975
	<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.		

8/26/2020	108464129	\$15.14	02/05/20 - 02/27/20	ACCT: 5062*99900538815	Payment amount based on \$299.10 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 6.329409% among all providers. Patient Initials: A.K. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1997
	Approx Mail Date: 8/29/2020				
	Mail To Address: PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
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. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: R.J. Patient Birth Year: 2003
	Approx Mail Date: 9/7/2020				
	Mail To Address: PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
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. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: C.K. Patient Birth Year: 1996
	Approx Mail Date: 8/29/2020				
	Mail To Address: PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
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. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: J.W. Patient Birth Year: N/A
	Approx Mail Date: 8/29/2020				
	Mail To Address: PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
	\$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. 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
	Approx Mail Date: Requested from OSF 1/9/18 Expected to be mailed by 1/23/18				
	Mail To Address: PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
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. 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
	Approx Mail Date: 7/31/2020				
	Mail To Address: PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
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. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: L.N. Patient Birth Year: 1991
	Approx Mail Date: 7/31/2020				
	Mail To Address: PO BOX 269048 OKLAHOMA CITY OK 73126-9048				
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. Total Bills exceed maximum award. Payment is prorated at 30.18452% among all providers. Patient Initials: B.D. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1999
	Approx Mail Date: 6/18/2020				
	Mail To Address: PO BOX 269048 OKLAHOMA CITY OK 73126-9048				

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>Patient Initials:</i> R.B.
	<i>Approx Mail Date:</i> 6/6/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1996
	<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048					
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.	<i>Patient Initials:</i> D.F.
	<i>Approx Mail Date:</i> 5/22/2020				Total Bills exceed maximum award. Payment is prorated at 92.70327% among all providers.	<i>Patient Birth Year:</i> 1991
	<i>Mail To Address:</i> 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.	<i>Patient Initials:</i> T.W.
	<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> 1961
	<i>Mail To Address:</i> 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.	<i>Patient Initials:</i> R.W.
	<i>Approx Mail Date:</i> 5/22/2020				Total Bills exceed maximum award. Payment is prorated at 11.33645% among all providers.	<i>Patient Birth Year:</i> 1995
	<i>Mail To Address:</i> PO BOX 269048 OKLAHOMA CITY OK 73126-9048					

THE PATHOLOGY GROUP

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>
12/17/2020	108521282	\$24.00	07/08/20	ACCT: 5166127196342	Payment amount based on \$30.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> G.J.
	<i>Approx Mail Date:</i> 12/20/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 2000
	<i>Mail To Address:</i> PO BOX 268984 OKLAHOMA CITY OK 73126					

BROWN'S FUNERAL SERVICE

Office of State Finance VendorID: 0000063314

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
1/12/2021	108530258	\$7,500.00	04/20/19	ACCT: N.C.	Payment amount based on \$8,198.84 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> B.C.
	<i>Approx Mail Date:</i> 1/15/2021					<i>Patient Birth Year:</i> 1988
	<i>Mail To Address:</i> 718 WEST 13TH ATOKA OK 74525					

BROWN'S DURANT FUNERAL HOME

Office of State Finance VendorID: 0000063316

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
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.	<i>Patient Initials:</i> L.G.
	<i>Approx Mail Date:</i> 9/28/2020					<i>Patient Birth Year:</i> 2020
	<i>Mail To Address:</i> PO BOX 966 DURANT OK 74702-0966					

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 *Patient Birth Year:* 2020
 DURANT OK 74702-0966

PARKS FUNERAL HOME

Office of State Finance VendorID: 0000243236

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
12/2/2020	108511978	\$838.80	08/24/20	ACCT: T.B.	Payment amount based on \$838.80 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 12/5/2020				<i>Patient Initials:</i> T.B.
		<i>Mail To Address:</i> P O BOX 271				<i>Patient Birth Year:</i> 1962
		OKEMAH OK 74859				
10/22/2020	108493518	\$838.80	2/29/2020	ACCT: T.R.	Payment amount based on \$838.80 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 10/25/2020				<i>Patient Initials:</i> T.R.
		<i>Mail To Address:</i> P O BOX 271				<i>Patient Birth Year:</i> 1998
		OKEMAH OK 74859				
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.	
		<i>Approx Mail Date:</i> 6/6/2020				<i>Patient Initials:</i> T.B.
		<i>Mail To Address:</i> P O BOX 271				<i>Patient Birth Year:</i> 1962
		OKEMAH OK 74859				

TULSA HOSPITALISTS, INC.

Office of State Finance VendorID: 0000063457

<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	108464217	\$388.00	11/19/19 - 11/20/19	ACCT: COLLA009	Payment amount based on \$485.00 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 8/29/2020				<i>Patient Initials:</i> L.C.
		<i>Mail To Address:</i> PO BOX 700930			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1959
		TULSA OK 74170-0930				

MEDICAL X-RAY CONSULTANTS PLLC

Office of State Finance VendorID: 0000063461

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
10/21/2020	108492705	\$911.20	09/28/19	ACCT: 353687	Payment amount based on \$1,139.00 patient balance after insurance and insurance adjustments.	
		<i>Approx Mail Date:</i> 10/24/2020				<i>Patient Initials:</i> B.S.
		<i>Mail To Address:</i> PO BOX 2419			Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 2002
		ADA OK 74821-2419				

HUDSON-PHILLIPS FUNERAL HOME

Office of State Finance VendorID: 0000200961

<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 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>
12/11/2020	108517610	\$3,872.00	12/26/17-1/23/2018	M.S - 12/26/17 - 1/31/2019 \$1,350.00; M.P 12/26/2017 - 1/29/19 \$1,100.00; C.S. 1/12/2017 - 1/23/19 \$1,190.00; K.P. 1/12/2017 - 1/23/19 \$1,190.00	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: 12/14/2020
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>
11/19/2020	108507349	\$1,243.30	11/23/18	ACCT: 601531741 - \$1,142.79; 66520204-51-1862 - \$100.51	Payment amount based on \$12,699.83 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> A.R.
					Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1999

Approx Mail Date: 11/22/2020
Mail To Address: 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.	Patient Initials: C.M.
	<i>Approx Mail Date:</i> 7/30/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1991
	<i>Mail To Address:</i> P O BOX 268871 OKLAHOMA CITY OK 73126					
7/27/2020	108448970	\$20.00	5/14/2019	ACCT:109100209	Payment amount based on \$25.00 patient balance after insurance and insurance adjustments.	Patient Initials: C.M.
	<i>Approx Mail Date:</i> 7/30/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1991
	<i>Mail To Address:</i> 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.	Patient Initials: C.M.
	<i>Approx Mail Date:</i> 7/30/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 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.	Patient Initials: C.M.
	<i>Approx Mail Date:</i> 7/30/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1991
	<i>Mail To Address:</i> P O BOX 268871 OKLAHOMA CITY OK 73126					

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.	Patient Initials: L.C.
	<i>Approx Mail Date:</i> 7/31/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: N/A
	<i>Mail To Address:</i> 6151 S. YALE AVE. SUITE 2402 TULSA OK 74136					

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>
10/16/2020	108490754	\$1,141.00	8/25/20	ACCT: T.G.	Payment amount based on \$1,141.00 patient balance after insurance and insurance adjustments.	Patient Initials: T.G.
	<i>Approx Mail Date:</i> 10/19/2020					Patient Birth Year: 2003
	<i>Mail To Address:</i> 2103 E 3RD ST TULSA OK 74104-1817					
10/16/2020	108490753	\$1,141.00	8/25/20	ACCT: R.G.	Payment amount based on \$1,141.00 patient balance after insurance and insurance adjustments.	Patient Initials: R.G.
	<i>Approx Mail Date:</i> 10/19/2020					Patient Birth Year: 2007
	<i>Mail To Address:</i> 2103 E 3RD ST TULSA OK 74104-1817					

BUTLER-STUMPF FUNERAL HOME

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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9/4/2020 108469018 \$1,200.00 8/12/2019 ACCOUNT: A.D.

