Victim Comp Checks Issued to Service Providers in Last 12 Months

Updated Wednesday, January 25, 2017 10:13 AM

MIDWEST OPEN MRI

Office of State Finance VendorID: 0000396100

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
8/3/2016	**107573692**	**$245.63**	08/31/15	ACCT: 577761C59	Payment amount based on $307.04 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016				***Patient Initials:***	M.P.
	Mail To Address:	PO BOX 26706 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1953

CLINICAL PARTNERS PA HILLCREST

Office of State Finance VendorID: 0000271110

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
9/30/2016	**107617386**	**$1,006.10**	02/02/16	ACCT: 11P5665399N2 - $614.32; 11P5665990N1 - $391.78	Payment amount based on $1,605.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 78.35652% among all providers.	***Patient Initials:***	D.L.
	Mail To Address:	PO BOX 1712 LONGVIEW TX 75606-1712			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1979
4/28/2016	**107504599**	**$870.65**	09/02/15	ACCT: 11A5617752N2	Payment amount based on $1,251.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 86.99495% among all providers.	***Patient Initials:***	N.B.
	Mail To Address:	PO BOX 1712 LONGVIEW TX 75606-1712			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1984

CLINICAL PARTNERS PA CLAREMORE

Office of State Finance VendorID: 0000271110

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
1/20/2017	**107687496**	**$896.00**	5/17/16	C575	Payment amount based on $1,120.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/23/2017				***Patient Initials:***	W.H.
	Mail To Address:	PO BOX 5188 LONGVIEW TX 75608-5188			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	2001

PHYSICIANS' HOSPITAL OF ANADARKO

Office of State Finance VendorID: 0000010976

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
5/4/2016	**107508644**	**$3,757.01**	09/19/15	ACCT: 10623	Payment amount based on $4,696.26 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/7/2016				***Patient Initials:***	C.H.
	Mail To Address:	1002 E CENTRAL BLVD ANADARKO OK 73005			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1991

JANE PHILLIPS SPECIALTY PHYSICIANS

Office of State Finance VendorID: 0000303817

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
5/27/2016	**107528300**	**$865.50**	04/06/14	ACCT: 50535V7661	Payment amount based on $1,081.88 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/30/2016				***Patient Initials:***	B.A.
	Mail To Address:	P O BOX 1089 TULSA OK 74101-1089			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1986

EAGLE PARTNERS, PLLC

Office of State Finance VendorID: 0000346540

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
12/23/2016	**107675708**	**$58.39**	8/20/16, 10/14/16	Acct: 43486-Qeagl	Payment amount based on $72.99 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/26/2016				***Patient Initials:***	K.W.
	Mail To Address:	PO BOX 205218 DALLAS TX 75320-5218			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1977
11/18/2016	**107651853**	**$9.87**	8/11/16	ACCT: 10875-EAGL	Payment amount based on $12.34 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/21/2016				***Patient Initials:***	S.C.
	Mail To Address:	PO BOX 205218 DALLAS TX 75320-5218			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1958
11/18/2016	**107651852**	**$165.42**	7/18/16 - 8/16/16	ACCT: 58556-EAGL	Payment amount based on $206.78 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/21/2016				***Patient Initials:***	E.P.
	Mail To Address:	PO BOX 205218 DALLAS TX 75320-5218			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1930
7/25/2016	**107566900**	**$1,236.00**	03/03/16	ACCT: 214202-QEAGL	Payment amount based on $1,545.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/28/2016				***Patient Initials:***	L.C.
	Mail To Address:	PO BOX 205218 DALLAS TX 75320-5218			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1975
7/20/2016	**107563642**	**$212.00**	10/12/15	ACCT: 175785	Payment amount based on $265.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016				***Patient Initials:***	R.S.
	Mail To Address:	PO BOX 205218 DALLAS TX 75320-5218			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1983
5/27/2016	**107528269**	**$388.00**	10/18/15 AND 10/19/15	ACCT: 6936-EAGL - $68.00; Z2AYJ15 - $320.00	Payment amount based on $485.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/30/2016				***Patient Initials:***	T.B.
	Mail To Address:	PO BOX 205218 DALLAS TX 75320-5218			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1962

4/28/2016	**107504613**	**$3.40**	12/16/15	ACCT: 194125-QEAGL	Payment amount based on $70.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.064521% among all providers.	***Patient Initials:*** N.G.
	Mail To Address:	PO BOX 205218 DALLAS TX 75320-5218			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1965

GREEN CO ER PHYS TULSA PLLC ***Office of State Finance VendorID:*** 0000271109

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
12/23/2016	**107675513**	**$614.26**	05/11/16	ACCT: 2581605110158	Payment amount based on $1,409.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 54.4946% among all providers.	***Patient Initials:*** M.B.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1977
11/21/2016	**107653076**	**$1,247.44**	06/17/16	ACCT: 2581606170004	Payment amount based on $1,629.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 95.72122% among all providers.	***Patient Initials:*** J.R.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1974
11/18/2016	**107651864**	**$253.60**	5/4/14	ACCT: 1229141280	Payment amount based on $317.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				***Patient Initials:*** B.F.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1980
11/18/2016	**107651863**	**$280.00**	6/1/16	ACCT: M023745385	Payment amount based on $350.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				***Patient Initials:*** P.J.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1964
11/1/2016	**107638870**	**$953.60**	7/29/15	ACCT: M023754137	Payment amount based on $1,192.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/4/2016				***Patient Initials:*** T.B.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1987
9/30/2016	**107617441**	**$688.28**	01/31/16	ACCT: 258160310007	Payment amount based on $1,098.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 78.35652% among all providers.	***Patient Initials:*** D.L.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1979
10/11/2016	**107624001**	**$1,306.40**	8/16/15, 8/26/15	ACCT: #2581508160113 $798.40; 2581508260086 $508.00	Payment amount based on $1,633.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				***Patient Initials:*** A.D.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1980

10/11/2016	**107624000**	**$1,057.60**	3/6/16	ACCT: 2591603060008	Payment amount based on $1,322.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** J.B.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990
10/11/2016	**107623999**	**$1,353.60**	5/22/16, 6/1/16	ACCT: M023246946 $1,073.60; M023246947 $280	Payment amount based on $1,692.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** P.J.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1964
9/9/2016	**107601342**	**$534.40**	7/4/14	ACCT: 2581407040070	Payment amount based on $668.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** W.T.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1988
8/26/2016	**107592790**	**$508.00**	10/12/15	ACCT: 2591510120038	Payment amount based on $635.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** K.B.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1983
6/7/2016	**107533989**	**$560.80**	09/16/15	ACCT: 2581509160107	Payment amount based on $701.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/10/2016			***Patient Initials:*** T.R.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1994
4/28/2016	**107504638**	**$266.40**	11/17/15	ACCT: 2581511170098	Payment amount based on $333.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** R.H.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1980
4/29/2016	**107506116**	**$630.40**	1/23/15	ACCT: 2581501230040	Payment amount based on $788.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/2/2016			***Patient Initials:*** M.P.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1978
4/28/2016	**107504637**	**$835.20**	08/14/15	ACCT: M019644027	Payment amount based on $1,044.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** N.M.
	Mail To Address:	P O BOX 268938 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1994

EXCEL THERAPY SPECIALISTS, LLC ***Office of State Finance VendorID:*** 0000308117

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

11/21/2016	**107653060**	**$1,628.00**	06/29/16 - 09/23/16	ACCT: PK4998	Payment amount based on $2,035.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/24/2016 ***Patient Initials:*** J.H.

Mail To Address: P O BOX 25887
OKLAHOMA CITY OK 73125

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1960

LAKESIDE DENTAL ***Office of State Finance VendorID:*** 0000269717

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
5/27/2016	**107528313**	**$72.00**	10/08/15	ACCT: 2879	Payment amount based on $90.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/30/2016 ***Patient Initials:*** S.C.

Mail To Address: 302 S. HAYES AVE.
WAGONER OK 74467

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

LILIANA F. SPEED , ED. D. ***Office of State Finance VendorID:*** 0000011816

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
9/9/2016	**107601405**	**$278.23**	3/11/15 - 1/26/16	ACCT: BURVR000	Payment amount based on $347.79 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/12/2016 ***Patient Initials:*** B.B.

Mail To Address: 1117 NW 50TH ST
OKLAHOMA CITY OK 73118

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

TOM JOSEPHSON, MA LPC ***Office of State Finance VendorID:*** 0000411148

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
12/16/2016	**107670869**	**$3,620.00**	01/05/16 - 07/31/16	ACCT: D.G. - $1,500.00; E.G. - $1,060.00; I.W. - $1,060.00	Payment amount based on $10,600.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/19/2016 ***Patient Initials:*** S.G.

Mail To Address: 1122 S. EVANSTON AVE.
TULSA OK 74104-4132

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

WOODWARD HEALTH SYSTEM LLC ***Office of State Finance VendorID:*** 0000196936

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
8/26/2016	**107592737**	**$140.00**	4/14/16	ACCT: 82352A1601	Payment amount based on $175.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2016 ***Patient Initials:*** M.G.

Mail To Address: P O BOX 555
WOODWARD OK 73802-0555

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

CMH DENTAL ***Office of State Finance VendorID:*** 0000406910

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

7/25/2016	**107566877**	**$28.00**	02/20/15	ACCT: DA0057	Payment amount based on $35.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				***Patient Initials:*** M.D.
	Mail To Address:	416 S. MUSTANG RD. SUITE A YUKON OK 73099			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1978

SAINT FRANCIS OUTREACH SERVICES — ***Office of State Finance VendorID:*** 0000013303

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/27/2016	**107550457**	**$7.44**	1/11/16	ACCT: 3035421910	Payment amount based on $9.30 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** K.C.
	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:*** 1990

EXCEL THERAPY SPECIALISTS — ***Office of State Finance VendorID:*** 0000308117

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
4/28/2016	**107504624**	**$3,940.31**	12/17/14 - 06/29/15	ACCT: SS2132	Payment amount based on $4,925.39 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				***Patient Initials:*** A.J.
	Mail To Address:	PO BOX 25887 OKLAHOMA CITY OK 73125			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1971

BETHEL MONUMENT CO INC — ***Office of State Finance VendorID:*** 0000245007

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/21/2016	**107653009**	**$919.47**	10/20/15	ACCT: O.F.	Payment amount based on $919.47 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				***Patient Initials:*** O.F.
	Mail To Address:	P O BOX 512 SEMINOLE OK 74818-0512				***Patient Birth Year:*** 1982
11/21/2016	**107653008**	**$1,287.36**		Josh Kevin Howell Monument	Payment amount based on $1,287.36 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				***Patient Initials:*** J.H.
	Mail To Address:	P O BOX 512 SEMINOLE OK 74818-0512				***Patient Birth Year:*** 1986
9/9/2016	**107601242**	**$5,032.28**	01/13/16	ACCT: S.G.	Payment amount based on $5,032.28 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** S.G.
	Mail To Address:	P O BOX 512 SEMINOLE OK 74818-0512				***Patient Birth Year:*** 1984

STIGLER HEALTH AND WELLNESS CENTER — ***Office of State Finance VendorID:*** 0000237848

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

4/28/2016	**107504739**	**$3.40**	06/28/12	ACCT: 52250	Payment amount based on $15.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.34055% among all providers. ***Patient Initials:*** A.B.
	Mail To Address:	P O BOX 179 STIGLER OK 74462-0179			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990

CAPITOL HILL CHURCH OF CHRIST — ***Office of State Finance VendorID:*** 0000405066

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
6/7/2016	**107533946**	**$1,100.00**	01/05/16	FUNERAL REIMBURSEMENT	Payment amount based on $1,100.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/10/2016			***Patient Initials:*** B.J.
	Mail To Address:	PO BOX 5885 EDMOND OK 73083			***Patient Birth Year:*** 1995

MCBRIDE ORTHOPEDIC HOSPITAL — ***Office of State Finance VendorID:*** 0000310462

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/30/2016	**107657862**	**$81.13**	10/26/15 - 01/04/16	ACCT: 528907	Payment amount based on $101.41 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/3/2016			***Patient Initials:*** T.J.
	Mail To Address:	9600 BROADWAY EXTN OKLAHOMA CITY OK 73114			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1996
11/30/2016	**107657861**	**$145.50**	10/26/15 - 02/18/16	ACCT: 528905	Payment amount based on $181.88 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/3/2016			***Patient Initials:*** J.J.
	Mail To Address:	9600 BROADWAY EXTN OKLAHOMA CITY OK 73114			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1971
5/24/2016	**107524676**	**$134.66**	7/28/15 - 9/8/15	ACCT: 523571	Payment amount based on $168.33 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/27/2016			***Patient Initials:*** E.B.
	Mail To Address:	9600 BROADWAY EXTN OKLAHOMA CITY OK 73114			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2006

EAR NOSE & THROAT SPECIALIST — ***Office of State Finance VendorID:*** 0000251222

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/21/2016	**107653051**	**$104.00**	03/29/16	ACCT: 5366090	Payment amount based on $130.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			***Patient Initials:*** V.T.
	Mail To Address:	P O BOX 21228 DEPT 262 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1989
9/9/2016	**107601310**	**$171.51**	7/7/14	ACCT: 1951340	Payment amount based on $214.39 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** W.T.
	Mail To Address:	P O BOX 21228 DEPT 262 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1988

LAB MEDICINE OF GREATER TULSA PC

Office of State Finance VendorID: 0000238140

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
11/21/2016	**107653117**	**$31.20**	5/31/15	330766175-0	Payment amount based on $39.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016				***Patient Initials:***	D.H.
	Mail To Address:	2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1963
6/20/2016	**107544881**	**$5.08**	01/26/16	ACCT: 3348542090	Payment amount based on $39.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 16.26405% among all providers.	***Patient Initials:***	L.H.
	Mail To Address:	2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1977
5/24/2016	**107524660**	**$28.80**	3/31/15	ACCT: 329683821	Payment amount based on $36.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/27/2016				***Patient Initials:***	K.M.
	Mail To Address:	2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1974
5/27/2016	**107528312**	**$31.20**	05/16/15	ACCT: 330534946-0	Payment amount based on $39.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/30/2016				***Patient Initials:***	C.C.
	Mail To Address:	2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1979
4/28/2016	**107504656**	**$65.60**	11/20/15 - 11/21/15	ACCT: 333952352	Payment amount based on $82.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016				***Patient Initials:***	J.S.
	Mail To Address:	2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1958
4/29/2016	**107506142**	**$44.00**	1/25/15	ACCT: 328502439	Payment amount based on $55.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/2/2016				***Patient Initials:***	M.P.
	Mail To Address:	2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1978
4/28/2016	**107504655**	**$22.00**	12/14/12	ACCT: 952185881	Payment amount based on $405.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.79013% among all providers.	***Patient Initials:***	P.W.
	Mail To Address:	2738 E 51ST STREET, SUITE 240 TULSA OK 74105-6271			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1987

SUNDANCE RADIOLOGY PA

Office of State Finance VendorID: 0000296517

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
1/23/2017	**107688938**	**$289.62**	08/18/16	ACCT: 1235104654	Payment amount based on $362.03 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017				***Patient Initials:***	J.T.
	Mail To Address:	P O BOX 52110 AMARILLO TX 79159-2110			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1959

UTICA PARK CLINIC

Office of State Finance VendorID: 0000224911

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/26/2016	107592902	$16.28	12/09/15	ACCT: 811403	Payment amount based on $20.35 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				Patient Initials: R.N.
	Mail To Address:	DEPT 2852 TULSA OK 74182-0001			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1969
6/20/2016	107544987	$508.26	04/26/15	ACCT: 27299	Payment amount based on $2,391.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 26.57145% among all providers.	Patient Initials: K.B.
	Mail To Address:	DEPT 2852 TULSA OK 74182-0001			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1969
4/28/2016	107504766	$73.60	07/22/14 - 10/28/14	ACCT: 618965	Payment amount based on $92.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				Patient Initials: A.J.
	Mail To Address:	DEPT 2852 TULSA OK 74182-0001			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1971
4/29/2016	107506214	$169.60	08/10/15	ACCT: 1050203	Payment amount based on $212.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/2/2016				Patient Initials: L.S.
	Mail To Address:	DEPT 2852 TULSA OK 74182-0001			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1970

UTICA PARK CLINIC

Office of State Finance VendorID: 0000224911

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
5/24/2016	107524801	$44.80	12/12/15	ACCT: 10U11532884	Payment amount based on $56.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				Patient Initials: G.H.
	Mail To Address:	DEPT 1100 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1959
4/28/2016	107504767	$2,416.37	09/02/15	ACCT: 03U12166201	Payment amount based on $3,472.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 86.99495% among all providers.	Patient Initials: N.B.
	Mail To Address:	DEPT 1100 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1984

OSU MEDICAL CENTER

Office of State Finance VendorID: 0000225029

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/1/2016	107638892	$711.22	10/31/14 - 11/1/14	ACCT: V0071702997	Payment amount based on $889.03 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/4/2016				Patient Initials: D.W.
	Mail To Address:	744 W. 9TH TULSA OK 74127			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1990

4/29/2016	**107506170**	**$684.37**	6/20/15	ACCT: V00072341720	Payment amount based on $855.46 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/2/2016				***Patient Initials:*** G.C.
	Mail To Address:	744 W. 9TH TULSA OK 74127			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1975

CUSHING REGIONAL HOSPITAL — ***Office of State Finance VendorID:*** 0000010135

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
9/9/2016	**107601180**	**$528.80**	10/11/15	ACCT: D1528400030	Payment amount based on $1,322.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** J.H.
	Mail To Address:	DEPARTMENT 2218 TULSA OK 74182-0001			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1993
6/7/2016	**107533916**	**$5,535.88**	12/26/15	ACCT: D1536000025	Payment amount based on $6,919.85 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** K.R.
	Mail To Address:	DEPARTMENT 2218 TULSA OK 74182-0001			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1994
5/24/2016	**107524509**	**$604.46**	1/21/16	ACCT: 1602100038	Payment amount based on $755.58 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				***Patient Initials:*** S.W.
	Mail To Address:	DEPARTMENT 2218 TULSA OK 74182-0001			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995

OMA, LLC — ***Office of State Finance VendorID:*** 0000062333

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
7/20/2016	**107563689**	**$58.66**	08/01/15	ACCT: 328734	Payment amount based on $713.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 10.27708% among all providers.	***Patient Initials:*** M.L.
	Mail To Address:	3724 NW 63RD ST., STE. 300 OKLAHOMA CITY OK 73116			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1975