Payment amount based on \$1,200.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/7/2020

Patient Initials: A.T.

Mail To Address: 2103 E 3RD STREET
TULSA OK 74104

Patient Birth Year: 1998

STUMPF MONUMENT COMPANY

Office of State Finance VendorID: 0000063923

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

Patient Identifiers

10/22/2020 108493536 \$1,800.00 8/21/20 ACCT:J.G.

Payment amount based on \$1,800.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/25/2020

Patient Initials: J.G.

Mail To Address: 9120 SOUTH TOLEDO AVE
TULSA OK 74137

Patient Birth Year: 1970

PATHWAYS PROFESSIONAL COUNSELING

Office of State Finance VendorID: 0000064102

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

Patient Identifiers

12/30/2020 108526156 \$340.00 8/6/20-9/3/20 ACCT: I.G.

Payment amount based on \$425.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/2/2021

Patient Initials: I.G.

Mail To Address: 13707 FAIRHILL AVE
OKLAHOMA CITY OK 73013

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

Patient Birth Year: 2018

NORTHEASTERN OKLA COMMUNITY HLTH CTRS

Office of State Finance VendorID: 0000217404

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

Patient Identifiers

1/22/2021 108536094 \$19.83 0924/19 - 04/29/20 ACCT: 56503

Payment amount based on \$545.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/25/2021

Total Bills exceed maximum award. Payment is prorated at 4.547349% among all providers.

Patient Initials: T.J.

Mail To Address: PO BOX 751
HULBERT OK 74441-0751

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

Patient Birth Year: 1977

RESTHAVEN-SUNSET MEMORIAL PARKS

Office of State Finance VendorID: 0000064187

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

Patient Identifiers

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.

Approx Mail Date: 7/11/2020

Patient Initials: J.T.

Mail To Address: PO BOX 1029
PONCA CITY OK 74602

Patient Birth Year: 1979

ARKANSAS VISION DEVELOPMENT CENTER

Office of State Finance VendorID: 0000510320

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

Patient Identifiers

8/12/2020 108456651 \$32.00 5/4/17 ACCT:731724452

Payment amount based on \$40.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/15/2020

Patient Initials: K.C.

Mail To Address: 1021 SOUTH WALDRON ROAD
FORT SMITH AR 72903-2555

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

Patient Birth Year: 1996

ANADARKO FIRE DEPARTMENT EMS

Office of State Finance VendorID: 0000064265

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

Patient Identifiers

1/22/2021 108536052 \$752.00 8/16/20 ACCT: 20-95304

Payment amount based on \$940.00 patient balance after insurance and insurance adjustments.

Patient Initials: E.M.

Approx Mail Date: 1/25/2021

Mail To Address: PO BOX 641880
OMAHA NE 68164

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

Patient Birth Year: 2002

ANTLERS FIRE/EMS

Office of State Finance VendorID: 0000076851

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

Patient Identifiers

12/17/2020 108521210 \$676.72 04/28/19 ACCT: 4716

Payment amount based on \$845.90 patient balance after insurance and insurance adjustments.

Patient Initials: M.M.

Approx Mail Date: 12/20/2020

Mail To Address: 100 SE 2ND
ANTLERS OK 74523

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

Patient Birth Year: 1985

CITY OF CHICKASHA EMS

Office of State Finance VendorID: 0000064271

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

Patient Identifiers

7/8/2020 108441694 \$523.20 04/10/19 ACCT: 00190072322

Payment amount based on \$654.00 patient balance after insurance and insurance adjustments.

Patient Initials: G.J.

Approx Mail Date: 7/11/2020

Mail To Address: 1700 HARLY DAY DRIVE
CHICKASHA OK 73018-1640

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

Patient Birth Year: 1966

CITY OF GUTHRIE EMS

Office of State Finance VendorID: 0000064282

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

Patient Identifiers

10/21/2020 108492647 \$423.93 02/22/20 ACCT: 56340607

Payment amount based on \$1,467.00 patient balance after insurance and insurance adjustments.

Patient Initials: K.P.

Approx Mail Date: 10/24/2020

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: 1971

7/28/2020 108449434 \$532.82 02/22/20 ACCT: 56340609

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

Patient Initials: T.J.

Approx Mail Date: 7/31/2020

Mail To Address: PO BOX 908
GUTHRIE OK 73044-0908

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

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

CITY OF MCALESTER-EMS

Office of State Finance VendorID: 0000076918

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
11/19/2020	108507308	\$212.23	07/12/20	ACCT: 57740562	Payment amount based on \$647.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 41.00276% among all providers. <i>Patient Initials:</i> D.D. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1998
<i>Approx Mail Date:</i> 11/22/2020					
<i>Mail To Address:</i> PO BOX 578 MCALESTER OK 74502-0578					
11/18/2020	108506193	\$517.60	4/18/20	ACCT:5687B242	Payment amount based on patient balance after insurance and insurance adjustments. <i>Patient Initials:</i> A.M. <i>Patient Birth Year:</i> 1994
<i>Approx Mail Date:</i> 11/21/2020					
<i>Mail To Address:</i> PO BOX 578 MCALESTER OK 74502-0578					

OKLAHOMA TAX COMMISSION

Office of State Finance VendorID: 0000000695

<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	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. <i>Patient Initials:</i> A.B. <i>Patient Birth Year:</i> 1977
<i>Approx Mail Date:</i> 9/26/2020					
<i>Mail To Address:</i> PO BOX 269058 OKLAHOMA CITY OK 73126-9058					

DEAN A. MCGEE EYE INSTITUTE

Office of State Finance VendorID: 0000064505

<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	108456701	\$43.59	12/19/2019-2/4/20	ACCT:335433	Payment amount based on \$54.49 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> D.J. <i>Patient Birth Year:</i> 1974
<i>Approx Mail Date:</i> 8/15/2020					
<i>Mail To Address:</i> PO BOX 27167 SALT LAKE CITY UT 84127-0167					

NORTHEASTERN HEALTH SYSTEM

Office of State Finance VendorID: 0000386462

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/22/2021	108536093	\$760.33	08/27/19	ACCT: 2000059263	Payment amount based on \$950.41 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.J. <i>Patient Birth Year:</i> 1977
<i>Approx Mail Date:</i> 1/25/2021					
<i>Mail To Address:</i> 1400 E DOWNING ST TAHLEQUAH OK 74464					