MICHAEL J SAUMUR, DDS — ***Office of State Finance VendorID:*** 0000255750

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
5/4/2016	**107508636**	**$142.40**	11/18/15	ACCT: 331095	Payment amount based on $178.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/7/2016				***Patient Initials:*** B.M.
	Mail To Address:	1112 RAMBLING OAKS NORMAN OK 73072			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1985

INTEGRIS — ***Office of State Finance VendorID:*** 0000245453

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

11/1/2016	**107638874**	**$28.00**	1/9/16	ACCT: 163332	Payment amount based on $35.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/4/2016				***Patient Initials:***	S.M.
	Mail To Address:	PO BOX 258877 OKLAHOMA CITY OK 73125		DEPT #88801	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1990

INTEGRIS MEDICAL GROUP — ***Office of State Finance VendorID:*** 0000245453

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
12/23/2016	**107675517**	**$35.78**	08/11/15	ACCT: 2137868	Payment amount based on $106.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 42.18752% among all providers.	***Patient Initials:***	C.K.
	Mail To Address:	PO BOX 12463 BELFAST ME 04915-4015			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1977
7/20/2016	**107563686**	**$717.38**	02/27/15	ACCT: 745011A6762	Payment amount based on $937.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 95.70235% among all providers.	***Patient Initials:***	E.W.
	Mail To Address:	PO BOX 12463 BELFAST ME 04915-4015			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1976
6/20/2016	**107544871**	**$888.61**	11/06/15 - 11/23/15	ACCT: 1229302A6762	Payment amount based on $1,502.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 73.95226% among all providers.	***Patient Initials:***	S.L.
	Mail To Address:	PO BOX 12463 BELFAST ME 04915-4015			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1981
5/17/2016	**107518809**	**$102.40**	09/10/15	ACCT: 189790A6762	Payment amount based on $128.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/20/2016				***Patient Initials:***	T.D.
	Mail To Address:	PO BOX 12463 BELFAST ME 04915-4015			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1975

RADIOLOGY ASSOCIATES — ***Office of State Finance VendorID:*** 0000266907

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
		$24.30	11/12/14	Acct#162464	Payment amount based on $30.38 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				***Patient Initials:***	R.L.
	Mail To Address:	3330 NW 56TH ST STE 206 OKLAHOMA CITY OK 73112-4426			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1980
8/3/2016	**107573726**	**$16.51**	3/17/16	ACCT: 248829	Payment amount based on $20.64 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016				***Patient Initials:***	J.B.
	Mail To Address:	3330 NW 56TH ST STE 206 OKLAHOMA CITY OK 73112-4426			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1991
8/3/2016	**107573727**	**$64.80**	03/20/15	ACCT: 4036584	Payment amount based on $81.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016				***Patient Initials:***	B.R.
	Mail To Address:	3330 NW 56TH ST STE 206 OKLAHOMA CITY OK 73112-4426			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1961

7/20/2016	**107563797**	**$520.88**	01/24/15 -02/03/15	ACCT: 176668	Payment amount based on $680.34 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 95.70235% among all providers. ***Patient Initials:*** E.W.
	Mail To Address:	3330 NW 56TH ST STE 206 OKLAHOMA CITY OK 73112-4426			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1976

DORIS LANGSTON — ***Office of State Finance VendorID:*** 0000232375

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
8/17/2016	**107584281**	**$56.00**	08/27/15	ACCT: L.M.B.	Payment amount based on $70.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/20/2016			***Patient Initials:*** S.R.
	Mail To Address:	1002 W GORE BLVD LAWTON OK 73501			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1999

DON'S MONUMENTS — ***Office of State Finance VendorID:*** 0000334473

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/16/2016	**107649919**	**$3,185.00**	07/26/16	ACCT: C.J.C.	Payment amount based on $3,185.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/19/2016			***Patient Initials:*** C.C.
	Mail To Address:	530 WEST 12TH STREET ADA OK 74820			***Patient Birth Year:*** 1958

BAILEY MEDICAL CENTER — ***Office of State Finance VendorID:*** 0000306582

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/29/2016	**107506036**	**$759.77**	2/4/15 - 2/5/15	ACCT: B1503501284	Payment amount based on $949.71 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/2/2016			***Patient Initials:*** T.H.
	Mail To Address:	DEPARTMENT 2387 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1978

ACUTE SURGICAL CARE SPECIALIST LLP — ***Office of State Finance VendorID:*** 0000337084

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/21/2016	**107652962**	**$5,835.60**	05/21/16	ACCT: 21257	Payment amount based on $21,473.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 33.97059% among all providers. ***Patient Initials:*** E.B.
	Mail To Address:	PO BOX 650823 DEPT 41681 DALLAS TX 752650823			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987

MCMAHANS FUNERAL HOME — ***Office of State Finance VendorID:*** 0000175083

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

10/19/2016	**107630469**	**$7,168.45**	07/06/16	ACCT: D.L.D.	Payment amount based on $7,168.45 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/22/2016			***Patient Initials:*** D.D.
	Mail To Address:	PO BOX 496 NOBLE OK 73068-0496			***Patient Birth Year:*** 1998

LIFE CONNECTION COUNSELING — ***Office of State Finance VendorID:*** 0000410662

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/18/2016	**107651874**	**$456.00**	2/5/15 - 8/12/16	ACCT: A.C.T.	Payment amount based on $570.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/21/2016			***Patient Initials:*** A.T.
	Mail To Address:	7145 S. BRADEN AVE TULSA OK 74136			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2001
11/18/2016	**107651875**	**$380.00**	1/29/16 - 8/12/16	ACCT: N.A.T.	Payment amount based on $475.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/21/2016			***Patient Initials:*** N.T.
	Mail To Address:	7145 S. BRADEN AVE TULSA OK 74136			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1999
11/18/2016	**107651876**	**$783.75**	2/5/16 - 8/12/16	ACCT: E.N.T.	Payment amount based on $979.69 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/21/2016			***Patient Initials:*** E.T.
	Mail To Address:	7145 S. BRADEN AVE TULSA OK 74136			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1966

CURTIS WOLF, M.D. — ***Office of State Finance VendorID:*** 0000291907

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/29/2016	**107506089**	**$212.80**	8/6/15	ACCT: 17480	Payment amount based on $266.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/2/2016			***Patient Initials:*** L.S.
	Mail To Address:	1145 SOUTH UTICA AVE, SUITE 362 TULSA OK 74104-4004			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1970

ALLIANCE HEALTH DEACONESS — ***Office of State Finance VendorID:*** 0000056214

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
1/23/2017	**107688757**	**$179.88**	06/20/15	ACCT: 4499383	Payment amount based on $224.85 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/26/2017			***Patient Initials:*** C.M.
	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:*** 1972
11/21/2016	**107653039**	**$163.60**	02/05/15	ACCT: 4470284 - $81.80; 4466143-15681 - $81.80	Payment amount based on $396.53 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 51.57423% among all providers. ***Patient Initials:*** R.S.
	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:*** 1963

11/21/2016	**107653040**	**$17,373.32**	12/12/15 - 12/17/15	4536628	Payment amount based on $47,379.96 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 45.835% among all providers.	***Patient Initials:*** D.P.
	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:*** 1996
9/9/2016	**107601301**	**$438.20**	04/10/15	ACCT: 4484339	Payment amount based on $547.75 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** T.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:*** 1993
6/8/2016	**107534948**	**$620.61**	12/7/15	ACCT: 4535352	Payment amount based on $775.76 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				***Patient Initials:*** M.H.
	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:*** 1955

DEACONESS PHYSICIAN SERVICES, LLC ***Office of State Finance VendorID:*** 0000274912

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
8/3/2016	**107573594**	**$184.00**	4/11/16	ACCT: 20356179A1889	Payment amount based on $230.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				***Patient Initials:*** J.B.
	Mail To Address:	PO BOX 8650 BELFAST ME 04915-8650			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1991

COMMUNITY HOSPITAL ***Office of State Finance VendorID:*** 0000258452

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
5/6/2016	**107511033**	**$379.33**	11/6/2015	ACCT: 0957124-01	Payment amount based on $474.16 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/9/2016				***Patient Initials:*** T.G.
	Mail To Address:	PO BOX 248823 OKLAHOMA CITY OK 73124-8823			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1969
5/6/2016	**107511034**	**$120.00**	4/15/15	ACCT: 925273	Payment amount based on $150.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/9/2016				***Patient Initials:*** M.L.
	Mail To Address:	PO BOX 248823 OKLAHOMA CITY OK 73124-8823			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1971

CEDAR RIDGE HOSPITAL ***Office of State Finance VendorID:*** 0000259972

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
9/9/2016	**107601263**	**$535.15**	7/18/16 - 7/26/16	ACCT: 20003750013	Payment amount based on $668.94 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** D.P.
	Mail To Address:	6505 NE 50TH STREET OKLAHOMA CITY OK 73141			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1997

9/9/2016	**107601264**	**$822.55**	04/10/15 - 04/15/15	ACCT: 10122190019	Payment amount based on $1,028.19 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** T.B.
	Mail To Address:	6505 NE 50TH STREET OKLAHOMA CITY OK 73141			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1993
6/27/2016	**107550326**	**$844.48**	4/18/16 - 4/25/16	ACCT: 10141290014	Payment amount based on $1,055.60 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/30/2016			***Patient Initials:*** D.P.
	Mail To Address:	6505 NE 50TH STREET OKLAHOMA CITY OK 73141			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1997

STILLWATER RADIOLOGY ***Office of State Finance VendorID:*** 0000366930

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
6/27/2016	**107550464**	**$29.60**	3/3/16	ACCT: 56306401	Payment amount based on $37.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/30/2016			***Patient Initials:*** D.H.
	Mail To Address:	816 S. WALNUT ST. STILLWATER OK 74074-4225			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1982
6/7/2016	**107534063**	**$104.00**	05/02/15	ACCT: 551726	Payment amount based on $130.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/10/2016			***Patient Initials:*** A.E.
	Mail To Address:	816 S. WALNUT ST. STILLWATER OK 74074-4225			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1995

RIVERSIDE GARDENS CEMETARY ***Office of State Finance VendorID:*** 0000310575

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
10/11/2016	**107624055**	**$3,150.00**	10/2/15	ACCT: E.S.	Payment amount based on $3,150.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** E.S.
	Mail To Address:	4720 NE 36TH ST. OKLAHOMA CITY OK 73121			***Patient Birth Year:*** 1982
6/7/2016	**107534048**	**$600.00**	04/04/15	ACCT: R.H.	Payment amount based on $600.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/10/2016			***Patient Initials:*** R.H.
	Mail To Address:	4720 NE 36TH ST. OKLAHOMA CITY OK 73121			***Patient Birth Year:*** 1989

ORAL & FACIAL SURGERY CENTER ***Office of State Finance VendorID:*** 0000250636

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/21/2016	**107653149**	**$46.73**	03/01/16	ACCT: 200966	Payment amount based on $113.25 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 51.57423% among all providers. ***Patient Initials:*** R.S.
	Mail To Address:	1000 N LINCOLN, STE 200 OKLAHOMA CITY OK 73104			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1963

6/20/2016	**107544906**	**$2,722.94**	01/22/16 - 01/26/16	ACCT: 202267	Payment amount based on $3,476.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 97.91947% among all providers.	***Patient Initials:*** K.L.
	Mail To Address:	1000 N LINCOLN, STE 200 OKLAHOMA CITY OK 73104			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1956

HOGLE EYECARE CENTER — ***Office of State Finance VendorID:*** 0000290956

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
7/20/2016	**107563677**	**$180.80**	5/4/2016	ACCT: E.M.	Payment amount based on $180.80 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** E.M.
	Mail To Address:	2500 CHANDLER ROAD MUSKOGEE OK 74403				***Patient Birth Year:*** 1993

MARY BOBO, LCSW — ***Office of State Finance VendorID:*** 0000257765

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/8/2016	**107534998**	**$135.37**	2/2/15- 2/1/16	ACCT: 11879-10109	Payment amount based on $169.21 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				***Patient Initials:*** S.T.
	Mail To Address:	501 N. MUSTANG RD, SUITE G MUSTANG OK 73064			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1963

ST. JOHN ANESTHESIA SERVICES — ***Office of State Finance VendorID:*** 0000263808

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
10/11/2016	**107624065**	**$58.29**	12/9/15	ACCT: 0085704974	Payment amount based on $72.86 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				***Patient Initials:*** D.M.
	Mail To Address:	PO BOX 21228 DEPT 151 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1936
6/20/2016	**107544953**	**$798.74**	04/26/15, 04/28/15, 05/18/15	ACCT: 0084227706 - $497.42; 84227706 - $172.18; 0084326046 - $129.14	Payment amount based on $3,757.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 26.57145% among all providers.	***Patient Initials:*** K.B.
	Mail To Address:	PO BOX 21228 DEPT 151 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1969

ST JOHN OWASSO — ***Office of State Finance VendorID:*** 0000289155

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
10/11/2016	**107624040**	**$1,544.06**	4/10/15	ACCT: W0007549827	Payment amount based on $1,930.08 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				***Patient Initials:*** D.B.
	Mail To Address:	1923 S UTICA AVE TULSA OK 74104-6502			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1996

8/26/2016	**107592846**	**$1,307.05**	12/15/14	ACCT: W0005297254	Payment amount based on $1,633.81 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** Y.S.
	Mail To Address:	1923 S UTICA AVE TULSA OK 74104-6502			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995
4/6/2016	**107486721**	**$655.38**	6/10/15	ACCT: W0022199145	Payment amount based on $819.23 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/9/2016				***Patient Initials:*** H.D.
	Mail To Address:	1923 S UTICA AVE TULSA OK 74104-6502			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1951

LOCUST GROVE FUNERAL HOME

Office of State Finance VendorID: 0000289510

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
7/25/2016	**107566968**	**$7,127.17**	02/06/16	ACCT: N.P.B.	Payment amount based on $7,127.17 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				***Patient Initials:*** N.B.
	Mail To Address:	PO BOX 517 LOCUST GROVE OK 74352				***Patient Birth Year:*** 1988

PONCA CITY MEDICAL CENTER

Office of State Finance VendorID: 0000056230

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/21/2016	**107653174**	**$8,097.33**	4/3/15 - 4/6/15	D6266456	Payment amount based on $10,121.66 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				***Patient Initials:*** J.T.
	Mail To Address:	PO BOX 504295 ST. LOUIS MO 63160			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1986
10/11/2016	**107624044**	**$1,080.27**	1/1/16 - 1/7/16	ACCT: D006779342	Payment amount based on $1,350.34 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				***Patient Initials:*** R.M.
	Mail To Address:	PO BOX 504295 ST. LOUIS MO 63160			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1983
7/20/2016	**107563789**	**$452.98**	02/01/16	ACCT: D006835151	Payment amount based on $3,562.84 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 15.89261% among all providers.	***Patient Initials:*** J.K.
	Mail To Address:	PO BOX 504295 ST. LOUIS MO 63160			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1996
6/8/2016	**107535016**	**$931.60**	11/8/15	ACCT: D06686745	Payment amount based on $1,164.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				***Patient Initials:*** B.W.
	Mail To Address:	PO BOX 504295 ST. LOUIS MO 63160			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995

MAYER EYE CARE

Office of State Finance VendorID: 0000253789

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

7/20/2016	**107563732**	**$17.17**	03/04/16	ACCT: J.K.	Payment amount based on $135.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 15.89261% among all providers.	***Patient Initials:*** J.K.
	Mail To Address:	1722 N. 4TH, SUITE C PONCA CITY OK 74601			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1996

WASHITA EMERGENCY PHYSICIANS — ***Office of State Finance VendorID:*** 0000281729

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
9/9/2016	**107601579**	**$46.94**	03/22/15	ACCT: PUV100142421	Payment amount based on $58.68 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** T.B.
	Mail To Address:	PO BOX 13581 PHILADELPHIA PA 19101-3581			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1993
9/9/2016	**107601578**	**$1,207.20**	08/30/15	ACCT: PUV100251289	Payment amount based on $1,509.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** B.C.
	Mail To Address:	PO BOX 13581 PHILADELPHIA PA 19101-3581			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1997

KAY COUNTY CLINIC COMPANY, LLC — ***Office of State Finance VendorID:*** 0000274060

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/21/2016	**107653110**	**$2,134.40**	3/31/15 - 10/22/15	Claim ID 144390, 146632 & 169283	Payment amount based on $2,668.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				***Patient Initials:*** J.T.
	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:*** 1986
10/11/2016	**107624018**	**$728.29**	1/1/16 - 1/2/16	ACCT: 178110V2289 $360.89, 178114V2289 $232.04, 178088V2289 $135.36	Payment amount based on $910.36 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				***Patient Initials:*** R.M.
	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:*** 1983

SHORTLINE DENTAL PLLC — ***Office of State Finance VendorID:*** 0000260686

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/19/2017	**107686535**	**$1,432.00**	05/11/16	ACCT: GO0274	Payment amount based on $1,790.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** A.G.
	Mail To Address:	MICHAEL L. RIGGS DDS TULSA OK 74129		9908 E 21 STREET	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1983

APOGEE MEDICAL GROUP — ***Office of State Finance VendorID:*** 0000403703

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

4/28/2016	**107504555**	**$317.30**	04/24/12 - 05/01/12	ACCT: B000206074	Payment amount based on $1,399.48 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/1/2016
Total Bills exceed maximum award. Payment is prorated at 28.34055% among all providers.
Patient Initials: A.B.

Mail To Address: PO BOX 708877
SANDY UT 708877
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Birth Year: 1990

DR. MELISSA S. BOWLER

Office of State Finance VendorID: 0000409738

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
10/19/2016	**107630406**	**$1,595.20**	07/28/16 - 08/15/16	ACCT: 7781 T.R.	Payment amount based on $1,994.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/22/2016
Patient Initials: T.R.

Mail To Address: 1310 W. MAIN ST.
COLLINSVILLE OK 74021
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Birth Year: 1994

ST. JOHN URGENT CARE CENTER

Office of State Finance VendorID: 0000332690

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/1/2016	**107638909**	**$487.20**	6/25/16 - 7/1/2016	ACCT: 2820852A7661	Payment amount based on $609.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/4/2016
Patient Initials: R.A.

Mail To Address: DEPT 328 PO BOX 21228
TULSA OK 74121
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Birth Year: 1996

DEARMAN'S WYNNEWOOD FUNERAL HOME

Office of State Finance VendorID: 0000272401

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
5/27/2016	**107528258**	**$7,428.01**	07/28/15	ACCT: M.F.	Payment amount based on $7,428.01 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/30/2016
Patient Initials: M.F.

Mail To Address: 103 EAST CHEROKEE ST.
WYNNEWOOD OK 73098
Patient Birth Year: 1975

FULTON EYECARE CENTER PLLC

Office of State Finance VendorID: 0000376414

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
		($720.00)	11/30/15	ACCT: 3913 **PROVIDER RETURNED PAYMENT, LESS $50 FOR CHARGE FOR ESTIMATE**	Payment amount based on ($900.00) patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 4/27/16 Expected to be mailed by 5/11/16
Patient Initials: P.A.

Mail To Address: 402 W. CHICKASHA AVE., STE 100
CHICKASHA OK 73018-2461
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Birth Year: 1964

5/4/2016	**107508590**	**$770.00**	11/30/15	ACCT: 3913	Payment amount based on $962.50 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/7/2016
Patient Initials: P.A.

Mail To Address: 402 W. CHICKASHA AVE., STE 100
CHICKASHA OK 73018-2461
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Birth Year: 1964

ROBERT BRYAN, DDS — *Office of State Finance VendorID:* 0000275789

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/18/2016	107651894	$1,151.20	10/2/15, 3/21/16	ACCT: 39819	Payment amount based on $1,439.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				*Patient Initials:* D.F.
	Mail To Address:	4320 MCAULEY BLVD. OKLAHOMA CITY OK 73120			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1987

BAHA ABU-ESHEH MD — *Office of State Finance VendorID:* 0000277189

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
7/25/2016	107566861	$185.42	03/05/14 - 02/13/16	ACCT: 1680	Payment amount based on $231.78 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				*Patient Initials:* L.L.
	Mail To Address:	PO BOX 268996 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1958

ATS COUNSELING — *Office of State Finance VendorID:* 0000278543

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/1/2016	107638840	$576.00	4/30/16 - 7/18/16	ACCT: L.Y.H.	Payment amount based on $720.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/4/2016				*Patient Initials:* L.H.
	Mail To Address:	1625 W OWEN K GARRIOTT ENID OK 73703-5653		STE F	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 2006
9/9/2016	107601207	$288.00	1/19/15 - 2/9/15	ACCT: M.K.	Payment amount based on $360.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				*Patient Initials:* M.K.
	Mail To Address:	1625 W OWEN K GARRIOTT ENID OK 73703-5653		STE F	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 2001
9/9/2016	107601208	$288.00	1/19/15 - 2/9/15	ACCT: A.K.	Payment amount based on $360.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				*Patient Initials:* A.K.
	Mail To Address:	1625 W OWEN K GARRIOTT ENID OK 73703-5653		STE F	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 2004
7/20/2016	107563559	$428.00	3/29/16-4/25/16	ACCT: L.Y.H.	Payment amount based on $535.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				*Patient Initials:* L.H.
	Mail To Address:	1625 W OWEN K GARRIOTT ENID OK 73703-5653		STE F	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 2006
4/6/2016	107486570	$1,812.00	3/12/15 - 9/14/15	ACCT: 90834	Payment amount based on $2,265.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/9/2016				*Patient Initials:* K.B.
	Mail To Address:	1625 W OWEN K GARRIOTT ENID OK 73703-5653		STE F	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 2000

ANESTHESIA OF ENID LLC — *Office of State Finance VendorID:* 0000285934

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
6/20/2016	107544778	$608.18	11/22/15	ACCT: 415601-106	Payment amount based on $1,028.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 73.95226% among all providers.	*Patient Initials:* S.L.
	Mail To Address:	P O BOX 6112 ENID OK 73702-6112			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1981

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

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
		$1,262.50	7/17/16	Acct #23904907	Payment amount based on $1,578.13 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				*Patient Initials:* K.W.
	Mail To Address:	PO BOX 890 DENISON TX 75020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1961

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

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
12/23/2016	107675580	$20,000.00	10/31/15 AND 11/12/15	ACCT: 22928097 - $16,520.27; 22975379 - $3,479.73	Payment amount based on $45,382.84 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 55.0869% among all providers.	*Patient Initials:* T.P.
	Mail To Address:	PO BOX 844768 DALLAS TX 75284-4768			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1963

HEATH GRIFFITH FUNERAL HOME & CREMATION CTR — *Office of State Finance VendorID:* 0000281721

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
1/20/2017	107687674	$2,500.00	3/29/16	3/29/16 funeral	Payment amount based on $2,500.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				*Patient Initials:* A.E.
	Mail To Address:	1823 W 51ST STREET TULSA OK 74107				*Patient Birth Year:* 1995

MUSKOGEE REG MED CTR LLC — *Office of State Finance VendorID:* 0000272947

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
10/11/2016	107624033	$1,351.28	6/1/16	ACCT: 60257	Payment amount based on $1,689.10 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				*Patient Initials:* P.J.
	Mail To Address:	P O BOX 281509 ATLANTA GA 30384-1509			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1964

8/26/2016	**107592828**	**$919.37**	10/12/15	ACCT: 29912	Payment amount based on $1,149.21 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				*Patient Initials:* K.B.
	Mail To Address:	P O BOX 281509 ATLANTA GA 30384-1509			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1983

MUSKOGEE REGIONAL MED CTR — *Office of State Finance VendorID:* 0000272947

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*
11/18/2016	**107651884**	**$1,352.08**	5/4/14	ACCT: 203725767	Payment amount based on $1,690.10 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				*Patient Initials:* B.F.
	Mail To Address:	DBA EASTAR HEALTH SYSTEM ATLANTA GA 30384-1509	PO BOX 281509		Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1980
11/18/2016	**107651883**	**$498.40**	5/31/16	ACCT: 205485212	Payment amount based on $623.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				*Patient Initials:* T.O.
	Mail To Address:	DBA EASTAR HEALTH SYSTEM ATLANTA GA 30384-1509	PO BOX 281509		Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1964
11/15/2016	**107648871**	**$6,235.31**	12/22/14	ACCT: 204265177	Payment amount based on $7,794.14 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/18/2016				*Patient Initials:* A.L.
	Mail To Address:	DBA EASTAR HEALTH SYSTEM ATLANTA GA 30384-1509	PO BOX 281509		Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1974

ST. MARY'S PHYSICIAN ASSOCIATES — *Office of State Finance VendorID:* 0000328372

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*
1/23/2017	**107688934**	**$636.09**	09/18/16	ACCT: 2124304	Payment amount based on $2,610.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 30.46392% among all providers.	*Patient Initials:* L.B.
	Mail To Address:	PO BOX 1746 ENID OK 73702			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1980

SOUTHER NEVADA INTERNISTS — *Office of State Finance VendorID:* 0000404123

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*
5/4/2016	**107508676**	**$725.18**	03/31/15 - 12/17/15	ACCT: 64	Payment amount based on $906.48 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/7/2016				*Patient Initials:* C.B.
	Mail To Address:	PO BOX 621406 LAS VEGAS NV 89162-0000			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1962

IBMC ER PHYSICIANS — *Office of State Finance VendorID:* 0000296961

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

11/15/2016	**107648848**	**$534.40**	09/27/15	ACCT: 68984648J	Payment amount based on $668.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/18/2016			***Patient Initials:*** L.G.
	Mail To Address:	PO BOX 960071 OKLAHOMA CITY OK 73196			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1956
8/26/2016	**107592798**	**$367.20**	01/11/16 AND 01/13/16	ACCT: 6990978J - $187.20; 70043956J - $180.00	Payment amount based on $459.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** H.W.
	Mail To Address:	PO BOX 960071 OKLAHOMA CITY OK 73196			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1991
7/25/2016	**107566936**	**$656.80**	09/11/15	ACCT: 407*0068859271	Payment amount based on $821.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/28/2016			***Patient Initials:*** L.G.
	Mail To Address:	PO BOX 960071 OKLAHOMA CITY OK 73196			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1956
7/20/2016	**107563682**	**$320.03**	01/24/15	ACCT: 66892762J	Payment amount based on $418.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 95.70235% among all providers. ***Patient Initials:*** E.W.
	Mail To Address:	PO BOX 960071 OKLAHOMA CITY OK 73196			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1976

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

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
1/20/2017	**107687737**	**$724.20**	4/28/16	310927579	Payment amount based on $905.25 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/23/2017			***Patient Initials:*** C.C.
	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:*** 1971

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

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/23/2016	**107675576**	**$6,269.60**	09/03/16 AND 09/05/16	ACCT: 311278626 - $5,821.40; 311280267 - $448.20	Payment amount based on $7,837.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***Patient Initials:*** K.B.
	Mail To Address:	FILE 749344 LOS ANGELES CA 90074-9344			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1979
10/11/2016	**107624067**	**$3,391.80**	1/24/16	ACCT: 310655931	Payment amount based on $4,239.75 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** J.J.
	Mail To Address:	FILE 749344 LOS ANGELES CA 90074-9344			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1983

5/27/2016	**107528405**	**$3,674.40**	05/11/15 AND 05/22/15	ACCT: 310088554 - $3,508.40; 310111489 - $166.00	Payment amount based on $4,593.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				***Patient Initials:*** M.H.
	Mail To Address:	FILE 749344 LOS ANGELES CA 90074-9344			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1968
4/6/2016	**107486753**	**$929.62**	9/11/15	ACCT: 310319553	Payment amount based on $1,162.03 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/9/2016				***Patient Initials:*** J.M.
	Mail To Address:	FILE 749344 LOS ANGELES CA 90074-9344			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2001

OK CHRISTIAN COUNSELING CENTER ***Office of State Finance VendorID:*** 0000014897

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/18/2016	**107651887**	**$176.00**	7/22/16, 9/14/16	ACCT: T77900	Payment amount based on $220.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				***Patient Initials:*** S.S.
	Mail To Address:	13301 N MERIDIAN AVE BLDG 100 OKLAHOMA CITY OK 73120-8357			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2003
5/6/2016	**107511096**	**$285.58**	11/10/15 - 1/26/16	ACCT: T77900	Payment amount based on $356.98 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/9/2016				***Patient Initials:*** S.S.
	Mail To Address:	13301 N MERIDIAN AVE BLDG 100 OKLAHOMA CITY OK 73120-8357			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2003

SAINT FRANCIS TRAUMA INSTITUTE ***Office of State Finance VendorID:*** 0000015376

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
9/30/2016	**107617574**	**$502.40**	06/18/13	ACCT: 12802986	Payment amount based on $628.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016				***Patient Initials:*** F.P.
	Mail To Address:	6600 S. YALE AVE. STE 1400 TULSA OK 74136			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1962
8/17/2016	**107584343**	**$12,196.40**	04/18/15 - 04/29/15	ACCT: 3029853300 - $9,272.89; 3029853310 - $240.16; 3029853320 - $1,119.73; 3029853330 - 1,408.27; 3029853340 - $155.35	Payment amount based on $16,251.33 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/20/2016			Total Bills exceed maximum award. Payment is prorated at 93.81084% among all providers.	***Patient Initials:*** M.B.
	Mail To Address:	6600 S. YALE AVE. STE 1400 TULSA OK 74136			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1998
7/25/2016	**107567040**	**$87.81**	05/25/14	ACCT: 02413655	Payment amount based on $109.76 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				***Patient Initials:*** L.S.
	Mail To Address:	6600 S. YALE AVE. STE 1400 TULSA OK 74136			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1968

4/29/2016	**107506182**	**$344.80**	5/12/14	ACCT: 01123607	Payment amount based on $431.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/2/2016			***Patient Initials:*** A.M.
	Mail To Address:	6600 S. YALE AVE. STE 1400 TULSA OK 74136			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1972
4/28/2016	**107504721**	**$348.00**	05/01/15 - 05/02/15	ACCT: 3025424990	Payment amount based on $435.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** J.R.
	Mail To Address:	6600 S. YALE AVE. STE 1400 TULSA OK 74136			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1968
4/28/2016	**107504720**	**$2,485.68**	12/13/12 - 01/31/13	ACCT: 02306633	Payment amount based on $45,759.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.79013% among all providers. ***Patient Initials:*** P.W.
	Mail To Address:	6600 S. YALE AVE. STE 1400 TULSA OK 74136			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987

CARE COMMUNICATIONS, LLC ***Office of State Finance VendorID:*** 0000015376

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
1/19/2017	**107686384**	**$2,282.40**	07/16/16 - 08/04/16	ACCT: 3039961690 - $705.60; 3039951700 - $524.80; 3039951710 - $243.20; 3039951720 - $243.20; 3040173420 - $337.60; 3040313510 - $168.80; 3041035290 - $59.20	Payment amount based on $2,853.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/22/2017			***Patient Initials:*** J.C.
	Mail To Address:	PO BOX 975471 DALLAS TX 75397-			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1981

ST JOHN BROKEN ARROW ***Office of State Finance VendorID:*** 0000324455

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
7/20/2016	**107563825**	**$6,621.60**	01/02/16	ACCT: B0034546649	Payment amount based on $8,277.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			***Patient Initials:*** J.E.
	Mail To Address:	DEPT 2714 TULSA OK 74182-0001			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1982

STROUD REGIONAL MEDICAL CENTER ***Office of State Finance VendorID:*** 0000336862

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
7/20/2016	**107563834**	**$540.68**	05/12/13 AND 05/17/13	ACCT: 7087	Payment amount based on $1,940.71 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 34.82462% among all providers. ***Patient Initials:*** J.J.
	Mail To Address:	PO BOX 12913 OKLAHOMA CITY OK 73157-2913			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1979

SOLUTIONS PRACTICE MANAGEMENT

Office of State Finance VendorID: 0000314682

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
9/9/2016	107601517	$329.60	8/3/15, 2/2/16, 3/16/16	ACCT: 54760	Payment amount based on $412.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				*Patient Initials:* M.S.
	Mail To Address:	PO BOX 1417 LOWELL AR 72745-1417			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1976

NRHS RADIOLOGY ASSOCIATES

Office of State Finance VendorID: 0000291219

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
7/20/2016	107563751	$134.01	07/31/15 - 08/01/15	ACCT: 147694	Payment amount based on $1,630.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 10.27708% among all providers.	*Patient Initials:* M.L.
	Mail To Address:	P O BOX 269065 OKLAHOMA CITY OK 73126-9065			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1975
6/20/2016	107544898	$109.53	11/22/15	ACCT: N00874574643	Payment amount based on $208.93 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 65.53194% among all providers.	*Patient Initials:* R.D.
	Mail To Address:	P O BOX 269065 OKLAHOMA CITY OK 73126-9065			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1992
5/4/2016	107508630	$456.00	11/14/15	ACCT: 168545	Payment amount based on $570.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/7/2016				*Patient Initials:* B.M.
	Mail To Address:	P O BOX 269065 OKLAHOMA CITY OK 73126-9065			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1985

OKLAHOMA HEART HOSPITAL

Office of State Finance VendorID: 0000324629

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
9/9/2016	107601449	$80.00	5/2/16	ACCT: 1601602	Payment amount based on $100.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				*Patient Initials:* B.B.
	Mail To Address:	PO BOX 248870 OKLAHOMA CITY OK 73124			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 2001
8/3/2016	107573700	$1,330.68	3/14/15	ACCT: 2015140828	Payment amount based on $1,663.35 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				*Patient Initials:* J.W.
	Mail To Address:	PO BOX 248870 OKLAHOMA CITY OK 73124			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1971

SOUTHWEST ANESTHESIA

Office of State Finance VendorID: 0000301597

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

6/20/2016	**107544949**	**$985.60**	12/04/15	ACCT: 4310*10184	Payment amount based on $1,232.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016				***Patient Initials:***	N.D.
	Mail To Address:	SECTION #3115 OKLAHOMA CITY OK 73126		PO BOX 26706	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1984
4/28/2016	**107504726**	**$916.41**	04/28/15	ACCT: 1154576779	Payment amount based on $2,926.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 39.14963% among all providers.	***Patient Initials:***	K.H.
	Mail To Address:	SECTION #3115 OKLAHOMA CITY OK 73126		PO BOX 26706	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1982

EMP OF TULSA COUNTY ***Office of State Finance VendorID:*** 0000294051

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
11/30/2016	**107657819**	**$69.27**	02/18/16	ACCT: 3684135A6385	Payment amount based on $86.59 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				***Patient Initials:***	T.W.
	Mail To Address:	PO BOX 848447 BOSTON MA 02284-8447			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1995
11/21/2016	**107653054**	**$1,022.00**	5/30/15	2885611A6385	Payment amount based on $1,277.50 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016				***Patient Initials:***	D.H.
	Mail To Address:	PO BOX 848447 BOSTON MA 02284-8447			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1963
6/7/2016	**107533976**	**$706.00**	07/19/15	ACCT: 5971175	Payment amount based on $882.50 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/10/2016				***Patient Initials:***	B.D.
	Mail To Address:	PO BOX 848447 BOSTON MA 02284-8447			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1995
6/7/2016	**107533975**	**$116.94**	09/03/15	ACCT: 3173741A6385	Payment amount based on $146.18 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/10/2016				***Patient Initials:***	C.P.
	Mail To Address:	PO BOX 848447 BOSTON MA 02284-8447			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1998
6/7/2016	**107533974**	**$594.40**	10/26/14	ACCT: 1798982A6385	Payment amount based on $743.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/10/2016				***Patient Initials:***	J.M.
	Mail To Address:	PO BOX 848447 BOSTON MA 02284-8447			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1987
5/27/2016	**107528271**	**$1,022.00**	05/16/15	ACCT: 39036859	Payment amount based on $1,277.50 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/30/2016				***Patient Initials:***	C.C.
	Mail To Address:	PO BOX 636803 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1979

4/28/2016	**107504619**	**$666.00**	11/21/15	ACCT: 889655A6385	Payment amount based on $832.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				***Patient Initials:*** R.H.
	Mail To Address:	PO BOX 636803 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1980
4/28/2016	**107504620**	**$982.00**	11/20/15	ACCT: 13180967V	Payment amount based on $1,227.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				***Patient Initials:*** J.S.
	Mail To Address:	PO BOX 636803 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1958
4/29/2016	**107506109**	**$626.20**	5/12/14	ACCT: 1672330A6385	Payment amount based on $782.75 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/2/2016				***Patient Initials:*** A.M.
	Mail To Address:	PO BOX 636803 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1972
4/28/2016	**107504618**	**$837.46**	07/12/15	ACCT: 3013813A6385	Payment amount based on $1,507.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 69.44086% among all providers.	***Patient Initials:*** C.M.
	Mail To Address:	PO BOX 636803 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1991
4/28/2016	**107504617**	**$113.40**	12/13/12	ACCT: M8518910	Payment amount based on $2,087.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.79013% among all providers.	***Patient Initials:*** P.W.
	Mail To Address:	PO BOX 636803 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1987