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. Total Bills exceed maximum award. Payment is prorated at 65.86092% among all providers. Patient Initials: R.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1964
<i>Approx Mail Date:</i> 8/29/2020					
<i>Mail To Address:</i> PO BOX 268961 OKLAHOMA CITY OK 73126					
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. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: J.W. Patient Birth Year: 1981
<i>Approx Mail Date:</i> 7/31/2020					
<i>Mail To Address:</i> PO BOX 268961 OKLAHOMA CITY OK 73126					
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. Total Bills exceed maximum award. Payment is prorated at 48.54606% among all providers. Patient Initials: S.L. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1996
<i>Approx Mail Date:</i> 7/31/2020					
<i>Mail To Address:</i> PO BOX 268961 OKLAHOMA CITY OK 73126					
6/3/2020	108427459	\$3,882.00	12/02/19	ACCT: N00889760052 - \$2,358.00; N00889784547 - \$1,280.00; N00889811340 - \$244.00	Payment amount based on \$4,852.50 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: B.O. Patient Birth Year: 1990
<i>Approx Mail Date:</i> 6/6/2020					
<i>Mail To Address:</i> PO BOX 268961 OKLAHOMA CITY OK 73126					
5/19/2020	108421333	\$11,795.20	09/25/19	ACCT: N00888858067 - \$11,551.20; N00888868089 - \$244.00	Payment amount based on \$14,744.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: N.N. Patient Birth Year: 1979
<i>Approx Mail Date:</i> 5/22/2020					
<i>Mail To Address:</i> PO BOX 268961 OKLAHOMA CITY OK 73126					

CHOCTAW MEMORIAL HOSPITAL

Office of State Finance VendorID: 0000077143

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
11/19/2020	108507307	\$995.81	03/28/18	ACCT: 10149435	Payment amount based on \$2,346.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 53.05898% among all providers. Patient Initials: K.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1985
<i>Approx Mail Date:</i> 11/22/2020					
<i>Mail To Address:</i> 1405 E KIRK ST HUGO OK 74743-3603					

EOMC

Office of State Finance VendorID: 0000186232

<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	108456711	\$421.10	5/3/17	ACCT:361774	Payment amount based on \$526.38 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: K.C. Patient Birth Year: 1996
<i>Approx Mail Date:</i> 8/15/2020					
<i>Mail To Address:</i> PO BOX 1148 POTEAU OK 74953-1148					

6/3/2020	108427409	\$436.44	01/18/20	ACCT: 455219	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.M.
	<i>Approx Mail Date:</i> 6/6/2020					<i>Patient Birth Year:</i> 1995
	<i>Mail To Address:</i> PO BOX 1148 POTEAU OK 74953-1148					

PUSHMATAHA HOSPITAL

Office of State Finance VendorID: 0000064439

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
1/12/2021	108530361	\$3,790.38	11/19/19	ACCT: 10049499	Payment amount based on \$4,737.98 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> C.B.
	<i>Approx Mail Date:</i> 1/15/2021					<i>Patient Birth Year:</i> 1995
	<i>Mail To Address:</i> PO BOX 518 ANTLERS OK 74523-0518				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
12/11/2020	108517664	\$64.00	11/4/2018	ACCT: 10044216	Payment amount based on \$80.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> K.G.
	<i>Approx Mail Date:</i> 12/14/2020					<i>Patient Birth Year:</i> 1971
	<i>Mail To Address:</i> PO BOX 518 ANTLERS OK 74523-0518				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

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.	<i>Patient Initials:</i> J.N.
	<i>Approx Mail Date:</i> 8/29/2020				Total Bills exceed maximum award. Payment is prorated at 30.14325% among all providers.	<i>Patient Birth Year:</i> 1962
	<i>Mail To Address:</i> 2220 W IOWA AVE CHICKASHA OK 73018				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
8/17/2020	108459194	\$1,285.83	03/01/19	ACCT: G001121518	Payment amount based on \$1,607.29 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> R.J.
	<i>Approx Mail Date:</i> 8/20/2020					<i>Patient Birth Year:</i> 2000
	<i>Mail To Address:</i> 2220 W IOWA AVE CHICKASHA OK 73018				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
7/27/2020	108448962	\$320.00	7/10/2019	ACCT: G001146247	Payment amount based on \$400.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> W.M.
	<i>Approx Mail Date:</i> 7/30/2020					<i>Patient Birth Year:</i> 1981
	<i>Mail To Address:</i> 2220 W IOWA AVE CHICKASHA OK 73018				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
7/27/2020	108448963	\$200.00	7/25/2019	ACCT: G001148774	Payment amount based on \$250.00 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> W.M.
	<i>Approx Mail Date:</i> 7/30/2020					<i>Patient Birth Year:</i> 1981
	<i>Mail To Address:</i> 2220 W IOWA AVE CHICKASHA OK 73018				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
7/8/2020	108441717	\$4,969.17	04/10/19	ACCT: G001129405	Payment amount based on \$6,211.46 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> 2220 W IOWA AVE CHICKASHA OK 73018				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

7/28/2020 108449445 \$177.80 05/09/18 AND 10/16/18 ACCT: 620532

Approx Mail Date: 7/31/2020

Mail To Address: PO BOX 26507
OKLAHOMA CITY OK 73126

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. Patient Initials: C.J.

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

5/19/2020 108421268 \$25.39 06/17/19 - 07/30/19 ACCT: 640500

Approx Mail Date: 5/22/2020

Mail To Address: PO BOX 26507
OKLAHOMA CITY OK 73126

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. Patient Initials: R.W.

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

STEPHENS GENERAL DENTISTRY

Office of State Finance VendorID: 0000064519

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

4/14/2020 108406901 \$1,226.16 06/13/18 - 08/16/18 ACCT: 2026900

Approx Mail Date: 4/17/2020

Mail To Address: 3518 CHANDLER ROAD
MUSKOGEE OK 74403

Payment amount based on \$1,532.70 patient balance after insurance and insurance adjustments.

Patient Initials: S.G.

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

PERRY MEMORIAL HOSPITAL

Office of State Finance VendorID: 0000064543

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

10/1/2020 108482965 \$3,825.60 03/04/20, 07/14/20, 07/23/20 ACCT: 141600 - \$88.00; 144667 - \$128.00; PE0000009063 - \$3,609.60

Approx Mail Date: 10/4/2020

Mail To Address: 501 N 14TH ST
PERRY OK 73077-5021

Payment amount based on \$4,782.00 patient balance after insurance and insurance adjustments.

Patient Initials: K.R.

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

BILLINGS FUNERAL HOME

Office of State Finance VendorID: 0000231015

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

4/22/2020 108410283 \$7,500.00 1/7/20 ACCT: M.L.

Approx Mail Date: 4/25/2020

Mail To Address: 1621 DOWNS AVENUE
WOODWARD OK 73801

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

Patient Initials: M.L.

Patient Birth Year: 1975

MC CURTAIN MEMORIAL HOSPITAL

Office of State Finance VendorID: 0000064669

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

1/22/2021 108536089 \$283.31 9/25/20 ACCT: 1206641

Approx Mail Date: 1/25/2021

Mail To Address: 1301 E. LINCOLN RD
IDABEL OK 74745-7300

Payment amount based on \$354.14 patient balance after insurance and insurance adjustments.

Patient Initials: L.R.