ORTHOPEDIC AND TRAUMA SERVICE OF OKLAHOMA

Office of State Finance VendorID: 0000295367

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
12/23/2016	**107675548**	**$12.27**	04/14/16	ACCT: 12799493	Payment amount based on $28.15 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 54.4946% among all providers.	***Patient Initials:*** M.B.
	Mail To Address:	2424 E 21ST STE 320 TULSA OK 74114			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1977
6/20/2016	**107544908**	**$338.98**	02/07/15 - 01/25/16	ACCT: 6276894	Payment amount based on $2,605.26 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 16.26405% among all providers.	***Patient Initials:*** L.H.
	Mail To Address:	2424 E 21ST STE 320 TULSA OK 74114			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1977

COUNSELING RESOURCE CENTER

Office of State Finance VendorID: 0000405877

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/27/2016	**107550340**	**$48.00**	5/23/15 - 4/28/16	ACCT: BENS001	Payment amount based on $60.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** S.B.
	Mail To Address:	500 MASON ST TOMBALL TX 77375			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2001

SOUTHWEST PATHOLOGY ASSOCIATES LLC

Office of State Finance VendorID: 0000303545

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/21/2016	107653209	$53.16	02/03/16	ACCT: 4462*41603400046	Payment amount based on $66.45 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				*Patient Initials:* N.D.
	Mail To Address:	P O BOX 21228 DEPT 113 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1983
4/22/2016	107500220	$74.40	02/11/13 AND 02/28/13	ACCT: 369065136 - $27.20; 4462*395492 - $47.20	Payment amount based on $93.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/25/2016				*Patient Initials:* K.T.
	Mail To Address:	P O BOX 21228 DEPT 113 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1950

HEALDTON MERCY HOSPITAL CORP

Office of State Finance VendorID: 0000298473

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
		$512.20	8/27/14	acct: 51142390030	Payment amount based on $640.25 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				*Patient Initials:* A.H.
	Mail To Address:	PO BOX 504292 ST. LOUIS MO 63150-4292			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1974
11/18/2016	107651865	$307.26	3/24/15	ACCT: 51150830037	Payment amount based on $384.08 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				*Patient Initials:* S.M.
	Mail To Address:	PO BOX 504292 ST. LOUIS MO 63150-4292			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1972

TALIHINA FAMILY DENTISTRY

Office of State Finance VendorID: 0000401166

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
5/24/2016	107524761	$996.00	4/12/16	M.N.	Payment amount based on $1,245.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				*Patient Initials:* M.N.
	Mail To Address:	200 DALLAS STREET TALIHINA OK 74571			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1996

METROPLEX NEPHROLOGY ASSOCIATES

Office of State Finance VendorID: 0000410655

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/21/2016	107653127	$273.12	06/07/16 - 06/14/16	ACCT: 14402	Payment amount based on $1,005.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 33.97059% among all providers.	*Patient Initials:* E.B.
	Mail To Address:	4100 W. 15TH ST. STE 100 PLANO TX 750935826			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1987

BRYAN STICE, PHD — *Office of State Finance VendorID:* 0000407249

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573566	$313.60	9/26/15 - 11/21/15	ACCT: 103135380	Payment amount based on $392.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				*Patient Initials:* S.O.
	Mail To Address:	419 W. GRAY NORMAN OK 73072			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1999

OSU MEDICAL CENTER TRUST — *Office of State Finance VendorID:* 0000313899

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
7/20/2016	107563760	$973.38	05/02/15	ACCT: VAB84046	Payment amount based on $1,216.73 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				*Patient Initials:* S.B.
	Mail To Address:	DEPT 2569 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1968
6/7/2016	107534027	$4,498.08	07/10/14	ACCT: 71475990	Payment amount based on $5,622.60 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				*Patient Initials:* W.T.
	Mail To Address:	DEPT 2569 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* N/A
4/28/2016	107504682	$14,685.92	09/29/14	ACCT: V00071637615	Payment amount based on $18,357.40 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				*Patient Initials:* C.V.
	Mail To Address:	DEPT 2569 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1978
4/22/2016	107500210	$2,800.09	11/26/12 - 03/04/13	ACCT: 62426994 - $1,155.41; 62767799 - $304.32; 62890040 - $986.52; VAA01324 - $353.84	Payment amount based on $3,500.11 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/25/2016				*Patient Initials:* K.T.
	Mail To Address:	DEPT 2569 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1950

FERRARA CHIROPRACTIC — *Office of State Finance VendorID:* 0000409226

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
9/30/2016	107617433	$8.99	03/02/16	ACCT: J.A.	Payment amount based on $840.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 1.33595% among all providers.	*Patient Initials:* J.A.
	Mail To Address:	60 NW SHERIDAN RD. #5 LAWTON OK 73505			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1983

RAY & MARTHA'S FUNERAL HOME — *Office of State Finance VendorID:* 0000252107

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

6/7/2016	**107534046**	**$7,500.00**	05/21/15	ACCT: P.G.	Payment amount based on $7,514.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/10/2016			***Patient Initials:*** P.G.
	Mail To Address:	20-22 WEST MAIN STREET CARNEGIE OK 73015			***Patient Birth Year:*** 1990

MERCY HEALTH OKLAHOMA COMMUNITIES ***Office of State Finance VendorID:*** 0000334305

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/23/2016	**107675539**	**$546.40**	06/10/16	ACCT: 111810956	Payment amount based on $683.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***Patient Initials:*** P.M.
	Mail To Address:	PO BOX 505119 ST. LOUIS MO 63150-5119			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1966
11/16/2016	**107649950**	**$78.24**	10/25/16	ACCT: 106125876	Payment amount based on $195.59 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/19/2016			***Patient Initials:*** K.R.
	Mail To Address:	PO BOX 505119 ST. LOUIS MO 63150-5119			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1966
9/9/2016	**107601427**	**$53.63**	4/21/15 - 4/22/15	ACCT: 105746939	Payment amount based on $67.04 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** G.L.
	Mail To Address:	PO BOX 505119 ST. LOUIS MO 63150-5119			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1996
8/26/2016	**107592821**	**$73.39**	06/27/15	ACCT: 102732402	Payment amount based on $91.74 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** K.J.
	Mail To Address:	PO BOX 505119 ST. LOUIS MO 63150-5119			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1998
8/3/2016	**107573686**	**$260.00**	12/24/15	ACCT: 108961234	Payment amount based on $325.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/6/2016			***Patient Initials:*** B.S.
	Mail To Address:	PO BOX 505119 ST. LOUIS MO 63150-5119			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1979
6/27/2016	**107550414**	**$124.00**	12/4/15	ACCT:106228929	Payment amount based on $155.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/30/2016			***Patient Initials:*** E.M.
	Mail To Address:	PO BOX 505119 ST. LOUIS MO 63150-5119			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1989
6/7/2016	**107534016**	**$129.87**	04/05/15	ACCT: 10611550	Payment amount based on $162.34 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/10/2016			***Patient Initials:*** J.R.
	Mail To Address:	PO BOX 505119 ST. LOUIS MO 63150-5119			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1984

5/24/2016	**107524678**	**$173.60**	12/13/14	ACCT: 500013367	Payment amount based on $217.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/27/2016			***Patient Initials:*** C.D.
	Mail To Address:	PO BOX 505119 ST. LOUIS MO 63150-5119			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1978
5/4/2016	**107508622**	**$82.40**	11/03/15 - 12/09/15	ACCT: 103226596	Payment amount based on $103.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/7/2016			***Patient Initials:*** P.A.
	Mail To Address:	PO BOX 505119 ST. LOUIS MO 63150-5119			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1964

CORNERSTONE FUNERAL HOME ***Office of State Finance VendorID:*** 0000327062

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
5/27/2016	**107528245**	**$6,074.20**	12/28/15	ACCT: D.E.G.	Payment amount based on $6,074.20 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/30/2016			***Patient Initials:*** D.G.
	Mail To Address:	1830 N. YORK ST. MUSKOGEE OK 74401			***Patient Birth Year:*** 1988

SPARKS REGIONAL MEDICAL CTR. ***Office of State Finance VendorID:*** 0000055594

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/28/2016	**107504731**	**$18,186.32**	04/24/12	ACCT: 4145423	Payment amount based on $80,213.34 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.34055% among all providers. ***Patient Initials:*** A.B.
	Mail To Address:	PO BOX 731781 DALLAS TX 75373-1781			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990

SPARKS CLINIC ***Office of State Finance VendorID:*** 0000329855

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/28/2016	**107504729**	**$245.20**	04/24/12	ACCT: 3000000087533	Payment amount based on $1,081.48 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.34055% among all providers. ***Patient Initials:*** A.B.
	Mail To Address:	PO BOX 402310 ATLANTA GA 30384-2310			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990

SPARKS HOME HEALTH OKLAHOMA ***Office of State Finance VendorID:*** 0000403704

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/28/2016	**107504730**	**$30.18**	05/02/12	ACCT: 000214	Payment amount based on $133.10 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.34055% among all providers. ***Patient Initials:*** A.B.
	Mail To Address:	307B EAST RAY FINE BLVD. ROLAND OK 74954-1579			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990

CMBS BILLING, LLC

Office of State Finance VendorID: 0000328093

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
7/20/2016	107563766	$990.40	05/02/15	ACCT: 0042406060	Payment amount based on $1,238.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016				Patient Initials:	S.B.
	Mail To Address:	9301 S. WESTERN AVE. OKLAHOMA CITY OK 73139-2728			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1968
6/7/2016	107534032	$728.00	07/10/14	ACCT: 07147599001	Payment amount based on $910.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/10/2016				Patient Initials:	W.T.
	Mail To Address:	9301 S. WESTERN AVE. OKLAHOMA CITY OK 73139-2728			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	N/A
4/22/2016	107500212	$88.00	11/25/12	ACCT: B1006272699401	Payment amount based on $110.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	4/25/2016				Patient Initials:	K.T.
	Mail To Address:	9301 S. WESTERN AVE. OKLAHOMA CITY OK 73139-2728			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1950

CISTERNA EMERGENCY PHYSICIAN

Office of State Finance VendorID: 0000342224

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
4/28/2016	107504596	$285.67	04/24/12	ACCT: SPK41454232	Payment amount based on $1,260.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.34055% among all providers.	Patient Initials:	A.B.
	Mail To Address:	PO BOX 37769 PHILADELPHIA PA 19101			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1990

FOCUS INSTITUTE

Office of State Finance VendorID: 0000318959

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
6/27/2016	107550361	$349.23	12/21/14 - 3/16/16	ACCT: S.M.	Payment amount based on $436.54 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/30/2016				Patient Initials:	S.M.
	Mail To Address:	920 S. MAIN STILLWATER OK 74074			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1995

POTTAWATOMIE EMERGENCY PHYSICIANS

Office of State Finance VendorID: 0000326309

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
9/30/2016	107617543	$78.31	01/14/14	ACCT: UOK00031528250	Payment amount based on $124.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 78.94467% among all providers.	Patient Initials:	S.A.
	Mail To Address:	PO BOX 98569 LAS VEGAS NV 89193			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1960

9/30/2016	**107617544**	**$540.80**	02/06/14	ACCT: UOK00031590904	Payment amount based on $676.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			***Patient Initials:*** A.J.
	Mail To Address:	PO BOX 98569 LAS VEGAS NV 89193			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1988
8/26/2016	**107592855**	**$484.00**	5/31/13	ACCT: 00030926497UOK **REPLACEMENT WARRANT #107675374 DATED 12/22/16 VOUCHER #00010707**	Payment amount based on $605.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** J.C.
	Mail To Address:	PO BOX 98569 LAS VEGAS NV 89193			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1986
8/26/2016	**107592854**	**$1,397.60**	5/31/13	ACCT: 00030926471UOK **REPLACEMENT WARRANT #107675373 DATED 12/22/16 VOUCHER #00010707	Payment amount based on $1,747.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** J.V.
	Mail To Address:	PO BOX 98569 LAS VEGAS NV 89193			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1964

OSU MEDICAL GROUP ***Office of State Finance VendorID:*** 0000339250

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/22/2016	**107500213**	**$347.87**	11/26/12 - 03/11/13	ACCT: 2-22579	Payment amount based on $434.84 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	4/25/2016			***Patient Initials:*** K.T.
	Mail To Address:	DEPT. 2732 TULSA OK 74182-0001			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1950

EMERGENCY SERVICES OF OKLAHOMA ***Office of State Finance VendorID:*** 0000325378

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/23/2016	**107675505**	**$245.36**	08/10/15	ACCT: 154676997/51	Payment amount based on $727.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 42.18752% among all providers. ***Patient Initials:*** C.K.
	Mail To Address:	PO BOX 636758 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1977
11/21/2016	**107653055**	**$352.75**	12/12/15	160682806/51	Payment amount based on $962.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 45.835% among all providers. ***Patient Initials:*** D.P.
	Mail To Address:	PO BOX 636758 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1996
10/19/2016	**107630411**	**$540.00**	10/28/14	ACCT: 141829374/51	Payment amount based on $675.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/22/2016			***Patient Initials:*** K.S.
	Mail To Address:	PO BOX 636758 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1969

9/9/2016	**107601319**	**$544.80**	7/12/15, 11/15/15	ACCT: 153403128/51 $173.60, 159295021/51 $371.20	Payment amount based on $681.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	9/12/2016				***Patient Initials:***	M.R.
	Mail To Address:	PO BOX 636758 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1975
9/9/2016	**107601320**	**$175.69**	07/08/15	ACCT: 51169214-51-3016	Payment amount based on $219.61 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	9/12/2016				***Patient Initials:***	T.B.
	Mail To Address:	PO BOX 636758 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1993
8/26/2016	**107592781**	**$1,103.20**	01/31/16	ACCT: 5973930-51-3014	Payment amount based on $1,379.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				***Patient Initials:***	D.P.
	Mail To Address:	PO BOX 636758 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1976
8/3/2016	**107573600**	**$371.20**	8/25/15	ACCT: 155214117	Payment amount based on $464.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016				***Patient Initials:***	C.S.
	Mail To Address:	PO BOX 636758 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1990
7/20/2016	**107563647**	**$110.42**	07/31/15	ACCT: 56499568-51-1863	Payment amount based on $1,343.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 10.27708% among all providers.	***Patient Initials:***	M.L.
	Mail To Address:	PO BOX 636758 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1975
6/20/2016	**107544851**	**$1,329.51**	11/22/15	ACCT: 159528137/51	Payment amount based on $2,536.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 65.53194% among all providers.	***Patient Initials:***	R.D.
	Mail To Address:	PO BOX 636758 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1992
5/24/2016	**107524596**	**$181.82**	7/24/15	ACCT: 153922000/51	Payment amount based on $227.28 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/27/2016				***Patient Initials:***	E.B.
	Mail To Address:	PO BOX 636758 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	2006
5/4/2016	**107508578**	**$809.60**	11/13/15	ACCT: 159301646/51	Payment amount based on $1,012.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/7/2016				***Patient Initials:***	B.M.
	Mail To Address:	PO BOX 636758 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1985

NORMAN EMERGENCY PHYSICIANS ***Office of State Finance VendorID:*** 0000325378

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

9/30/2016	**107617427**	**$868.80**	12/19/15	ACCT: 53619755-51-1864	Payment amount based on $1,086.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016				***Patient Initials:*** M.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:*** 1980
8/26/2016	**107592782**	**$542.40**	12/15/15	ACCT: 5843145551	Payment amount based on $678.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** K.K.
	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:*** 1974
6/27/2016	**107550353**	**$40.82**	4/18/16	ACCT: 60260218-51-1863	Payment amount based on $51.03 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** D.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:*** 1997
6/20/2016	**107544850**	**$299.91**	09/26/15	ACCT: 5041261451	Payment amount based on $2,078.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 18.0406% among all providers.	***Patient Initials:*** J.G.
	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:*** 1986
4/28/2016	**107504621**	**$1,424.80**	12/14/15	ACCT: 43415594511863	Payment amount based on $1,781.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				***Patient Initials:*** K.K.
	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:*** 1974

COMANCHE EMERGENCY PHYSICIANS ***Office of State Finance VendorID:*** 0000332815

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/20/2016	**107544947**	**$632.00**	11/28/15 AND 01/06/16	ACCT: 495340001-50-1875	Payment amount based on $790.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** N.D.
	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:*** 1984
6/7/2016	**107534056**	**$416.80**	12/03/15 AND 12/19/15	ACCT: 49702071-50-1875	Payment amount based on $521.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** C.B.
	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:*** 1990
5/6/2016	**107511126**	**$103.58**	7/19/15	ACCT: 46315047-50-1875	Payment amount based on $129.48 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/9/2016				***Patient Initials:*** A.J.
	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:*** 1992

4/28/2016	**107504724**	**$678.40**	07/05/15	ACCT: 56131485-50-1875	Payment amount based on $848.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				***Patient Initials:*** L.D.
	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:*** 1950

WOODWARD EMERGENCY PHYSICIANS ***Office of State Finance VendorID:*** 0000332815

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/20/2017	**107687733**	**$766.40**	6/28/16	170374685	Payment amount based on $958.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				***Patient Initials:*** L.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:*** 1981
11/30/2016	**107657913**	**$1,130.40**	06/25/16	ACCT: 49605909-51-3014	Payment amount based on $1,413.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/3/2016				***Patient Initials:*** M.V.
	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:*** 1994
8/26/2016	**107592872**	**$992.80**	02/23/16	ACCT: 59417770-51-3014	Payment amount based on $1,241.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** T.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:*** 1971

ST. ANTHONY EMERGENCY PHYSICIANS ***Office of State Finance VendorID:*** 0000332815

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/20/2017	**107687731**	**$244.00**	5/26/16	51710226-56-5601	Payment amount based on $305.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				***Patient Initials:*** W.M.
	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:*** 1964
8/26/2016	**107592871**	**$869.60**	01/11/16	ACCT: 57157026-56-56002	Payment amount based on $1,087.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** H.W.
	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:*** 1991
5/4/2016	**107508673**	**$1,643.20**	04/27/15	ACCT: 55101276/56	Payment amount based on $2,054.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/7/2016				***Patient Initials:*** C.J.
	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:*** 1955
4/6/2016	**107486749**	**$22.11**	7/10/15	ACCT: 56196662-56-56002	Payment amount based on $27.64 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/9/2016				***Patient Initials:*** D.R.
	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:*** 1979

ST. ANTHONY HEALTHPLEX EAST EME

Office of State Finance VendorID: 0000332815

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
12/16/2016	107670857	$523.20	06/05/15	ACCT: 55687990-56-5616	Payment amount based on $654.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/19/2016				*Patient Initials:* S.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:* 1984
6/20/2016	107544945	$1,703.20	08/10/15	ACCT: 46541022-56-56001	Payment amount based on $2,129.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				*Patient Initials:* D.R.
	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:* 1958

OU EMERGENCY PHYSICIANS

Office of State Finance VendorID: 0000332815

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
7/20/2016	107563819	$346.85	03/14/13	ACCT: 46365554750	Payment amount based on $1,245.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 34.82462% among all providers.	*Patient Initials:* J.J.
	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:* 1979

INTEGRIS SOUTHWEST EMERGENCY PHYSICIANS

Office of State Finance VendorID: 0000332815

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573749	$18.10	3/17/16	ACCT: 59777035-51-1862	Payment amount based on $22.63 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				*Patient Initials:* J.B.
	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:* 1991

ST MARY'S EMERGENCY PHYSICIANS

Office of State Finance VendorID: 0000325378

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
12/23/2016	107675506	$1,707.20	09/03/16 AND 09/05/16	ACCT: 4820400/51 - DOS 9/3/16 - $1,184.00; DOS 9/5/16 - $523.20	Payment amount based on $2,134.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				*Patient Initials:* K.B.
	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:* 1979
5/27/2016	107528273	$1,489.60	05/11/15 AND 05/22/15	ACCT: 50628828-51-51000 - $744.80; 0151126270-50628825 - $744.80	Payment amount based on $1,862.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				*Patient Initials:* M.H.
	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:* 1968

5/17/2016	**107518798**	**$1,023.20**	09/01/15 AND 09/02/15	ACCT: 48020311-51-51000	Payment amount based on $1,279.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/20/2016				***Patient Initials:*** T.D.
	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:*** 1975

MCALESTER EMERGENCY PHYSICIANS — ***Office of State Finance VendorID:*** 0000332815

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/20/2016	**107544946**	**$3,004.00**	1/3/16	ACCT: 58670742-56-5602	Payment amount based on $3,755.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** M.M.
	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:*** 1983

PONCA CITY EMERGENCY PHYSICIANS — ***Office of State Finance VendorID:*** 0000325378

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/21/2016	**107653056**	**$773.60**	3/25/15	44473465-51-1880	Payment amount based on $967.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				***Patient Initials:*** J.T.
	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:*** 1986
7/20/2016	**107563648**	**$176.47**	02/01/16	ACCT: 163038723	Payment amount based on $1,388.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 15.89261% among all providers.	***Patient Initials:*** J.K.
	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:*** 1996
6/8/2016	**107534957**	**$527.20**	11/8/15	ACCT: 48104132-51-1880	Payment amount based on $659.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				***Patient Initials:*** B.W.
	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

OKLAHOMA EMERGENCY SERVICES PC — ***Office of State Finance VendorID:*** 0000325769

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/20/2016	**107544901**	**$267.97**	09/16/15	ACCT: 0156458943-54649841	Payment amount based on $558.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 60.02819% among all providers.	***Patient Initials:*** L.B.
	Mail To Address:	PO BOX 636760 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1966
4/28/2016	**107504680**	**$11.26**	02/16/16	ACCT: 58439670-50-1875	Payment amount based on $232.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.064521% among all providers.	***Patient Initials:*** N.G.
	Mail To Address:	PO BOX 636760 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1965

4/6/2016	**107486717**	**$35.14**	8/15/13 - 8/22/13	ACCT: 47631175-50-1875	Payment amount based on $43.93 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	4/9/2016				*Patient Initials:*	P.S.
	Mail To Address:	PO BOX 636760 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1954

The Pain Management Solution — *Office of State Finance VendorID:* Requested

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
		$2,140.94	4/16/15 - 9/15/15	Acct: 1982	Payment amount based on $2,676.18 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				*Patient Initials:*	M.H.
	Mail To Address:	P.O. Box 268977 Oklahoma City OK 73126-8977			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1955

RADIOLOGY ASSOCIATES OF EASTERN OKLAHOMA — *Office of State Finance VendorID:* 0000334138

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
6/20/2016	**107544928**	**$20.80**	1/3/16	ACCT: 42525	Payment amount based on $26.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016				*Patient Initials:*	M.M.
	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:*	1983

AMY BARTEL, LMFT — *Office of State Finance VendorID:* 0000405691

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
6/27/2016	**107550304**	**$80.00**	3/14/16	ACCT: N.C.	Payment amount based on $100.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/30/2016				*Patient Initials:*	N.C.
	Mail To Address:	3750 W. MAIN ST. NORMAN OK 73072		#168	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1995

LANE FAMILY CLINIC — *Office of State Finance VendorID:* 0000407961

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
8/26/2016	**107592813**	**$60.00**	2/11/16	ACCT: 133311	Payment amount based on $75.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				*Patient Initials:*	C.B.
	Mail To Address:	207 W 10TH ST WRIGHT CITY OK 74766		PO BOX 650	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1962

STILLWATER EMERGENCY PHYSICIAN — *Office of State Finance VendorID:* 0000329911

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

11/1/2016	**107638927**	**$158.72**	4/21/16	ACCT: 52334765-47-8108	Payment amount based on $198.40 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/4/2016				***Patient Initials:*** C.W.
	Mail To Address:	PO BOX 740022 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1990
7/25/2016	**107567095**	**$330.40**	10/24/15	ACCT: 57711503-47-8108	Payment amount based on $413.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				***Patient Initials:*** K.C.
	Mail To Address:	PO BOX 740022 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995
6/7/2016	**107534074**	**$46.84**	05/02/15	ACCT: 55190237-47-8108	Payment amount based on $58.55 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** A.E.
	Mail To Address:	PO BOX 740022 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995
5/27/2016	**107528447**	**$432.00**	06/30/14	ACCT: 51338690-47-8108	Payment amount based on $540.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				***Patient Initials:*** A.C.
	Mail To Address:	PO BOX 740022 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2000
5/6/2016	**107511158**	**$421.60**	6/26/15	ACCT: 55995051-47-8108	Payment amount based on $527.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/9/2016				***Patient Initials:*** A.S.
	Mail To Address:	PO BOX 740022 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1963

WESTSIDE DENTAL ***Office of State Finance VendorID:*** 0000387203

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
7/20/2016	**107576733**	**$372.00**	08/25/15	ACCT: 6470	Payment amount based on $372.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** C.G.
	Mail To Address:	500 S. MACARTHUR STE 200 OKLAHOMA CITY OK 73128				***Patient Birth Year:*** 1971

ORTHOTEXAS PHYSICIANS & SURGEONS ***Office of State Finance VendorID:*** 0000403225

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
4/22/2016	**107500211**	**$226.46**	11/19/13 - 12/11/14	ACCT: 466191	Payment amount based on $283.08 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/25/2016				***Patient Initials:*** M.B.
	Mail To Address:	4780 N. JOSEY LANE CARROLLTON TX 75010-4615			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1936

SOUTH CENTRAL EMERGENCY SERVICES ***Office of State Finance VendorID:*** 0000332815

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

12/16/2016	**107670858**	**$96.00**	10/10/12	ACCT: 115869220/47	Payment amount based on $120.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/19/2016				***Patient Initials:*** A.S.
	Mail To Address:	PO BOX 740022 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1973
7/20/2016	**107563820**	**$388.80**	10/13/15	ACCT: 157781099/47	Payment amount based on $486.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** M.S.
	Mail To Address:	PO BOX 740022 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1963
5/27/2016	**107528400**	**$1,153.60**	10/18/15	ACCT: 158046169/47	Payment amount based on $1,442.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				***Patient Initials:*** T.B.
	Mail To Address:	PO BOX 740022 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1962
5/4/2016	**107508674**	**$334.74**	03./14/15	ACCT: 147629908/47	Payment amount based on $418.43 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/7/2016				***Patient Initials:*** C.B.
	Mail To Address:	PO BOX 740022 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1962
4/28/2016	**107504725**	**$120.17**	12/16/15	ACCT: 160990726/47	Payment amount based on $2,477.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.064521% among all providers.	***Patient Initials:*** N.G.
	Mail To Address:	PO BOX 740022 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1965

HILLCREST CLAREMORE EMERGENCY

Office of State Finance VendorID: 0000332815

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
8/26/2016	**107592870**	**$418.40**	01/19/15	ACCT: 52999108-47-8053	Payment amount based on $523.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** J.A.
	Mail To Address:	PO BOX 740022 CINCINNATI OH			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1993

HILLCREST CUSHING EMERGENCY PH

Office of State Finance VendorID: 0000332815

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/7/2016	**107534055**	**$1,696.00**	12/26/15	ACCT: 45845286-47-8054	Payment amount based on $2,120.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** K.R.
	Mail To Address:	PO BOX 740022 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1994
5/24/2016	**107524743**	**$123.59**	1/21/16	ACCT: 58932935-47-8054	Payment amount based on $154.49 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				***Patient Initials:*** S.W.
	Mail To Address:	PO BOX 740022 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995

SOUTH CENTRAL EMERGENCY SERVICES

Office of State Finance VendorID: 0000332815

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
1/20/2017	107687732	$35.75	11/22/15	159642051/47	Payment amount based on $44.69 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/23/2017				Patient Initials:	K.O.
	Mail To Address:	PO BOX 637113 CINCINNATI OH 45263-7113			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1975
6/27/2016	107550455	$64.66	1/2/16	ACCT: 161343710/47	Payment amount based on $80.83 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/30/2016				Patient Initials:	C.S.
	Mail To Address:	PO BOX 637113 CINCINNATI OH 45263-7113			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1993
6/8/2016	107535038	$170.54	12/7/14	ACCT: 0143823984-43649090	Payment amount based on $213.18 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/11/2016				Patient Initials:	B.F.
	Mail To Address:	PO BOX 637113 CINCINNATI OH 45263-7113			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1984
6/8/2016	107535039	$748.80	12/7/14	ACCT: 0143824356-53201305	Payment amount based on $936.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/11/2016				Patient Initials:	P.F.
	Mail To Address:	PO BOX 637113 CINCINNATI OH 45263-7113			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	2007

INTEGRIS EDMOND EMERGENCY PHYSICIANS

Office of State Finance VendorID: 0000332815

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
11/1/2016	107638905	$415.20	4/14/16	ACCT: 60232665-47-8011	Payment amount based on $519.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/4/2016				Patient Initials:	C.B.
	Mail To Address:	PO BOX 637113 CINCINNATI OH 45263-7113			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1991

INTEGRIS GROVE EMERGENCY PHYS.

Office of State Finance VendorID: 0000332815

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
11/21/2016	107653207	$1,675.20	1/18/15	23632472-51-1866	Payment amount based on $2,094.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016				Patient Initials:	J.W.
	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:	1960

LITTLE RIVER EMERGENCY PHYSICIANS

Office of State Finance VendorID: 0000340903

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

12/23/2016	**107675530**	**$1,460.80**	02/04/16	ACCT: 10726263MIO	Payment amount based on $1,826.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				***Patient Initials:*** S.B.
	Mail To Address:	PO BOX 98543 LAS VEGAS NV 89193-8543			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1962
11/30/2016	**107657857**	**$656.80**	09/12/15	ACCT: MIO10608552	Payment amount based on $821.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/3/2016				***Patient Initials:*** R.S.
	Mail To Address:	PO BOX 98543 LAS VEGAS NV 89193-8543			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1972
11/15/2016	**107648861**	**$1,487.20**	01/03/16	ACCT:MIO10699031	Payment amount based on $1,859.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/18/2016				***Patient Initials:*** P.Q.
	Mail To Address:	PO BOX 98543 LAS VEGAS NV 89193-8543			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1979
6/8/2016	**107534989**	**$740.00**	9/29/15	ACCT: MIO10623213	Payment amount based on $925.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				***Patient Initials:*** K.S.
	Mail To Address:	PO BOX 98543 LAS VEGAS NV 89193-8543			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1991
5/27/2016	**107528318**	**$2,567.20**	06/27/15	ACCT: MIO0542223	Payment amount based on $3,209.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				***Patient Initials:*** D.C.
	Mail To Address:	PO BOX 98543 LAS VEGAS NV 89193-8543			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1993

UTB ANESTHESIA, PLLC

Office of State Finance VendorID: 0000330166

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
4/22/2016	**107500232**	**$446.95**	11/26/12, 2/14/13, AND 2/28/13	ACCT: 9586 - $189.60; 8510 - $14.15; 9373 - $243.20	Payment amount based on $558.69 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/25/2016				***Patient Initials:*** K.T.
	Mail To Address:	PO BOX 700390 TULSA OK 74170-0390			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1950

IMAGING SERVICES OF OKLAHOMA

Office of State Finance VendorID: 0000333221

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/18/2016	**107651869**	**$112.00**	9/11/16	ACCT: 0206014714	Payment amount based on $140.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				***Patient Initials:*** P.J.
	Mail To Address:	PO BOX 2038 OKLAHOMA CITY OK 73101			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1964

10/11/2016	**107624009**	**$324.00**	3/6/16	ACCT: 138329	Payment amount based on $405.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** J.B.
	Mail To Address:	PO BOX 2038 OKLAHOMA CITY OK 73101			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990
8/26/2016	**107592799**	**$48.00**	5/22/16 - 5/23/16	ACCT: 0205467095	Payment amount based on $60.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** P.J.
	Mail To Address:	PO BOX 2038 OKLAHOMA CITY OK 73101			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1964

EVANS FAMILY DENTISTRY ***Office of State Finance VendorID:*** 0000395030

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/16/2016	**107649924**	**$2,076.80**	05/01/15 - 05/24/16	ACCT: RAO090	Payment amount based on $2,596.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/19/2016			***Patient Initials:*** R.R.
	Mail To Address:	8149 E. 31ST. ST., SUITE D TULSA OK 74145-1715			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1966

INTEGRITY PATHWAYS ***Office of State Finance VendorID:*** 0000327604

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/29/2016	**107506120**	**$2,280.00**	11/3/15 - 2/23/16	ACCT: J.B.	Payment amount based on $2,850.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/2/2016			***Patient Initials:*** J.B.
	Mail To Address:	1805 N YORK ST MUSKOGEE OK 74403		STE. G	Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1981

AMBER M. PRATHER, MA, LPC ***Office of State Finance VendorID:*** 0000403802

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/29/2016	**107506015**	**$600.00**	11/18/15 - 2/17/16	ACCT: K.W.	Payment amount based on $750.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/2/2016			***Patient Initials:*** S.L.
	Mail To Address:	9225 LAKE HEFNER PARKWAY OKLAHOMA CITY OK 73120-2061		SUITE 101	Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1992

NANCY SCHNEIDER LCSW ***Office of State Finance VendorID:*** 0000099779

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/9/2016	**107601439**	**$584.29**	05/06/15 - 04/07/16	ACCT: T.F. 00108	Payment amount based on $730.36 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** T.F.
	Mail To Address:	860-A COPPERFIELD DR. NORMAN OK 73072			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1996

ANGELA L. ZAYAS, LCSW — *Office of State Finance VendorID:* 0000405223

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
6/8/2016	107534908	$245.25	4/30/13 - 4/12/16	ACCT: NORKAY	Payment amount based on $306.56 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				*Patient Initials:* K.N.
	Mail To Address:	3908 N. PENIEL BETHANY OK 73008		SUITE 420	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 2000

CHILDSAFE COLORADO — *Office of State Finance VendorID:* 0000410064

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/15/2016	107648833	$2,160.00	05/20/15 - 12/23/15	ACCT: KRAU00002	Payment amount based on $2,700.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/18/2016				*Patient Initials:* E.K.
	Mail To Address:	1148 E. ELIZABETH ST. FORT COLLINS CO 80524			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 2007

WAGONER COMMUNITY HOSPITAL — *Office of State Finance VendorID:* 0000272747

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
5/27/2016	107528442	$2,157.80	09/03/15	ACCT: 309564	Payment amount based on $2,697.25 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				*Patient Initials:* S.C.
	Mail To Address:	DEPT 2403 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1987

ST. JOHN HOME CARE, LLC — *Office of State Finance VendorID:* 0000366820

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
6/20/2016	107544955	$351.45	05/06/15 - 06/01/15	ACCT: 22372	Payment amount based on $1,653.33 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 26.57145% among all providers.	*Patient Initials:* K.B.
	Mail To Address:	DEPT 2590 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1969

ST FRANCIS HEALTH SYSTEM — *Office of State Finance VendorID:* 0000400656

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
10/11/2016	107624064	$7,393.38	12/20/14	ACCT: 600749506	Payment amount based on $9,241.73 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				*Patient Initials:* E.D.
	Mail To Address:	PO BOX 732214 DALLAS TX 75373			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1970

9/9/2016	**107601521**	**$34.11**	10/11/15 - 10/14/15	ACCT: 601739862	Payment amount based on $85.28 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** J.H.
	Mail To Address:	PO BOX 732214 DALLAS TX 75373			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1993

SUMMERFIELD VILLAGE APARTMENTS — ***Office of State Finance VendorID:*** 0000321607

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/19/2017	**107686544**	**$910.48**	03/01/16	CRIME SCENE CLEANUP	Payment amount based on $2,700.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** K.K.
	Mail To Address:	920 E. LINDSEY #1 NORMAN OK 73071				***Patient Birth Year:*** 1974

ST JOHN BROKEN ARROW — ***Office of State Finance VendorID:*** 0000344580

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/19/2017	**107686537**	**$6,913.40**	02/04/16	ACCT: 0034589739	Payment amount based on $8,641.75 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** F.L.
	Mail To Address:	DEPT 2752 TULSA OK 74182-4900			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1992
8/3/2016	**107573752**	**$800.08**	4/14/15	ACCT: B0034206929	Payment amount based on $1,000.10 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				***Patient Initials:*** A.C.
	Mail To Address:	DEPT 2752 TULSA OK 74182-4900			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1998
6/20/2016	**107544954**	**$3,294.48**	11/29/15 - 11/30/15	ACCT: B0013607023	Payment amount based on $4,118.10 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** H.F.
	Mail To Address:	DEPT 2752 TULSA OK 74182-4900			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1997

PAFFORD MEDICAL SERVICES INC — ***Office of State Finance VendorID:*** 0000257242