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

1/22/2021	108536088	\$902.95	3/20/20	ACCT: 1191564	Payment amount based on \$1,128.69 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	C.G.
	<i>Approx Mail Date:</i> 1/25/2021					<i>Patient Birth Year:</i>	1969
	<i>Mail To Address:</i> 1301 E. LINCOLN RD						
			IDABEL OK 74745-7300				
1/12/2021	108530345	\$4,144.77	12/29/19	ACCT: 1185373	Payment amount based on \$5,180.96 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	R.F.
	<i>Approx Mail Date:</i> 1/15/2021					<i>Patient Birth Year:</i>	1959
	<i>Mail To Address:</i> 1301 E. LINCOLN RD						
			IDABEL OK 74745-7300				
10/21/2020	108492703	\$5,965.20	05/16/20	ACCT: 64482 - \$288.00; 1194623 - \$5,677.20	Payment amount based on \$7,456.50 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.B.
	<i>Approx Mail Date:</i> 10/24/2020					<i>Patient Birth Year:</i>	1994
	<i>Mail To Address:</i> 1301 E. LINCOLN RD						
			IDABEL OK 74745-7300				
10/21/2020	108492702	\$5,594.12	09/02/18	ACCT: 1151454	Payment amount based on \$6,992.65 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.C.
	<i>Approx Mail Date:</i> 10/24/2020					<i>Patient Birth Year:</i>	1980
	<i>Mail To Address:</i> 1301 E. LINCOLN RD						
			IDABEL OK 74745-7300				
10/16/2020	108490803	\$751.64	10-31-19	ACCT: 1181149	Payment amount based on \$939.55 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	G.C.
	<i>Approx Mail Date:</i> 10/19/2020					<i>Patient Birth Year:</i>	1979
	<i>Mail To Address:</i> 1301 E. LINCOLN RD						
			IDABEL OK 74745-7300				
8/26/2020	108464094	\$7,530.88	04/11/18 AND 04/25/18	ACCTI 1142548	Payment amount based on \$9,413.60 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	T.P.
	<i>Approx Mail Date:</i> 8/29/2020					<i>Patient Birth Year:</i>	1987
	<i>Mail To Address:</i> 1301 E. LINCOLN RD						
			IDABEL OK 74745-7300				
8/12/2020	108456745	\$824.94	3/5/20	ACCT: 1190573 \$536.94 ACCT:267248Z41537 \$288.00	Payment amount based on patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i>	J.T.
	<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Birth Year:</i>	1968
	<i>Mail To Address:</i> 1301 E. LINCOLN RD						
			IDABEL OK 74745-7300				

MERCY HOSPITAL EL RENO

Office of State Finance VendorID: 0000064670

<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	108464150	\$897.00	10/27/2017	ACCT:58000029047	Payment amount based on \$1,121.25 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> J.S.
	<i>Approx Mail Date:</i> 8/29/2020					<i>Patient Birth Year:</i> 2000
	<i>Mail To Address:</i> 2115 PARKVIEW DR.					
			EL RENO OK 73036-0129			

WADLEY REGIONAL MEDICAL CENTER

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>
		\$1,888.79	06/23/19	ACCT: 5001664346	
<i>Approx Mail Date:</i> Requested from OSF 1/8/21 Expected to be mailed by 1/22/21					<i>Patient Initials:</i> R.R.
<i>Mail To Address:</i> PO BOX 1878 TEXARKANA TX 75504-1878					<i>Patient Birth Year:</i> 1960
Payment amount based on \$2,360.99 patient balance after insurance and insurance adjustments.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

PATHOLOGISTS BIO-MEDICAL LABS

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>
		\$39.28	03/28/18	ACCT: 520962500144	
<i>Approx Mail Date:</i> Requested from OSF 11/10/20 Expected to be mailed by 11/24/20					<i>Patient Initials:</i> K.S.
<i>Mail To Address:</i> 3600 GASTON AVE DALLAS TX 75246					<i>Patient Birth Year:</i> 1985
Payment amount based on \$92.55 patient balance after insurance and insurance adjustments.					
Total Bills exceed maximum award. Payment is prorated at 53.05898% among all providers.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

SHERMAN RADIOLOGY ASSOC

Office of State Finance VendorID: 0000065149

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
11/19/2020	108507432	\$424.83	05/12/20	ACCT: 2950338	
<i>Approx Mail Date:</i> 11/22/2020					<i>Patient Initials:</i> C.B.
<i>Mail To Address:</i> PO BOX 340 SHERMAN TX 75090-0340					<i>Patient Birth Year:</i> 1969
Payment amount based on \$531.04 patient balance after insurance and insurance adjustments.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					
10/21/2020	108492753	\$132.01	05/05/20	ACCT: 9006553870	
<i>Approx Mail Date:</i> 10/24/2020					<i>Patient Initials:</i> R.W.
<i>Mail To Address:</i> PO BOX 340 SHERMAN TX 75090-0340					<i>Patient Birth Year:</i> 2001
Payment amount based on \$165.01 patient balance after insurance and insurance adjustments.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

TEXAS RADIOLOGY ASSOCIATES

Office of State Finance VendorID: 0000065178

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
12/17/2020	108521330	\$423.67	07/13/18	ACCT: 751459885	
<i>Approx Mail Date:</i> 12/20/2020					<i>Patient Initials:</i> E.A.
<i>Mail To Address:</i> P O BOX 2285 INDIANAPOLIS IN 46206-2285					<i>Patient Birth Year:</i> 1997
Payment amount based on \$582.88 patient balance after insurance and insurance adjustments.					
Total Bills exceed maximum award. Payment is prorated at 90.85773% among all providers.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					
10/21/2020	108492763	\$810.40	05/16/20	ACCT: 695539	
<i>Approx Mail Date:</i> 10/24/2020					<i>Patient Initials:</i> J.B.
<i>Mail To Address:</i> P O BOX 2285 INDIANAPOLIS IN 46206-2285					<i>Patient Birth Year:</i> 1994
Payment amount based on \$1,013.00 patient balance after insurance and insurance adjustments.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

TEXARKANA RADIOLOGY ASSOCIATES

Office of State Finance VendorID: 0000065236

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
1/12/2021	108530377	\$277.60	06/23/19	ACCT: 250486-QTEXA	
<i>Approx Mail Date:</i> 1/15/2021 <i>Mail To Address:</i> PO BOX 1831 TEXARKANA TX 75504-1831					Payment amount based on \$347.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment.
					<i>Patient Initials:</i> R.R. <i>Patient Birth Year:</i> 1960

BAYLOR UNIVERSITY MEDICAL CENTER

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>
		\$11,712.44	03/29/18 - 03/31/18	ACCT: 062500144	
<i>Approx Mail Date:</i> Requested from OSF 11/10/20 Expected to be mailed by 11/24/20 <i>Mail To Address:</i> P O BOX 842022 DALLAS TX 75284-2022					Payment amount based on \$27,592.96 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 53.05898% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment.
					<i>Patient Initials:</i> K.S. <i>Patient Birth Year:</i> 1985

AMERIPATH DALLAS AP

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>
		\$83.23	07/13/18	ACCT: 70AV26823144	
<i>Approx Mail Date:</i> Requested from OSF 12/8/20 Expected to be mailed by 12/22/20 <i>Mail To Address:</i> DFW 5.01(A) CORP DALLAS OK 75284-4810					Payment amount based on \$114.50 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 90.85773% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment.
					<i>Patient Initials:</i> E.A. <i>Patient Birth Year:</i> 1997