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/21/2016	**107653163**	**$1,038.40**	02/03/16	ACCT: 9181601980	Payment amount based on $1,298.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				***Patient Initials:*** N.D.
	Mail To Address:	P O BOX 1120 HOPE AR 71802			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1983
11/21/2016	**107653164**	**$942.40**	05/02/16	ACCT: 69201	Payment amount based on $1,178.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				***Patient Initials:*** M.B.
	Mail To Address:	P O BOX 1120 HOPE AR 71802			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1970

8/26/2016	**107592848**	**$1,966.40**	01/19/15	ACCT: 918500884 - $908.80; 918500885 - $1,057.60	Payment amount based on $2,458.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** J.A.
	Mail To Address:	P O BOX 1120 HOPE AR 71802			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1993
7/20/2016	**107563780**	**$1,038.40**	10/13/15	ACCT: 918514668A	Payment amount based on $1,298.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			***Patient Initials:*** M.S.
	Mail To Address:	P O BOX 1120 HOPE AR 71802			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1963
5/4/2016	**107508639**	**$659.89**	03/14/15	ACCT: 56968	Payment amount based on $824.86 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/7/2016			***Patient Initials:*** C.B.
	Mail To Address:	P O BOX 1120 HOPE AR 71802			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1962

METS AMBULANCE ***Office of State Finance VendorID:*** 0000372151

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/30/2016	**107617495**	**$1,034.63**	06/08/15	ACCT: 83920747	Payment amount based on $4,223.85 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 30.61857% among all providers. ***Patient Initials:*** Q.A.
	Mail To Address:	625 S. VIRGINIA AVE. JOPLIN MO 64801			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1967

AIR EVAC LIFETEAM ***Office of State Finance VendorID:*** 0000020236

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
1/23/2017	**107688624**	**$6,505.53**	04/26/15	ACCT: 30015474738A	Payment amount based on $8,131.91 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/26/2017			***Patient Initials:*** A.S.
	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:*** 1994
11/21/2016	**107652968**	**$6,568.60**	12/20/15	ACCT: 30015551446A	Payment amount based on $42,204.14 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 19.45485% among all providers. ***Patient Initials:*** A.W.
	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:*** 1963
11/21/2016	**107652969**	**$12,801.03**	05/21/16	ACCT: 30016600088A	Payment amount based on $47,103.38 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 33.97059% among all providers. ***Patient Initials:*** E.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:*** 1987

11/21/2016	**107652970**	**$6,377.81**	06/29/16	ACCT: 30016614348A	Payment amount based on $36,931.08 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 21.58687% among all providers. ***Patient Initials:*** A.W.
	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:*** 1983
11/16/2016	**107649908**	**$1,458.84**	10/25/15	ACCT: 30015534634A	Payment amount based on $3,647.11 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/19/2016			***Patient Initials:*** K.R.
	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:*** 1966
11/15/2016	**107648825**	**$1,015.62**	08/18/15	ACCT: 30015512002A	Payment amount based on $1,269.53 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/18/2016			***Patient Initials:*** G.M.
	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:*** 1960
11/15/2016	**107648824**	**$1,015.62**			Payment amount based on $1,269.53 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/18/2016			***Patient Initials:*** G.M.
	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:*** 1960
9/30/2016	**107617332**	**$9,024.82**	03/11/14	ACCT: 30014356062A	Payment amount based on $16,751.23 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 67.34457% among all providers. ***Patient Initials:*** L.D.
	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:*** 1971
4/28/2016	**107504545**	**$1,954.33**	12/16/15	ACCT: 30015550050A	Payment amount based on $40,282.09 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.064521% among all providers. ***Patient Initials:*** N.G.
	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:*** 1965

OZARKS COMMUNITY HOSPITAL

Office of State Finance VendorID: 0000409161

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/30/2016	**107617529**	**$9,706.40**	04/14/14 - 04/17/14	ACCT: Y1144353 - $7,843.20; Y1144352 - $1,863.20	Payment amount based on $12,133.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			***Patient Initials:*** D.P.
	Mail To Address:	PO BOX 9227 SPRINGFIELD MO 65801			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1961

FREEMAN HEALTH SYSTEM

Office of State Finance VendorID: 0000020396

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

1/19/2017	**107686433**	**$194.96**	05/18/16	ACCT: J00342487063	Payment amount based on $243.70 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/22/2017			***Patient Initials:*** S.E.
	Mail To Address:	PO BOX 2325 JOPLIN MO 64803			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1993

FREEMAN HEALTH ESSENTIALS — ***Office of State Finance VendorID:*** 0000020396

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/30/2016	**107617438**	**$14.70**	07/14/15	ACCT: 863674	Payment amount based on $60.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 30.61857% among all providers. ***Patient Initials:*** Q.A.
	Mail To Address:	1130 EAST 32ND ST JOPLIN MO 64804		SUITE F	Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1967

FREEMAN PHYSICIAN GROUP — ***Office of State Finance VendorID:*** 0000020396

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/30/2016	**107617439**	**$1,103.27**	06/16/15 - 07/03/15	ACCT: 506704FHS - $43.21; 115612 FHA - $329.38; 47986 FCI - $730.68	Payment amount based on $4,504.10 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 30.61857% among all providers. ***Patient Initials:*** Q.A.
	Mail To Address:	P O BOX 3810 JOPLIN MO 64803-3810			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1967

EMERGENCY SERVICES OF OKLAHOMA — ***Office of State Finance VendorID:*** 0000062085

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
6/7/2016	**107533977**	**$1,900.00**	02/20/15	ACCT: 54222481-50-1875	Payment amount based on $2,375.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/10/2016			***Patient Initials:*** R.B.
	Mail To Address:	3075 E. IMPERIAL HWY, STE 200 BREA CA 92821			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1975

UNIVERSITY OF MISSOURI HEALTH SYSTEM — ***Office of State Finance VendorID:*** 0000069990

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/30/2016	**107617611**	**$6,966.88**	06/08/15	ACCT: 15278251	Payment amount based on $28,442.21 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 30.61857% among all providers. ***Patient Initials:*** Q.A.
	Mail To Address:	PO BOX 807003 KANSAS CITY MO 64180-7003			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1967

TERESA FARRELL — ***Office of State Finance VendorID:*** 0000323991

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

11/1/2016	**107638912**	**$378.13**	3/7/16 - 8/10/16	$200/counseling reimbursement, $178.13/mileage	Payment amount based on $472.66 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/4/2016 ***Patient Initials:*** B.F.

Mail To Address: 5807 S. BROADWAY AVE.
OKLAHOMA CITY OK 73109-

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2004

8/26/2016	**107592890**	**$253.36**	3/31/16, 4/11/16, 5/14/16, 6/23/16, 7/28/16	medical reimbursement	Payment amount based on $316.70 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2016 ***Patient Initials:*** B.F.

Mail To Address: 5807 S. BROADWAY AVE.
OKLAHOMA CITY OK 73109-

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2004

7/20/2016	**107563846**	**$116.19**	5/2/16 - 6/13/16	counseling reimbursement and mileage	Payment amount based on $145.24 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/23/2016 ***Patient Initials:*** B.F.

Mail To Address: 5807 S. BROADWAY AVE.
OKLAHOMA CITY OK 73109-

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2004

5/24/2016	**107524763**	**$800.25**	8/17/15 - 4/18/16	counseling reimbursement $250, mileage $500.25	Payment amount based on $1,000.31 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/27/2016 ***Patient Initials:*** B.F.

Mail To Address: 5807 S. BROADWAY AVE.
OKLAHOMA CITY OK 73109-

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2004

KENT D MCINTIRE, DO

Office of State Finance VendorID: 0000325200

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/30/2016	**107617481**	**$703.00**	07/03/15	ACCT: 47986	Payment amount based on $2,870.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/3/2016

Total Bills exceed maximum award. Payment is prorated at 30.61857% among all providers. ***Patient Initials:*** Q.A.

Mail To Address: PO BOX 3810
JOPLIN MO 64803

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

TJ & R AUTO RESTORATION & CUSTOMIZING LLC

Office of State Finance VendorID: 0000410922

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/30/2016	**107657933**	**$2,851.40**	11/10/16	ACCT: J.P.	Payment amount based on $2,851.40 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/3/2016 ***Patient Initials:*** J.P.

Mail To Address: 1402 OLD MILITARY ROAD
STIGLER OK 74462

Patient Birth Year: 1980

CROWE CHIROPRACTIC

Office of State Finance VendorID: 0000247166

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

11/18/2016	**107651846**	**$600.00**	8/18/16-10/6/16	ACCT: 4321	Payment amount based on $750.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/21/2016 ***Patient Initials:*** J.R.

Mail To Address: 4409 N. KICKAPOO #121
SHAWNEE OK 74804

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1954

8/26/2016	**107592770**	**$528.00**	5/26/16 - 7/21/16	ACCT: 4321	Payment amount based on $660.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2016 ***Patient Initials:*** J.R.

Mail To Address: 4409 N. KICKAPOO #121
SHAWNEE OK 74804

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1954

6/27/2016	**107550344**	**$160.00**	4/28/16 - 5/19/16	ACCT: J.R.	Payment amount based on $200.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/30/2016 ***Patient Initials:*** J.R.

Mail To Address: 4409 N. KICKAPOO #121
SHAWNEE OK 74804

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1954

5/24/2016	**107524588**	**$200.00**	1/11/16 - 4/20/16	ACCT: J.R.	Payment amount based on $250.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/27/2016 ***Patient Initials:*** J.R.

Mail To Address: 4409 N. KICKAPOO #121
SHAWNEE OK 74804

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1954

STEPHANIE FARLEY

Office of State Finance VendorID: 0000365400

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
10/19/2016	**107630412**	**$720.00**	1/12/16 - 6/22/16	ACCT: S.F.L.	Payment amount based on $900.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/22/2016 ***Patient Initials:*** S.F.

Mail To Address: 993 FARLEY RD
HAWORTH OK 74740

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

SALENA WATASHE

Office of State Finance VendorID: 0000409331

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
10/11/2016	**107624057**	**$1,591.25**	4/30/16	burial reimbursement	Payment amount based on $1,591.25 patient balance after insurance and insurance adjustments.

Approx Mail Date: 10/14/2016 ***Patient Initials:*** D.W.

Mail To Address: 17580 S. HICKORY ST.
SAPULPA OK 74066

Patient Birth Year: 1979

ANJOLI ROBINSON

Office of State Finance VendorID: 0000402109

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
1/19/2017	**107686337**	**$7,958.71**	01/01/17 - 12/31/17	LOSS OF SUPPORT	Payment amount based on $7,958.71 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/22/2017 ***Patient Initials:*** C.C.

Mail To Address: 1601 NE 42ND
OKLAHOMA CITY OK 73111

Patient Birth Year: 1984

RICK GREGORY — *Office of State Finance VendorID:* 0000411880

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
1/19/2017	107686524	$5,221.00	03/13/15	FUNERAL REIMBURSEMENT	Payment amount based on $5,221.00 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 1/22/2017
Mail To Address: 16601 OK HWY 177W
ARDMORE OK 73401
Patient Initials: R.H.
Patient Birth Year: 1974

CURTIS SWART, LPC — *Office of State Finance VendorID:* 0000343861

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573587	$728.00	5/2/16 - 6/27/16	ACCT: I.J.	Payment amount based on $910.00 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 8/6/2016
Mail To Address: 2801 PARKLAWN DR. STE 402
MIDWEST CITY OK 73110
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: I.J.
Patient Birth Year: 1983

ANDREA GARCIA ANDRES — *Office of State Finance VendorID:* 0000409330

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
10/11/2016	107623949	$2,425.25	5/9/15	funeral reimbursement	Payment amount based on $2,425.25 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 10/14/2016
Mail To Address: PO BOX 584
COLBERT OK 74733
Patient Initials: J.R.
Patient Birth Year: 1955

BYTE & ASSOCIATES, LLC — *Office of State Finance VendorID:* 0000404044

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573567	$95.40	2/29/16 - 4/11/16	ACCT: 0406520211	Payment amount based on $119.25 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 8/6/2016
Mail To Address: 117 S. 7TH ST
CHICKASHA OK 73018
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: D.P.
Patient Birth Year: 1997

5/6/2016	107511014	$354.00	9/8/15 - 2/15/16	ACCT: 0406520211	Payment amount based on $442.50 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 5/9/2016
Mail To Address: 117 S. 7TH ST
CHICKASHA OK 73018
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: D.P.
Patient Birth Year: 1997

Antonio Robledo — *Office of State Finance VendorID:* 0000412277

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

	$300.00	8/2/16	Cust. No: 5894	Payment amount based on $300.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17			***Patient Initials:*** M.L.
	Mail To Address:	37 SE 31 St. Oklahoma City ok 73129			***Patient Birth Year:*** 1989

TLC DENTAL — ***Office of State Finance VendorID:*** 0000409162

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
10/11/2016	**107624076**	**$971.20**	5/18/16	ACCT: 18192	Payment amount based on $1,214.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				***Patient Initials:*** J.J.
	Mail To Address:	1710 W. WILLOW ENID OK 73703		SUITE 15	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1983

INTEGRIS HEALTH-EDMOND — ***Office of State Finance VendorID:*** 0000332506

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/20/2017	**107687570**	**$1,647.94**	11/22/15	11890002	Payment amount based on $2,059.93 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				***Patient Initials:*** K.O.
	Mail To Address:	PO BOX 960423 OKLAHOMA CITY OK 73196			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1975

KIM MULLINS, LPC — ***Office of State Finance VendorID:*** 0000334275

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
12/16/2016	**107670804**	**$800.00**	04/02/15 - 03/24/16	ACCT: A.B.	Payment amount based on $1,000.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/19/2016				***Patient Initials:*** A.B.
	Mail To Address:	1002 W GORE LAWTON OK 73505			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1984

DR. CHRISTOPHER MASTIN, DDS — ***Office of State Finance VendorID:*** 0000345486

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
12/23/2016	**107675482**	**$1,440.84**	05/16/16	ACCT: 16972	Payment amount based on $3,305.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 54.4946% among all providers.	***Patient Initials:*** M.B.
	Mail To Address:	9118 S. TOLEDO AVE. TULSA OK 74137			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1977

AGENT MALLORY MARTIN FUNERAL HOME — ***Office of State Finance VendorID:*** 0000382580

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

6/20/2016	**107544772**	**$7,500.00**	10/05/15	ACCT: P.D.C.	Payment amount based on $11,325.12 patient balance after insurance and insurance adjustments.

Approx Mail Date: 6/23/2016 ***Patient Initials:*** P.C.
Mail To Address: PO BOX 566 SALLISAW OK 74955 ***Patient Birth Year:*** 1984

FRAME OF MIND COUNSELING ***Office of State Finance VendorID:*** 0000410477

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
11/18/2016	**107651861**	**$240.00**	9/9/15 - 10/21/15	ACCT: L.T.	Payment amount based on $300.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/21/2016 ***Patient Initials:*** L.T.
Mail To Address: 516 W. BROADWAY ENID OK 73701 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1982

HILLCREST HOSPITAL CLAREMORE ***Office of State Finance VendorID:*** 0000332101

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
5/4/2016	**107508596**	**$355.43**	03/14/15	ACCT: 1507300241	Payment amount based on $444.29 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/7/2016 ***Patient Initials:*** C.B.
Mail To Address: 1202 NORTH MUSKOGEE PLACE CLAREMORE OK 74017-3058 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1962

HILLCREST HOSPITAL CLAREMORE ***Office of State Finance VendorID:*** 0000332101

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
1/20/2017	**107687566**	**$3,126.66**	5/17/16	K1613700475	Payment amount based on $3,908.33 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/23/2017 ***Patient Initials:*** W.H.
Mail To Address: PO BOX 2805 TULSA OK 74182 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2001

1/20/2017	**107687565**	**$1,400.64**	5/14/16	K1613500010	Payment amount based on $1,750.80 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/23/2017 ***Patient Initials:*** W.H.
Mail To Address: PO BOX 2805 TULSA OK 74182 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2001

1/19/2017	**107686441**	**$1,013.67**	02/14/16	ACCT: K1604500439	Payment amount based on $1,267.09 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/22/2017 ***Patient Initials:*** R.Y.
Mail To Address: PO BOX 2805 TULSA OK 74182 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1997

11/21/2016	**107653084**	**$8,213.74**	02/03/16	ACCT: 1603400046	Payment amount based on $10,267.18 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/24/2016 ***Patient Initials:*** N.D.
Mail To Address: PO BOX 2805 TULSA OK 74182 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1983

8/26/2016	**107592792**	**$1,697.08**	01/19/15	ACCT: K1501900031	Payment amount based on $2,121.35 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** J.A.
	Mail To Address:	PO BOX 2805 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1993
7/20/2016	**107563676**	**$7,029.70**	10/13/15	ACCT: 1528600345	Payment amount based on $8,787.13 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** M.S.
	Mail To Address:	PO BOX 2805 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1963

CANNON ORAL & MAXILLOFACIAL SURGERY — ***Office of State Finance VendorID:*** 0000342407

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/19/2017	**107686382**	**$1,429.82**	11/30/15	ACCT: 413247	Payment amount based on $1,787.28 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** A.G.
	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:*** 1983

OKLAHOMA SURGICAL GROUP — ***Office of State Finance VendorID:*** 0000341463

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/21/2016	**107653144**	**$1,926.17**	12/12/15	93828	Payment amount based on $5,253.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 45.835% among all providers.	***Patient Initials:*** D.P.
	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:*** 1996
6/20/2016	**107544903**	**$258.46**	11/22/15	ACCT: 82058	Payment amount based on $493.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 65.53194% among all providers.	***Patient Initials:*** R.D.
	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:*** 1992

LANDRUM ENT — ***Office of State Finance VendorID:*** 0000406733

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
7/20/2016	**107563714**	**$392.00**	3/4/2016	ACCT: 8889	Payment amount based on $490.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** S.H.
	Mail To Address:	520 N MONTE VISTA ADA OK 74820		SUITE B	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1968

BIOVENTUS — ***Office of State Finance VendorID:*** 0000402857

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

4/4/2016	**107484623**	**$153.99**	9/4/14 - 5/14/15	ACCT: L.M.	Payment amount based on $192.49 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/7/2016				***Patient Initials:*** L.M.
	Mail To Address:	PO BOX 951838 DALLAS TX 75395			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1962

DENTAL DEPOT SOUTH TULSA — ***Office of State Finance VendorID:*** 0000396953

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/8/2016	**107534951**	**$4,407.20**	5/13/16	ACCT: F.C.G.	Payment amount based on $5,509.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				***Patient Initials:*** F.G.
	Mail To Address:	10004 S. MEMORIAL DR TULSA OK 74133			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1983

BROWN-WINTERS FUNERAL HOME — ***Office of State Finance VendorID:*** 0000344734

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
10/19/2016	**107630375**	**$4,242.40**	01/30/16	ACCT: C.F.	Payment amount based on $4,242.40 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/22/2016				***Patient Initials:*** C.F.
	Mail To Address:	5 B. NW MIAMI OK 74354				***Patient Birth Year:*** 1992

ALLEN MEDICAL, PLLC — ***Office of State Finance VendorID:*** 0000412092

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/20/2017	**107687404**	**$22.40**	9/26/15 - 10/1/15	35030	Payment amount based on $28.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				***Patient Initials:*** R.M.
	Mail To Address:	1226 N SHARTEL, STE 100 OKLAHOMA CITY OK 73103-2421			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1948

THREE FORKS ER PHYSICIANS — ***Office of State Finance VendorID:*** 0000346006

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/15/2016	**107648891**	**$34.20**	05/23/13	ACCT: MOK02030770941	Payment amount based on $42.75 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/18/2016				***Patient Initials:*** F.D.
	Mail To Address:	PO BOX 1654 GREEN BAY WI 54305			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1969

FOCUS MENTAL HEALTH — ***Office of State Finance VendorID:*** 0000411276

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

12/16/2016	**107670785**	**$48.00**	11/08/16 AND 11/22/16	ACCT: K.C.	Payment amount based on $60.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/19/2016				***Patient Initials:*** J.C.
	Mail To Address:	33207 45TH ST. SHAWNEE OK 74804			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1989

ST. ANTHONY SHAWNEE HOSPITAL ***Office of State Finance VendorID:*** 0000342737

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
		$617.85	5/29/16	Acct: 24161500111	Payment amount based on $772.31 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				***Patient Initials:*** S.J.
	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:*** 1971
1/20/2017	**107687734**	**$3,054.50**	5/31/15	J00032878548	Payment amount based on $3,818.13 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				***Patient Initials:*** L.D.
	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:*** 1982
9/30/2016	**107617586**	**$208.57**	01/14/14	ACCT: JAF19028	Payment amount based on $330.25 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 78.94467% among all providers.	***Patient Initials:*** S.A.
	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:*** 1960
9/30/2016	**107617587**	**$264.20**	01/14/14	ACCT: JAF19027	Payment amount based on $330.25 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016				***Patient Initials:*** A.J.
	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:*** 1988
9/9/2016	**107601520**	**$4,669.62**	09/21/15 - 09/24/15	ACCT: J00033345356	Payment amount based on $5,837.03 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** D.H.
	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:*** 1982
7/20/2016	**-107544952**	**($9,920.86)**	08/10/15	ACCT: 40152220024 **VOID, WRONG PROVIDER**	Payment amount based on ($12,401.08) patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** D.R.
	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:*** 1958
6/27/2016	**107550456**	**$638.53**	6/3/15	ACCT: J00032890279	Payment amount based on $798.16 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** M.M.
	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:*** 1993

6/20/2016	**107544952**	**$9,920.86**	08/10/15	ACCT: 40152220024	Payment amount based on $12,401.08 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			***Patient Initials:*** D.R.
	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:*** 1958
5/4/2016	**107508677**	**$5,040.00**	04/27/15 AND 05/06/15	ACCT: J00032764219 - $4,754.66; J00032790149 - $285.34	Payment amount based on $6,300.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/7/2016			***Patient Initials:*** C.J.
	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:*** 1955

ALLRAD PLLC ***Office of State Finance VendorID:*** 0000369170

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/21/2016	**107652973**	**$56.00**	3/25/15	SAR 24030	Payment amount based on $70.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			***Patient Initials:*** J.T.
	Mail To Address:	PO BOX 10 OKLAHOMA CITY OK 73101-0010			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1986
6/8/2016	**107534899**	**$24.00**	11/8/15	ACCT: 122438	Payment amount based on $30.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/11/2016			***Patient Initials:*** B.W.
	Mail To Address:	PO BOX 10 OKLAHOMA CITY OK 73101-0010			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1995

EDWARD K. LORENTS, DDS ***Office of State Finance VendorID:*** 0000364759

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/9/2016	**107601311**	**$9,739.45**	08/16/16	ACCT: 192300	Payment amount based on $25,035.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			Total Bills exceed maximum award. Payment is prorated at 48.62917% among all providers. ***Patient Initials:*** E.W.
	Mail To Address:	10420 NE 23RD ST. OKLAHOMA CITY OK 73141			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1976

BACK TO WELLNESS CHIROPRACTIC ***Office of State Finance VendorID:*** 0000406911

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
7/20/2016	**107563582**	**$212.04**	01/06/16 -02/01/16	ACCT: 1073	Payment amount based on $425.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 62.36396% among all providers. ***Patient Initials:*** B.B.
	Mail To Address:	3560 S. BLVD. SUITE 100 EDMOND OK 73013-4680			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1989

PREMIER BEHAVIORAL HEALTH CENTER ***Office of State Finance VendorID:*** 0000406732

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

7/20/2016	**107563790**	**$598.40**	3/3/16-5/19/16	ACCT: G.L.	Payment amount based on $748.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** G.L.
	Mail To Address:	2305 SW H AVE #1 LAWTON OK 73501			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2006

OKLAHOMA EM PHYS PART PLLC — ***Office of State Finance VendorID:*** 0000365680

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
9/9/2016	**107601448**	**$618.40**	3/29/14	ACCT: 8286-01	Payment amount based on $773.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** C.K.
	Mail To Address:	PO BOX 975213 DALLAS TX 75397-5213			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1955
6/27/2016	**107550429**	**$849.60**	8/24/13	ACCT: SEM000004343	Payment amount based on $1,062.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** J.D.
	Mail To Address:	PO BOX 975213 DALLAS TX 75397-5213			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1978

STEVIE WILSON, LPC — ***Office of State Finance VendorID:*** 0000409856

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/22/2016	**-107630521**	**($1,416.00)**	03/03/16 - 05/18/16	ACCT: L.S. VOID CHECK - ISSUED TO WRONG PROVIDER IN ERROR	Payment amount based on $1,770.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/25/2016				***Patient Initials:*** L.S.
	Mail To Address:	10317 GREENBRIAR PL., SUITE 300 OKLAHOMA CITY OK 73159			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1989
10/19/2016	**107630521**	**$1,416.00**	03/03/16 - 05/18/16	ACCT: L.S.	Payment amount based on $1,770.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/22/2016				***Patient Initials:*** L.S.
	Mail To Address:	10317 GREENBRIAR PL., SUITE 300 OKLAHOMA CITY OK 73159			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1989

OKLAHOMA HEARING CENTER — ***Office of State Finance VendorID:*** 0000370272

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
8/3/2016	**107573699**	**$28.66**	08/25/15	ACCT: 2480167D	Payment amount based on $35.83 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				***Patient Initials:*** M.P.
	Mail To Address:	PO BOX 96-0472 OKLAHOMA CITY OK 73196-0472			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1953

SPRING DENTAL — ***Office of State Finance VendorID:*** 0000366076

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

12/23/2016	**107675573**	**$4,054.00**	09/09/16	ACCT: 15150	Payment amount based on $5,067.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***Patient Initials:*** J.C.
	Mail To Address:	6634 S. MEMORIAL DR. TULSA OK 74133			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1948

MERCY HOSPITAL ADA INC — ***Office of State Finance VendorID:*** 0000365877

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
6/7/2016	**107534017**	**$618.17**	04/05/15 - 04/06/15	ACCT: 507150950069	Payment amount based on $772.71 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/10/2016			***Patient Initials:*** J.R.
	Mail To Address:	430 N. MONTE VISTA ST. ADA OK 74820			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1984

CINDY R. LEE, LCSW, LADC — ***Office of State Finance VendorID:*** 0000406731

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
7/20/2016	**107563613**	**$80.00**	5/2/16 - 6/13/16	ACCT: B.F.	Payment amount based on $100.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			***Patient Initials:*** B.F.
	Mail To Address:	429 W. WILSHIRE OKLAHOMA CITY OK 73116		SUITE C	Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2004

LARRY VAN DYCK, DDS — ***Office of State Finance VendorID:*** 0000370852

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
6/7/2016	**107534004**	**$96.00**	01/06/16	ACCT: 003468	Payment amount based on $120.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/10/2016			***Patient Initials:*** S.T.
	Mail To Address:	PO BOX 40 SILOAM SPRINGS AR 72761			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1972

Jacqueline Harris MA — ***Office of State Finance VendorID:*** 0000390253

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/23/2016	**107675739**	**$140.00**	9/26/16	ACCT: 2124010061	Payment amount based on $175.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***Patient Initials:*** M.F.
	Mail To Address:	7371 W. Charleston Blvd. Suite #130 Las Vegas NV 89117			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2009
10/11/2016	**107624012**	**$420.00**	7/19/16, 8/1/16, 8/22/16	ACCT: 2124010061	Payment amount based on $525.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** M.F.
	Mail To Address:	7371 W. Charleston Blvd. Suite #130 Las Vegas NV 89117			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2009

8/3/2016	**107573638**	**$140.00**	7/5/16	ACCT: M.F.	Payment amount based on $175.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/6/2016 — ***Patient Initials:*** M.F.

Mail To Address: 7371 W. Charleston Blvd. Suite #130, Las Vegas NV 89117 — Acceptance of payment may require a provider write-off. EOB will accompany payment. — ***Patient Birth Year:*** 2009

5/6/2016	**107511067**	**$260.00**	2/25/16 - 3/16/16	ACCT: 2124010061	Payment amount based on $325.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/9/2016 — ***Patient Initials:*** M.F.

Mail To Address: 7371 W. Charleston Blvd. Suite #130, Las Vegas NV 89117 — Acceptance of payment may require a provider write-off. EOB will accompany payment. — ***Patient Birth Year:*** 2009

WILLIAMS FAMILY CHIROPRACTIC & REHABILITATION CENTER

Office of State Finance VendorID: 0000390523

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
8/26/2016	**107592908**	**$64.00**	7/21/16	ACCT: 1233	Payment amount based on $80.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2016 — ***Patient Initials:*** M.R.

Mail To Address: 110 W CHOCTAW, LINDSAY OK 73052 — Acceptance of payment may require a provider write-off. EOB will accompany payment. — ***Patient Birth Year:*** 1982

ADAMS CREST FUNERAL HOME

Office of State Finance VendorID: 0000399896

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/16/2016	**107670687**	**$7,500.00**	05/07/15	ACCT: C.G.	Payment amount based on $7,500.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/19/2016 — ***Patient Initials:*** C.G.

Mail To Address: 1916 S SHERIDAN, TULSA OK 74112 — ***Patient Birth Year:*** 1995

12/16/2016	**107670686**	**$4,500.00**	06/13/16	ACCT: B.F.	Payment amount based on $4,500.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/19/2016 — ***Patient Initials:*** B.F.

Mail To Address: 1916 S SHERIDAN, TULSA OK 74112 — ***Patient Birth Year:*** 1963

ROSE HILL FUNERAL HOME

Office of State Finance VendorID: 0000403900

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/28/2016	**107504713**	**$3,821.90**	10/10/15	ACCT: T.R.	Payment amount based on $3,821.90 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/1/2016 — ***Patient Initials:*** T.R.

Mail To Address: 4161 E. ADMIRAL PL, TULSA OK 74115 — ***Patient Birth Year:*** 1997

FAILS FUNERAL HOME

Office of State Finance VendorID: 0000379737

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

11/30/2016	**107657822**	**$7,203.95**	05/25/16	ACCT: A.P.	Payment amount based on $7,665.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/3/2016			Total Bills exceed maximum award. Payment is prorated at 93.98496% among all providers.	***Patient Initials:*** A.P.
	Mail To Address:	103 N OKLAHOMA AVE MANGUM OK 73554			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2015
11/30/2016	**107657821**	**$8,151.50**	05/25/16	ACCT: W.P.	Payment amount based on $8,151.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/3/2016				***Patient Initials:*** W.P.
	Mail To Address:	103 N OKLAHOMA AVE MANGUM OK 73554				***Patient Birth Year:*** 1956

JILL NEWMAN, M. ED., LPC ***Office of State Finance VendorID:*** 0000405201

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
12/23/2016	**107675745**	**$240.00**	11/9/16 - 12/6/16	ACCT: R.W.	Payment amount based on $300.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				***Patient Initials:*** R.W.
	Mail To Address:	1605 N. HARRISON SHAWNEE OK 74802			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2002
11/1/2016	**107638880**	**$240.00**	8/31/16 - 10/11/16	ACCT: R,M.W.	Payment amount based on $300.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/4/2016				***Patient Initials:*** R.W.
	Mail To Address:	1605 N. HARRISON SHAWNEE OK 74802			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2002
9/9/2016	**107601373**	**$300.00**	7/21/16 - 8/11/16	ACCT: R.W.	Payment amount based on $375.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** R.W.
	Mail To Address:	1605 N. HARRISON SHAWNEE OK 74802			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2002
7/20/2016	**107563696**	**$380.00**	6/20/16 - 7/11/16	ACCT: R.W.	Payment amount based on $475.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** R.W.
	Mail To Address:	1605 N. HARRISON SHAWNEE OK 74802			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2002
6/27/2016	**107550386**	**$620.00**	5/16/16 - 6/15/16	ACCT: R.M.W.	Payment amount based on $775.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** R.W.
	Mail To Address:	1605 N. HARRISON SHAWNEE OK 74802			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2002
6/8/2016	**107534976**	**$500.00**	3/15/16 - 5/9/16	ACCT: S.W.	Payment amount based on $625.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				***Patient Initials:*** R.W.
	Mail To Address:	1605 N. HARRISON SHAWNEE OK 74802			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2002

CAVANAL HILL EMERG PHYS, LLC ***Office of State Finance VendorID:*** 0000410665

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

1/20/2017	**107687470**	**$850.40**	5/14/16	16135000103lar	Payment amount based on $1,063.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				***Patient Initials:*** W.H.
	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:*** 2001
1/19/2017	**107686385**	**$458.56**	02/14/16	ACCT: LAR16045004393	Payment amount based on $573.20 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** R.Y.
	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:*** 1997
11/21/2016	**107653014**	**$1,302.40**	02/03/16	ACCT: LAR16034000469	Payment amount based on $1,628.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				***Patient Initials:*** N.D.
	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:*** 1983
11/18/2016	**107651836**	**$1,267.20**	5/26/16	ACCT: 16147000125LAR	Payment amount based on $1,584.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				***Patient Initials:*** S.R.
	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:*** 1997

BALANCE WOMEN'S HEALTH ***Office of State Finance VendorID:*** 0000402517

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
		$225.00	11/17/16	Acct#12186	Payment amount based on $281.25 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				***Patient Initials:*** S.B.
	Mail To Address:	1105 SW 30TH COURT MOORE OK 73160			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1994
6/27/2016	**107550313**	**$224.00**	3/4/16 - 5/4/16	ACCT: D.B.L	Payment amount based on $280.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** D.L.
	Mail To Address:	1105 SW 30TH COURT MOORE OK 73160			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995
4/29/2016	**107506037**	**$288.00**	11/13/16 - 2/19/16	ACCT: 9934	Payment amount based on $360.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/2/2016				***Patient Initials:*** D.L.
	Mail To Address:	1105 SW 30TH COURT MOORE OK 73160			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995

GRACIE MOYER ***Office of State Finance VendorID:*** 0000405657

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/20/2016	**107544858**	**$732.00**	09/24/15 - 04/06/16	ACCT: G.B.	Payment amount based on $732.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** R.B.
	Mail To Address:	3855 S. BOULEVARD STE 100 EDMOND OK 73013				***Patient Birth Year:*** 1956

KATHY THOMAS, PH.D. — *Office of State Finance VendorID:* 0000047198

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/21/2016	107653108	$100.00	03/05/16 - 09/13/16	ACCT: 1295549278	Payment amount based on $125.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				*Patient Initials:* J.H.
	Mail To Address:	2222 W 12TH AVE STILLWATER OK 74074-5154			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1960

EMERGENCY PHYSICIANS — *Office of State Finance VendorID:* 0000401844

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
		$154.66	5/29/16	Acct: 53370325-56-5601	Payment amount based on $193.33 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				*Patient Initials:* S.J.
	Mail To Address:	PO BOX 638568 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1971
5/27/2016	107528272	$62.78	09/07/15	ACCT: 155316432/56	Payment amount based on $78.48 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				*Patient Initials:* S.H.
	Mail To Address:	PO BOX 638568 CINCINNATI OH 45263			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1966

FARMINGTON DENTAL & ORTHODONTICS — *Office of State Finance VendorID:* 0000405878

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/18/2016	107651858	$784.80	8/4/16, 8/23/16	ACCT: 14324	Payment amount based on $981.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				*Patient Initials:* D.T.
	Mail To Address:	181 W. MAIN ST. FARMINGTON AR 72730			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1969

PHYSICAL THERAPY CENTRAL — *Office of State Finance VendorID:* 0000396407

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/30/2016	107657887	$86.40	11/13/15 - 01/07/16	ACCT: P591830908	Payment amount based on $108.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/3/2016				*Patient Initials:* T.J.
	Mail To Address:	440 MERCHANT DR. NORMAN OK 73069-6470			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1996
11/30/2016	107657886	$153.60	11/24/15 - 02/11/16	ACCT: P591824668	Payment amount based on $192.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/3/2016				*Patient Initials:* J.J.
	Mail To Address:	440 MERCHANT DR. NORMAN OK 73069-6470			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1971

FOREVER MEMORIES FUNERAL SERVICES — *Office of State Finance VendorID:* 0000398999

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
1/19/2017	107686432	$7,500.00	10/21/16	ACCT: B.J.M.	Payment amount based on $7,500.00 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 1/22/2017
Mail To Address: 463505 HWY 101
SALLISAW OK 74955
Patient Initials: B.M.
Patient Birth Year: 1967

ELLIOTT VISION CARE, PLLC — *Office of State Finance VendorID:* 0000404045

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
5/6/2016	107511045	$212.00	2/29/16	ACCT: 9199	Payment amount based on $212.00 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 5/9/2016
Mail To Address: 1139 NORTH HILLS CENTRE
ADA OK 74820
Patient Initials: K.B.
Patient Birth Year: 1948

BROWN-THOMAS FUNERAL HOME — *Office of State Finance VendorID:* 0000410771

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/30/2016	107657772	$2,594.08	03/30/16	ACCT: G.F.	Payment amount based on $2,594.08 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 12/3/2016
Mail To Address: 401 S. 1ST STREET
CHICKASHA OK 73023
Patient Initials: G.F.
Patient Birth Year: 1977