HEALTH TEXAS PROVIDER NETWORK

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>
		\$1,190.30	03/29/18 - 03/31/18	ACCT: 105169719	
<i>Approx Mail Date:</i> Requested from OSF 11/10/20 Expected to be mailed by 11/24/20 <i>Mail To Address:</i> PO BOX 842727 DALLAS TX 75284					Payment amount based on \$2,804.20 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 53.05898% among all providers. Acceptance of payment may require a provider write-off. EOB will accompany payment.
					<i>Patient Initials:</i> K.S. <i>Patient Birth Year:</i> 1985

MARK R CAMPBELL MD

Office of State Finance VendorID: 0000065564

<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	108476148	\$452.00	08/07/18 AND 08/09/18	ACCT: 20234C2K - \$320.00 20234C2L - \$132.00	
<i>Approx Mail Date:</i> 9/21/2020 <i>Mail To Address:</i> 420 N COLLEGIATE STE 300 PARIS TX 75460-3460					Payment amount based on \$565.00 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.A. <i>Patient Birth Year:</i> 1998

RED RIVER VALLEY PATHOLOGY

Office of State Finance VendorID:

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

Patient Identifiers

\$12.74 03/28/18 ACCT: 51508

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

Approx Mail Date: Requested from OSF 11/10/20 Expected to be mailed by 11/24/20

Total Bills exceed maximum award. Payment is prorated at 53.05898% among all providers. *Patient Initials:* K.S.

Mail To Address: PO BOX 100
PARIS TX 75461

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1985

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.

Payment amount based on \$260.00 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: K.K.

Mail To Address: 6010 E. HWY 191 SUITE 246
ODESSA TX 79762

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1964

ORTHOPAEDIC TRAUMA SURGEONS

Office of State Finance VendorID:

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

Patient Identifiers

\$672.76 06/02/20 ACCT: 23741

Payment amount based on \$999.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 11/10/20 Expected to be mailed by 11/24/20

Total Bills exceed maximum award. Payment is prorated at 84.17979% among all providers. *Patient Initials:* A.T.

Mail To Address: 3600 GASTON #755 WADLEY
DALLAS TX 75246

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

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

CITY OF PARIS EMS

Office of State Finance VendorID: 0000519169

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

Patient Identifiers

11/19/2020 108507309 **\$719.90** 03/28/18 ACCT: 54014087

Payment amount based on \$1,696.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/22/2020

Total Bills exceed maximum award. Payment is prorated at 53.05898% among all providers. *Patient Initials:* K.S.

Mail To Address: PO BOX 9037
PARIS TX 75461

Acceptance of payment may require a provider write-off. EOB will accompany payment. *Patient Birth Year:* 1985

RESTHAVEN FUNERAL HOME

Office of State Finance VendorID: 0000065883

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
1/22/2021	108536043	\$21.00	5/27/20	ACCOUNT: S.C.	Payment amount based on \$21.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 1/25/2021					<i>Patient Initials:</i> S.C.
<i>Mail To Address:</i> 500 SW 104TH ST OKLAHOMA CITY OK 73139-5528					<i>Patient Birth Year:</i> 1942

US ANESTHESIA PARTNERS OF TEXAS

Office of State Finance VendorID: 0000476855

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
11/19/2020	108507447	\$1,684.30	03/29/18	ACCT: 3-52356083	Payment amount based on \$3,968.00 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 11/22/2020					Total Bills exceed maximum award. Payment is prorated at 53.05898% among all providers. <i>Patient Initials:</i> K.S.
<i>Mail To Address:</i> PO BOX 840855 DALLAS TX 75284-0855					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1985

FARHAN QURESHI MD PC

Office of State Finance VendorID:

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		\$369.77	01/10/20 - 03/04/20	ACCT: HF275001661	Payment amount based on \$462.21 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> Requested from OSF 1/12/21 Expected to be mailed by 1/26/21					<i>Patient Initials:</i> L.H.
<i>Mail To Address:</i> 1601 HEALTH CENTER PKWY STE 200 YUKON OK 73099-6396					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1966

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.
<i>Approx Mail Date:</i> 10/4/2020					<i>Patient Initials:</i> M.D.
<i>Mail To Address:</i> PO BOX 268986 OKLAHOMA CITY OK 73126					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 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	Payment amount based on \$343.56 patient balance after insurance and insurance adjustments.
<i>Approx Mail Date:</i> 6/18/2020					<i>Patient Initials:</i> J.N.
<i>Mail To Address:</i> PO BOX 956542 ST LOUIS MO 63195					Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1979

5/19/2020	108421378	\$921.49	12/21/18	ACCT: P35750370	Payment amount based on \$1,151.86 patient balance after insurance and insurance adjustments.	<i>Patient Initials:</i> M.G.
	<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> 1974
	<i>Mail To Address:</i> PO BOX 956542 ST LOUIS MO 63195					

HILLCREST HEALTH 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>
10/21/2020	108492684	\$14,024.19	03/27/20	ACCT: 20004509484	Payment amount based on \$20,893.83 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> 10/24/2020				Total Bills exceed maximum award. Payment is prorated at 83.90154% among all providers.	<i>Patient Initials:</i> J.C.
	<i>Mail To Address:</i> DEPT 572 TULSA OK 74182				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1986
8/26/2020	108464050	\$14,166.89	11/18/19- 11/27/19	ACCT: H2000377320700 - \$12,355.69; H2000383355000 - \$1,811.20	Payment amount based on \$17,708.61 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> 8/29/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Initials:</i> L.C.
	<i>Mail To Address:</i> DEPT 572 TULSA OK 74182					<i>Patient Birth Year:</i> 1959
7/28/2020	108449467	\$1,131.01	09/19/16	ACCT: A1626301275	Payment amount based on \$1,413.76 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> 7/31/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Initials:</i> S.C.
	<i>Mail To Address:</i> DEPT 572 TULSA OK 74182					<i>Patient Birth Year:</i> 1984

BIBLE MEMORIALS

Office of State Finance VendorID: 0000326920

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>		<i>Patient Identifiers</i>
12/21/2020	108523063	\$1,570.87	10/05/20	ACCT: J.J.	Payment amount based on \$1,570.87 patient balance after insurance and insurance adjustments.	
	<i>Approx Mail Date:</i> 12/24/2020					<i>Patient Initials:</i> J.J.
	<i>Mail To Address:</i> 13677 STATE HWY 56 SASAKWA OK 74867					<i>Patient Birth Year:</i> 1990

QUESTCARE EM OKLAHOMA, LLC

Office of State Finance VendorID: 0000372132

<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	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.	
	<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 678216 DALLAS TX 75267-8216				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1983
		\$32.88	11/06/16	ACCT: 63-E002768539	Payment amount based on \$915.00 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 678216 DALLAS TX 75267-8216				Acceptance of payment may require a provider write-off. EOB will accompany payment.	<i>Patient Birth Year:</i> 1963

7/28/2020 108449532 \$128.15 10/12/17 ACCT: QKE110660027802
Approx Mail Date: 7/31/2020
Mail To Address: PO BOX 678216
 DALLAS TX 75267-8216

Payment amount based on \$489.00 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

QUESTCARE EM OKLAHOMA, LLC

Office of State Finance VendorID: 0000372132

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
12/17/2020	108521298	\$998.76	01/27/20	ACCT: QKE1199900537685	
<i>Approx Mail Date:</i> 12/20/2020 <i>Mail To Address:</i> PO BOX 99083 LAS VEGAS NV 89193-9083					Payment amount based on \$1,516.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 82.35184% among all providers. <i>Patient Initials:</i> K.O. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1979
12/17/2020	108521299	\$2,395.20	01/23/20	ACCT: QKE119990536873	
<i>Approx Mail Date:</i> 12/20/2020 <i>Mail To Address:</i> PO BOX 99083 LAS VEGAS NV 89193-9083					Payment amount based on \$2,994.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Initials:</i> R.W. <i>Patient Birth Year:</i> 1978
12/17/2020	108521297	\$1,082.68	05/04/19	ACCT: QKE1199900502024 - \$436.99; QKE110666034853 - \$645.69	
<i>Approx Mail Date:</i> 12/20/2020 <i>Mail To Address:</i> PO BOX 99083 LAS VEGAS NV 89193-9083					Payment amount based on \$2,542.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 53.23933% among all providers. <i>Patient Initials:</i> J.R. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1984
11/18/2020	108506142	\$130.02	10/25/18	ACCT: QKE1199900479718	
<i>Approx Mail Date:</i> 11/21/2020 <i>Mail To Address:</i> PO BOX 99083 LAS VEGAS NV 89193-9083					Payment amount based on \$1,328.06 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.R. <i>Patient Birth Year:</i> 1999
10/21/2020	108492739	\$494.62	09/08/19	ACCT: 10002191236	
<i>Approx Mail Date:</i> 10/24/2020 <i>Mail To Address:</i> PO BOX 99083 LAS VEGAS NV 89193-9083					Payment amount based on \$1,516.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 40.78328% among all providers. <i>Patient Initials:</i> R.F. Acceptance of payment may require a provider write-off. EOB will accompany payment. <i>Patient Birth Year:</i> 1968
10/21/2020	108492738	\$707.15	02/22/20	ACCT: 540909	
<i>Approx Mail Date:</i> 10/24/2020 <i>Mail To Address:</i> PO BOX 99083 LAS VEGAS NV 89193-9083					Payment amount based on \$2,447.00 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.P. <i>Patient Birth Year:</i> 1971
10/21/2020	108492737	\$161.92	01/25/20	ACCT: QKE1199900537368	
<i>Approx Mail Date:</i> 10/24/2020 <i>Mail To Address:</i> PO BOX 99083 LAS VEGAS NV 89193-9083					Payment amount based on \$202.40 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.F. <i>Patient Birth Year:</i> 1978

9/18/2020	108476180	\$778.00	02/08/20	ACCT: QKE1199900539235	Payment amount based on \$1,026.00 patient balance after insurance and insurance adjustments. 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
	Approx Mail Date:	9/21/2020			
	Mail To Address:	PO BOX 99083 LAS VEGAS NV 89193-9083			
9/18/2020	108476178	\$39.25	07/12/19	ACCT: 119990051112QKE	Payment amount based on \$2,389.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 2.053886% among all providers. Patient Initials: P.C. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1987
	Approx Mail Date:	9/21/2020			
	Mail To Address:	PO BOX 99083 LAS VEGAS NV 89193-9083			
8/26/2020	108464168	\$1,538.42	03/02/20	ACCT: QKE1199900542131	Payment amount based on \$2,389.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 80.49522% among all providers. Patient Initials: S.S. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1975
	Approx Mail Date:	8/29/2020			
	Mail To Address:	PO BOX 99083 LAS VEGAS NV 89193-9083			
8/26/2020	108464167	\$164.70	02/09/20	ACCT: QKE110668890506	Payment amount based on \$683.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 30.14325% among all providers. Patient Initials: J.N. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1962
	Approx Mail Date:	8/29/2020			
	Mail To Address:	PO BOX 99083 LAS VEGAS NV 89193-9083			
8/26/2020	108464166	\$80.97	02/05/20	ACCT: QKE1199900538815	Payment amount based on \$1,599.00 patient balance after insurance and insurance adjustments. Total Bills exceed maximum award. Payment is prorated at 6.329409% among all providers. Patient Initials: A.K. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1997
	Approx Mail Date:	8/29/2020			
	Mail To Address:	PO BOX 99083 LAS VEGAS NV 89193-9083			
8/26/2020	108464165	\$820.80	03/10/19	ACCT: QKE1199900495647	Payment amount based on \$1,026.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: S.W. Patient Birth Year: 1996
	Approx Mail Date:	8/29/2020			
	Mail To Address:	PO BOX 99083 LAS VEGAS NV 89193-9083			
8/26/2020	108464164	\$1,911.20	04/13/18	ACCT: QKE1199900449133	Payment amount based on \$2,389.00 patient balance after insurance and insurance adjustments. Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Initials: C.K. Patient Birth Year: 1996
	Approx Mail Date:	8/29/2020			
	Mail To Address:	PO BOX 99083 LAS VEGAS NV 89193-9083			
8/12/2020	108456763	\$140.95	2-12-20	ACCT:QKE221005118080	Payment amount based on patient balance after insurance and insurance adjustments. Patient Initials: M.S. Patient Birth Year: 1999
	Approx Mail Date:	8/15/2020			
	Mail To Address:	PO BOX 99083 LAS VEGAS NV 89193-9083			
7/28/2020	108449534	\$568.06	02/22/20	ACCT: QKE1199900540911	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
	Approx Mail Date:	7/31/2020			
	Mail To Address:	PO BOX 99083 LAS VEGAS NV 89193-9083			

7/28/2020	108449533	\$820.80	04/27/19	ACCT: QKE110665788342	Payment amount based on \$1,026.00 patient balance after insurance and insurance adjustments.	Patient Initials: A.N.
	Approx Mail Date: 7/31/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1992
	Mail To Address: PO BOX 99083 LAS VEGAS NV 89193-9083					
7/27/2020	108449007	\$1,696.80	3/26/20	ACCT: QKE1199900844820	Payment amount based on patient balance after insurance and insurance adjustments.	Patient Initials: J.B.
	Approx Mail Date: 7/30/2020					Patient Birth Year: 1982
	Mail To Address: PO BOX 99083 LAS VEGAS NV 89193-9083					
6/3/2020	108427490	\$1,405.60	09/10/19 and 09/17/19	ACCT: QKE110667321891 - \$859.20; QKE110667247374 - \$546.40	Payment amount based on \$1,757.00 patient balance after insurance and insurance adjustments.	Patient Initials: R.B.
	Approx Mail Date: 6/6/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1996
	Mail To Address: PO BOX 99083 LAS VEGAS NV 89193-9083					
5/19/2020	108421364	\$166.53	06/14/19	ACCT: QKE110666323781	Payment amount based on \$683.00 patient balance after insurance and insurance adjustments.	Patient Initials: J.W.
	Approx Mail Date: 5/22/2020				Total Bills exceed maximum award. Payment is prorated at 30.47813% among all providers.	Patient Birth Year: 1988
	Mail To Address: PO BOX 99083 LAS VEGAS NV 89193-9083				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
5/19/2020	108421362	\$137.49	05/27/19	ACCT: QKE1199900504775	Payment amount based on \$1,516.00 patient balance after insurance and insurance adjustments.	Patient Initials: R.W.
	Approx Mail Date: 5/22/2020				Total Bills exceed maximum award. Payment is prorated at 11.33645% among all providers.	Patient Birth Year: 1995
	Mail To Address: PO BOX 99083 LAS VEGAS NV 89193-9083				Acceptance of payment may require a provider write-off. EOB will accompany payment.	
5/19/2020	108421363	\$1,403.20	04/17/19	ACCT: QKE1199900500044	Payment amount based on \$1,754.00 patient balance after insurance and insurance adjustments.	Patient Initials: T.W.
	Approx Mail Date: 5/22/2020				Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1961
	Mail To Address: PO BOX 99083 LAS VEGAS NV 89193-9083					
5/19/2020	108421361	\$1,228.37	09/26/18	ACCT: 11999004765600145509 - \$779.49; 11999004765600145514 - \$448.88	Payment amount based on \$2,389.00 patient balance after insurance and insurance adjustments.	Patient Initials: B.S.
	Approx Mail Date: 5/22/2020				Total Bills exceed maximum award. Payment is prorated at 64.27231% among all providers.	Patient Birth Year: 1988
	Mail To Address: PO BOX 99083 LAS VEGAS NV 89193-9083				Acceptance of payment may require a provider write-off. EOB will accompany payment.	

CENTURY INTEGRATED PARTNERS, INC

Office of State Finance VendorID:

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
		\$378.46	03/29/18	ACCT: 0543918	
	Approx Mail Date: Requested from OSF 11/10/20 Expected to be mailed by 11/24/20				Payment amount based on \$891.60 patient balance after insurance and insurance adjustments.
	Mail To Address: PO BOX 844409 DALLAS TX 75284-4409				Total Bills exceed maximum award. Payment is prorated at 53.05898% among all providers. Patient Initials: K.S.
					Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1985

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>
		\$464.00	04/14/20	ACCT: 12650910	
<i>Approx Mail Date:</i> Requested from OSF 9/25/20 Expected to be mailed by 10/9/20					<i>Patient Initials:</i> I.R.
<i>Mail To Address:</i> 5510 E 41ST ST., SUITE C TULSA OK 74135					<i>Patient Birth Year:</i> 2000
Payment amount based on \$580.00 patient balance after insurance and insurance adjustments.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

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>
8/12/2020	108456712	\$80.00	8/17/15	ACCT: 17994	
<i>Approx Mail Date:</i> 8/15/2020					<i>Patient Initials:</i> D.B.
<i>Mail To Address:</i> 1619 N. 5TH ST PONCA CITY OK 74601-2703					<i>Patient Birth Year:</i> 1970
Payment amount based on \$100.00 patient balance after insurance and insurance adjustments.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

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>
6/25/2020	108438962	\$26.10	04-21-20	ACCT: L.C.	
<i>Approx Mail Date:</i> 6/28/2020					<i>Patient Initials:</i> L.C.
<i>Mail To Address:</i> 8988 S SHERIDAN RD, SUITE D2 TULSA OK 74133					<i>Patient Birth Year:</i> 1973
Payment amount based on \$46.60 patient balance after insurance and insurance adjustments.					
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>
9/23/2020	108478732	\$382.38	03/30/20 - 06/15/20	ACCT: HF283380449	
<i>Approx Mail Date:</i> 9/26/2020					<i>Patient Initials:</i> S.S.
<i>Mail To Address:</i> 507 NE 12TH ST. MOORE OK 73160-5833					<i>Patient Birth Year:</i> 1975
Payment amount based on \$593.80 patient balance after insurance and insurance adjustments.					
Total Bills exceed maximum award. Payment is prorated at 80.49522% among all providers.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

DENTAL DEPOT RENO & ROCKWELL

Office of State Finance VendorID: 0000506089

<i>Check Date:</i>	<i>Check #:</i>	<i>Amount:</i>	<i>Service Date(s):</i>	<i>Provider Reference:</i>	<i>Patient Identifiers</i>
12/4/2020	108513687	\$19,560.00	08/26/19 AND 09/03/20	ACCT: 12653 S.C.	
<i>Approx Mail Date:</i> 12/7/2020					<i>Patient Initials:</i> S.C.
<i>Mail To Address:</i> 25 N ROCKWELL OKLAHOMA CITY OK 73127-6112					<i>Patient Birth Year:</i> 2001
Payment amount based on \$26,615.00 patient balance after insurance and insurance adjustments.					
Total Bills exceed maximum award. Payment is prorated at 91.86549% among all providers.					
Acceptance of payment may require a provider write-off. EOB will accompany payment.					

11/30/2020 108510754 \$440.00 05/09/19 - 01/22/20 ACCT: 12653

Payment amount based on \$550.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/3/2020

Patient Initials: S.C.

Mail To Address: 25 N ROCKWELL
OKLAHOMA CITY OK 73127-6112

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

Patient Birth Year: 2001

KEISAU FUNERAL HOME

Office of State Finance VendorID:

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

Patient Identifiers

\$10.00 8/13/2019 ACCT: E.A.

Payment amount based on \$10.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 8/21/20 Expected to be mailed by 9/4/20

Patient Initials: E.A.

Mail To Address: 2500 W MODELLE AVE
CLINTON OK 73601-3726

Patient Birth Year: 1966

ADVANCED ORTHOPEDICS OF OKLAHOMA

Office of State Finance VendorID: 0000466629

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

Patient Identifiers

1/22/2021 108536013 \$81.16 07/14/19 ACCT: 478165

Payment amount based on \$2,231.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/25/2021

Total Bills exceed maximum award. Payment is prorated at 4.547349% among all providers. Patient Initials: T.J.

Mail To Address: PO BOX 844222
KANSAS CITY MO 64184-4222

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

CORNERSTONE PHYSICIAN PARTNERS

Office of State Finance VendorID:

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

Patient Identifiers

\$605.30 03/28/18 ACCT: 10498

Payment amount based on \$1,426.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 11/10/20 Expected to be mailed by 11/24/20

Total Bills exceed maximum award. Payment is prorated at 53.05898% among all providers. Patient Initials: K.S.

Mail To Address: 5100 ELDORADO PKWY STE 102
MC KINNEY TX 75070-7295

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1985

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

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

Approx Mail Date: 5/22/2020

Total Bills exceed maximum award. Payment is prorated at 98.92601% among all providers. Patient Initials: D.S.

Mail To Address: PO BOX 707001
TULSA OK 74170

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

Payment amount based on \$2,008.46 patient balance after insurance and insurance adjustments.

Approx Mail Date: 4/17/2020

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

Mail To Address: PO BOX 707001
TULSA OK 74170

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

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.	
<i>Approx Mail Date:</i> 10/4/2020					<i>Patient Initials:</i> M.Y.
<i>Mail To Address:</i> 1212 S AIR DEPOT BLVD STE 19B MIDWEST CITY OK 73110					<i>Patient Birth Year:</i> 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**	
<i>Approx Mail Date:</i> 6/28/2020					<i>Patient Initials:</i> S.J.
<i>Mail To Address:</i> 2529 S KELLY AVE, SUITE C EDMOND OK 73013					<i>Patient Birth Year:</i> 1957

6/25/2020	108438904	\$468.00	1/13/20 - 3/12/20	ACCT: CJ	
<i>Approx Mail Date:</i> 6/28/2020					<i>Patient Initials:</i> S.J.
<i>Mail To Address:</i> 2529 S KELLY AVE, SUITE C EDMOND OK 73013					<i>Patient Birth Year:</i> 1957

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	
<i>Approx Mail Date:</i> Requested from OSF 10/13/20 Expected to be mailed by 10/27/20					<i>Patient Initials:</i> J.C.
<i>Mail To Address:</i> PO BOX 207529 DALLAS TX 75320-7529					<i>Patient Birth Year:</i> 1986

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.	
<i>Approx Mail Date:</i> 6/28/2020					<i>Patient Initials:</i> K.S.
<i>Mail To Address:</i> 1823 TEXAS AVE WOODWARD OK 73801					<i>Patient Birth Year:</i> 1981

HARMON COUNTY FUNERAL HOME

Office of State Finance VendorID:

Check Date:	Check #:	Amount:	Service Date(s):	Provider Reference:	Patient Identifiers
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\$3,583.10

12/21/19

ACCT: V.G.

Payment amount based on \$3,583.10 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: V.G.

Mail To Address: 417 E BROADWAY
HOLLIS OK 73550

Patient Birth Year: 2007

ELIZABETH WILLIAMS LPC PLLC

Office of State Finance VendorID: 0000495969

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

Patient Identifiers

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
EDMOND OK 73013

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

Patient Birth Year: 1961

SQUARE ONE DENTAL

Office of State Finance VendorID:

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

Patient Identifiers

\$2,800.00 09/28/20 ACCT: 1000 A.Y.

Payment amount based on \$3,500.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 1/8/21 Expected to be mailed by 1/22/21

Patient Initials: A.Y.

Mail To Address: 1141 NW 1ST ST.
OKLAHOMA CITY OK 73034

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

Patient Birth Year: 1978

ROGERS FUNERAL HOME

Office of State Finance VendorID: 0000224723

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

Patient Identifiers

8/11/2020 108455935 \$3,379.00 2/21/20 ACCOUNT: S.M.

Payment amount based on \$3,379.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/14/2020

Patient Initials: S.G.

Mail To Address: 1302 WEST MAIN
HENRYETTA OK 74437

Patient Birth Year: 1986

BIO SERVICES, LLC

Office of State Finance VendorID: 0000498536

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

Patient Identifiers

10/21/2020 108492634 \$2,000.00 09/27/19 ACCT: 917

Payment amount based on \$2,000.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/24/2020

Patient Initials: R.F.

Mail To Address: BIO-ONE OKC
MUSTANG OK 73064 60 N MUSTANG RD, PO BOX 545

Patient Birth Year: 1968

BELMAR EMERGENCY GROUP PC

Office of State Finance VendorID: 0000500654

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

Patient Identifiers

1/12/2021 108530281 \$1,671.20 12/29/19 ACCT: 14X64460138

Payment amount based on \$2,089.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/15/2021

Patient Initials: R.F.

Mail To Address: PO BOX 731584
DALLAS TX 75373-1584

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

Patient Birth Year: 1959

HEART CLINIC PC

Office of State Finance VendorID:

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

Patient Identifiers

\$23.74 02/05/20 ACCT: SANDA000

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

Approx Mail Date: 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. Patient Initials: D.S.

Mail To Address: 2720 W BROADWAY ST
MUSKOGEE OK 74401-2141

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

MELISSA HOLLY SHOCKLEY

Office of State Finance VendorID: 0000501344

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

Patient Identifiers

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.

Approx Mail Date: 7/11/2020

Patient Initials: N.C.

Mail To Address: THRIVE CHRISTIAN COUNSELING 13939 TECHNOLOGY DRIVE
OKLAHOMA CITY OK 73013

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1981

SCOTT A. SHEPPARD, DDS, PLLC

Office of State Finance VendorID: 0000519263

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

Patient Identifiers

12/2/2020 108511995 \$3,763.20 11/15/18 AND 08/26/20 ACCT: BO0268 P.B.

Payment amount based on \$4,704.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/5/2020

Patient Initials: P.B.

Mail To Address: SHEPPARD FAMILY DENTAL CARE 4206 SW LEE BLVD
LAWTON OK 73505

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1985

CORNERSTONE FAMILY DENTISTRY

Office of State Finance VendorID: 0000520064

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

Patient Identifiers

12/15/2020 108519524 \$166.40 03/04/20 ACCT: FR0066

Payment amount based on \$208.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/18/2020

Patient Initials: J.F.

Mail To Address: 1325 S SANGRE RD
STILLWATER OK 74074

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1978

PREMIER PHYSICIAN STAFFING 2 PLLC

Office of State Finance VendorID:

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

Patient Identifiers

\$414.40 12/08/19 ACCT: 12859590

Approx Mail Date: Requested from OSF 12/10/20 Expected to be mailed by 12/24/20

Mail To Address: 1 EAST CLARK BASS BLVD
MCALESTER OK 74501

Payment amount based on \$518.00 patient balance after insurance and insurance adjustments.

Patient Initials: D.E.

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

Patient Birth Year: 1974

BAKER & BAKER

Office of State Finance VendorID: 0000521629

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

Patient Identifiers

\$320.00 06/24/2019-10/28/2019 ACCT: MJ

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

Approx Mail Date: Requested from OSF 12/7/20 Expected to be mailed by 12/21/20

Patient Initials: M.J.

Mail To Address: 214 S. CENTRAL AVE
OKMULGEE OK 74447

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

Patient Birth Year: 1949

ESS OF STILLWELL, LLC

Office of State Finance VendorID:

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

Patient Identifiers

\$486.40 11/9/2019 ACCT: 0085195707

Payment amount based on \$608.00 patient balance after insurance and insurance adjustments.

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

Patient Initials: A.G.

Mail To Address: P.O. BOX 222030
DALLAS TX 75222-2030

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

Patient Birth Year: 2000

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

OKLAHOMA CITY ORTHOPEDICS AND SPORTS MEDICINE PLLC

Office of State Finance VendorID: 0000249954

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

Patient Identifiers

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.

Approx Mail Date: 5/22/2020

Patient Initials: O.P.

Mail To Address: 5701 N PORTLAND STE 205
OKLAHOMA CITY OK 73112

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

Patient Birth Year: 1995

ROCKY MOUNTAIN HOLDINGS, LLC

Office of State Finance VendorID: 0000066696

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

Patient Identifiers

12/17/2020 108521308 \$9,205.02 06/18/20 ACCT: 20-97966

Approx Mail Date: 12/20/2020

Mail To Address: PO BOX 713375
CINCINNATI OH 45271-3375

Payment amount based on \$59,864.80 patient balance after insurance and insurance adjustments.

Total Bills exceed maximum award. Payment is prorated at 19.22044% among all providers. Patient Initials: W.F.

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

ALL ABOUT SMILES DENTISTRY

Office of State Finance VendorID: 0000260937

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

11/19/2020 108507274 \$404.80 08/17/20 ACCT: 20066

Approx Mail Date: 11/22/2020

Mail To Address: P O BOX 1637
DURANT OK 74702

Payment amount based on \$506.00 patient balance after insurance and insurance adjustments.

Patient Initials: C.B.

Acceptance of payment may require a provider write-off. EOB will accompany payment. Patient Birth Year: 1969

SHARECARE

Office of State Finance VendorID:

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

\$16.04 09/14/20 ACCT: BEDG9FWP4 INVOICE :
1135143

Approx Mail Date: Requested from OSF 1/12/21 Expected to be mailed by 1/26/21

Mail To Address: HEALTH DATA SERVICES LLC 8344 CLAIREMONT MESA BLVD,
SAN DIEGO CA 92111

Payment amount based on \$16.04 patient balance after insurance and insurance adjustments.

Patient Initials: E.J.

Patient Birth Year: 1977