DIANNE BRADLEY PHD — *Office of State Finance VendorID:* 0000397817

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/17/2016	107584277	$416.00	09/29/15 -11/05/15	ACCT: T.H.	Payment amount based on $520.00 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 8/20/2016
Mail To Address: 321 BILLINGSLEY CT. #3
FRANKLIN TN 37064
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: A.D.
Patient Birth Year: 1989

LACEY REIKOWSKY, LPC — *Office of State Finance VendorID:* 0000404588

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
12/23/2016	107675760	$192.00	6/15/16 - 6/29/16	ACCT: V.M.	Payment amount based on $240.00 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 12/26/2016
Mail To Address: 3000 UNITED FOUNDERS BLVD SUITE 148
OKLAHOMA CITY OK 73112
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: M.M.
Patient Birth Year: N/A

8/26/2016	**107592812**	**$816.00**	04/11/16 - 05/24/16	ACCT: M.M.	Payment amount based on $1,020.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** M.M.
	Mail To Address:	3000 UNITED FOUNDERS BLVD OKLAHOMA CITY OK 73112	SUITE 148		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1977
6/27/2016	**107550398**	**$192.00**	5/4/16 - 5/24/16	ACCT: V.M.	Payment amount based on $240.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** M.M.
	Mail To Address:	3000 UNITED FOUNDERS BLVD OKLAHOMA CITY OK 73112	SUITE 148		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** N/A
5/24/2016	**107524661**	**$720.00**	2/11/16-4/27/16	ACCT: V.M.	Payment amount based on $900.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				***Patient Initials:*** M.M.
	Mail To Address:	3000 UNITED FOUNDERS BLVD OKLAHOMA CITY OK 73112	SUITE 148		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** N/A

PATRICK CROWLEY DDS PLLC ***Office of State Finance VendorID:*** 0000404816

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/7/2016	**107534037**	**$1,880.00**	1/12/16, 3/3/16, AND 4/27/16	ACCT: K.N.	Payment amount based on $2,350.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** K.N.
	Mail To Address:	4401 W. MEMORIAL RD. SUITE 135 OKLAHOMA CITY OK 73134			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1982

SOUTHWEST ORAL SURGERY ***Office of State Finance VendorID:*** 0000405143

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/7/2016	**107534057**	**$176.00**	12/09/15	ACCT: 304	Payment amount based on $220.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** C.B.
	Mail To Address:	916 SW 38TH ST. LAWTON OK 73505	SUITE A		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1990

MCCLAIN EMERGENCY GROUP ***Office of State Finance VendorID:*** 0000409920

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/15/2016	**107648865**	**$970.40**	02/25/16	ACCT: 14X319833388	Payment amount based on $1,213.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/18/2016				***Patient Initials:*** S.T.
	Mail To Address:	PO BOX 731584 DALLAS TX 75373			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1969
11/15/2016	**107648864**	**$1,436.00**	12/03/15	ACCT: 31057389	Payment amount based on $1,795.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/18/2016				***Patient Initials:*** G.H.
	Mail To Address:	PO BOX 731584 DALLAS TX 75373			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1959

XPRESS WELLNESS, LLC — *Office of State Finance VendorID:* 0000408622

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
9/9/2016	107601592	$431.20	5/9/16	ACCT: 58617	Payment amount based on $539.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				*Patient Initials:* B.M.
	Mail To Address:	PO BOX 412697 KANSAN CITY MO 64141			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1969

MCCLENDON-WINTERS FUNERAL HOME — *Office of State Finance VendorID:* 0000404590

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
5/27/2016	107528327	$7,500.00	10/19/15	ACCT: R.H.	Payment amount based on $9,934.59 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				*Patient Initials:* R.H.
	Mail To Address:	PO BOX 750 BEGGS OK 74421				*Patient Birth Year:* 1953

SPRING DENTAL & BRACES — *Office of State Finance VendorID:* 0000410070

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
12/23/2016	107675841	$804.00	11/16/16	Acct: 3424	Payment amount based on $1,005.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				*Patient Initials:* J.G.
	Mail To Address:	101 S. ADAIR ST. PRYOR CREEK OK 74361			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1986

SUMNER CO HOSPITAL — *Office of State Finance VendorID:* 0000160554

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
6/20/2016	107544966	$920.40	11/05/15 AND 11/13/15	ACCT: 106231 - $609.85; 106339 - $310.55	Payment amount based on $1,555.74 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 73.95226% among all providers.	*Patient Initials:* S.L.
	Mail To Address:	601 SOUTH OSAGE CALDWELL KS 67022			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1981

CYTOCHECK LABORATORY LLC — *Office of State Finance VendorID:* 0000408322

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
9/9/2016	107601293	$92.80	03/16/16	ACCT: 191771	Payment amount based on $116.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				*Patient Initials:* M.S.
	Mail To Address:	1201 CORPORATE DRIVE PARSONS KS 67357			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1976

MARGARET M. DURHAM, LPC, LMFT

Office of State Finance VendorID: 0000243657

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573680	$2,688.00	1/25/16-3/18/16, 10/27/15-7/11/16	ACCTS: S.V. $560, A.H. $2,688	Payment amount based on $3,360.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				*Patient Initials:* S.O.
	Mail To Address:	1300 MCGEE DR NORMAN OK 73072		SUITE 103	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1994
7/20/2016	107563724	$1,232.00	3/28/16-5/23/16, 4/6/16-5/23/16	ACCT: S.T. $672, A.L.H. $560	Payment amount based on $1,540.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				*Patient Initials:* S.O.
	Mail To Address:	1300 MCGEE DR NORMAN OK 73072		SUITE 103	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1994
4/6/2016	107486697	$896.00	10/12/15 - 12/7/15	ACCT: S.V.	Payment amount based on $1,120.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/9/2016				*Patient Initials:* S.O.
	Mail To Address:	1300 MCGEE DR NORMAN OK 73072		SUITE 103	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1994

DJ ORTHOPEDICS, LLC

Office of State Finance VendorID: 0000051064

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
9/30/2016	107617415	$200.44	02/12/16	ACCT: 593972	Payment amount based on $319.75 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 78.35652% among all providers.	*Patient Initials:* D.L.
	Mail To Address:	PO BOX 515471 LOS ANGELES CA 90051-6771			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1979

GIBSON COUNSELING SRVS INC

Office of State Finance VendorID: 0000227766

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
7/25/2016	107566925	$118.82	03/15/15 - 05/26/15	ACCT: C.L.	Payment amount based on $148.53 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				*Patient Initials:* L.L.
	Mail To Address:	27 "B" STREET SW ARDMORE OK 73403		PO BOX 5775	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1958

ELIZABETH PALMER, PSY.D.

Office of State Finance VendorID: 0000410674

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/30/2016	107657816	$1,056.00	05/24/16 - 07/22/16	ACCT: A.K.	Payment amount based on $1,320.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/3/2016				*Patient Initials:* A.K.
	Mail To Address:	7220 W. JEFFERSON AVE. #109 LAKEWOOD CO 80235			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 2011

MARK HUMPHRIES, PH.D. — *Office of State Finance VendorID:* 0000404275

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
5/6/2016	107511080	$302.00	12/30/15 - 3/8/16	ACCT: R.H.	Payment amount based on $377.50 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 5/9/2016
Mail To Address: 615 N. NEVADA AVE.
COLORADO SPRIN CO 80903

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

Patient Initials: R.H.
Patient Birth Year: 1998

HEART AND VASCULAR CENTER — *Office of State Finance VendorID:* 0000403095

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
4/6/2016	107486646	$3.31	8/15/13	ACCT: 222774	Payment amount based on $4.14 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 4/9/2016
Mail To Address: 3106 NW ARLINGTON AVE
LAWTON OK 73505

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

Patient Initials: P.S.
Patient Birth Year: 1954

LAKELAND REGIONAL HOSPITAL — *Office of State Finance VendorID:* 0000240820

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573663	$224.00	10/8/15 - 1/31/16	ACCT: 104329204	Payment amount based on $280.00 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 8/6/2016
Mail To Address: 440 SOUTH MARKET AVE
SPRINGFIELD MO 65806-2026

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

Patient Initials: N.S.
Patient Birth Year: 2004

HEALTHPORT — *Office of State Finance VendorID:* 0000310567

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/16/2016	107649927	$1.74	10/04/15	ACCT: 582659941	Payment amount based on $2.18 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 11/19/2016
Mail To Address: PO BOX 409900
ATLANT GA 30384-9900

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

Patient Initials: B.Y.
Patient Birth Year: 1974

TOWER IMAGING INC. — *Office of State Finance VendorID:* 0000411700

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
12/23/2016	107675860	$7.05	4/13/16	Acct: 303223	Payment amount based on $8.81 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 12/26/2016
Mail To Address: P.O. BOX 31249
TAMPA FL 33631-3249

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

Patient Initials: T.B.
Patient Birth Year: 1955

MEMORIAL MED GRP PATHOLOGY

Office of State Finance VendorID: 0000405656

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
6/20/2016	107544890	$21.31	09/16/15	ACCT: 491520	Payment amount based on $44.38 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 60.02819% among all providers.	*Patient Initials:*	L.B.
	Mail To Address:	PO BOX 2309 SECTION #6 LAWTON OK 73502-2309			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1966

ALLIANCE HEALTH WOODWARD

Office of State Finance VendorID: 0000196936

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
1/20/2017	107687803	$1,372.60	6/28/16	2346557	Payment amount based on $1,715.75 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/23/2017				*Patient Initials:*	L.S.
	Mail To Address:	900 17TH ST. WOODWARD OK 73801			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1981
11/30/2016	107657962	$4,070.65	06/28/16	ACCT: 2346561	Payment amount based on $5,088.31 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				*Patient Initials:*	M.V.
	Mail To Address:	900 17TH ST. WOODWARD OK 73801			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1994
8/26/2016	107592911	$4,248.84	01/31/16	ACCT: 2324820	Payment amount based on $5,311.05 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				*Patient Initials:*	D.P.
	Mail To Address:	900 17TH ST. WOODWARD OK 73801			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1976
8/26/2016	107592910	$1,145.18	02/23/16	ACCT: 2328104	Payment amount based on $1,431.48 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				*Patient Initials:*	T.P.
	Mail To Address:	900 17TH ST. WOODWARD OK 73801			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1971
8/3/2016	107573793	$527.74	10/16/15	ACCT: 2309720-01	Payment amount based on $659.68 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016				*Patient Initials:*	T.D.
	Mail To Address:	900 17TH ST. WOODWARD OK 73801			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1971

OU MEDICAL CENTER OF EDMOND

Office of State Finance VendorID: 0000071817

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
		$320.60	7/22/15	Acct#652034833	Payment amount based on $400.75 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				*Patient Initials:*	S.B.
	Mail To Address:	PO BOX 740782 CINCINNATI OH 45274-0782			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1994

OU MEDICAL CTR — *Office of State Finance VendorID:* 0000071817

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
		$221.60	1/12/16, 1/19/16	Acct: 653737048, 653719901	Payment amount based on $277.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				*Patient Initials:* K.G.
	Mail To Address:	1200 EVERETT DR. OKLAHOMA CITY OK 73104-5407			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1991
11/21/2016	**107653152**	**$19,825.40**	1/5/16 - 1/12/16	99900360969	Payment amount based on $379,123.45 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 6.53659% among all providers.	*Patient Initials:* D.H.
	Mail To Address:	1200 EVERETT DR. OKLAHOMA CITY OK 73104-5407			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1993
11/21/2016	**107653153**	**$19,196.21**	1/16/16	99900361733	Payment amount based on $34,199.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 70.1626% among all providers.	*Patient Initials:* C.T.
	Mail To Address:	1200 EVERETT DR. OKLAHOMA CITY OK 73104-5407			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1988
7/20/2016	**107563767**	**$115.89**	1/13/2016	ACCT: 99900361466	Payment amount based on $144.86 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				*Patient Initials:* D.M.
	Mail To Address:	1200 EVERETT DR. OKLAHOMA CITY OK 73104-5407			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1950
6/27/2016	**107550432**	**$79.49**	8/4/15	ACCT: 99900346452	Payment amount based on $99.36 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				*Patient Initials:* T.K.
	Mail To Address:	1200 EVERETT DR. OKLAHOMA CITY OK 73104-5407			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1963
6/8/2016	**107535009**	**$488.14**	12/10/15	ACCT: 653242025	Payment amount based on $610.18 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				*Patient Initials:* E.T.
	Mail To Address:	1200 EVERETT DR. OKLAHOMA CITY OK 73104-5407			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 2015

OU MEDICAL CENTER — *Office of State Finance VendorID:* 0000071817

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
1/23/2017	**107688880**	**$3,271.21**	08/19/16	ACCT: 655902368	Payment amount based on $4,089.01 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017				*Patient Initials:* J.T.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1959
1/23/2017	**107688877**	**$17,618.76**	05/02/16 - 05/06/16	ACCT: 99900379211	Payment amount based on $26,688.13 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 82.52151% among all providers.	*Patient Initials:* A.A.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1956

1/23/2017	**107688878**	**$18,607.98**	04/28/16 - 04/30/16	ACCT: 9990037889 - $18,570.09; 654930897 - $37.89	Payment amount based on $77,837.99 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 29.88255% among all providers. ***Patient Initials:*** R.H.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1973
1/23/2017	**107688879**	**$12,635.05**	7/28/16 - 8/9/16, 8/16/16, 9/20/16	ACCT: 99900387496 - $12,626.60; 655814424 - $4.22; 65601118 - $4.22	Payment amount based on $339,763.58 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 4.64847% among all providers. ***Patient Initials:*** A.T.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1972
1/23/2017	**107688875**	**$18,207.94**	01/10/16 - 02/11/16	ACCT: 99900361252 - $18,086.70; 653952626 - $17.96; 653865114 - $6.21; 653865532 - $6.21; 653978442 - $55.54; 653968807 - $35.32	Payment amount based on $406,236.13 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 5.60263% among all providers. ***Patient Initials:*** J.O.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990
1/23/2017	**107688876**	**$12,341.26**	10/26/15 - 10/27/15	ACCT: 99900355071	Payment amount based on $40,691.53 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 37.91102% among all providers. ***Patient Initials:*** M.J.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1984
1/23/2017	**107688874**	**$5,342.00**	08/25/15 AND 10/23/15	ACCT: 652308151 - $20.00; 652976625 - $5,322.00	Payment amount based on $6,677.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/26/2017			***Patient Initials:*** D.D.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1994
12/23/2016	**107675553**	**$4,848.07**	11/20/16, 11/30/15, 11/25/15	ACCT: 653806324 - $3,182.68; 653312149 - $1,205.25; 653308241 - $460.14	Payment amount based on $6,060.09 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***Patient Initials:*** M.I.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1974
12/23/2016	**107675554**	**$18,459.50**	06/13/15 - 09/02/15	ACCT: 99900340943 - $18,417.31; 651723249 - $13.28; 657125217 - $15.63; 652186896 - $13.28	Payment amount based on $157,715.25 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 14.6304% among all providers. ***Patient Initials:*** D.S.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1980
12/23/2016	**107675552**	**$19,299.45**	11/29/15 - 12/02/15	ACCT: 99900357671	Payment amount based on $103,198.83 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 23.37654% among all providers. ***Patient Initials:*** J.F.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1961

12/23/2016	**107675551**	**$18,722.49**	10/27/15 - 10/30/15	ACCT: 99900355069	Payment amount based on $67,840.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 34.49727% among all providers. ***Patient Initials:*** K.H.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1995
12/23/2016	**107675549**	**$16,729.71**	08/27/15	ACCT: 652308567	Payment amount based on $49,569.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 42.18752% among all providers. ***Patient Initials:*** C.K.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1977
12/23/2016	**107675550**	**$18,453.81**	09/18/15 - 09/22/15	ACCT: 99900350944	Payment amount based on $200,185.69 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 11.52293% among all providers. ***Patient Initials:*** G.W.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1974
11/21/2016	**107653151**	**$12,565.93**	01/28/15 - 10/23/15	ACCT: 99900329038 - $12,276.24; 651080663 - $21.05; 651279082 - $36.43; 652936467 - $154.23; 650376330 - $77.99	Payment amount based on $30,455.94 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 51.57423% among all providers. ***Patient Initials:*** R.S.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1963
11/21/2016	**107653154**	**$18,443.21**	01/23/16 - 03/22/16	ACCT: 653838559 - $11,422.88; 654038794 - $5.00; 654132201 - $6,990.83; 654438730 - $24.50	Payment amount based on $419,051.89 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 5.50147% among all providers. ***Patient Initials:*** J.L.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1970
11/30/2016	**107657881**	**$1,299.01**	11/15/15	ACCT: 99900356592	Payment amount based on $2,105.20 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/3/2016			***Patient Initials:*** N.L.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990
11/21/2016	**107653155**	**$19,152.35**	01/03/16 - 02/03/16	ACCT: 653982073 - $299.83; 65365371 - $14,204.49; 653648936 - $4,648.03	Payment amount based on $25,599.86 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 93.51787% among all providers. ***Patient Initials:*** S.A.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1969
11/21/2016	**107653156**	**$12,928.55**	06/29/16 - 07/01/16	ACCT: 99900384577	Payment amount based on $74,863.49 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 21.58687% among all providers. ***Patient Initials:*** A.W.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1983

11/1/2016	**107638893**	**$1,145.63**	1/12/16	ACCT: 2205914	Payment amount based on $1,432.04 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/4/2016			***Patient Initials:*** R.J.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1988
9/30/2016	**107617521**	**$14,278.14**	03/14/16 - 09/06/16	ACCT: 99900366721 - $14,180.13; 654496871 - $8.10; 654508575 - $43.49; 655213660 - $46.42	Payment amount based on $244,243.23 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 7.307336% among all providers. ***Patient Initials:*** A.J.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1985
9/30/2016	**107617520**	**$4,633.94**	03/21/15 - 05/13/15	ACCT: 99900332946 - $4,621.18; 651113715 - $4.97; 651350781 - $7.79	Payment amount based on $433,581.43 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 1.33595% among all providers. ***Patient Initials:*** J.A.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1983
9/30/2016	**107617519**	**$3,331.60**	12/19/15 - 03/22/16	ACCT: 653540077 - $2,093.00; 653668611 - $425.60; 654434376 - $813.00	Payment amount based on $4,164.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			***Patient Initials:*** M.P.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1980
9/30/2016	**107617517**	**$19,142.64**	08/11/15 - 09/30/15	ACCT: 99900347353 - $18,910.87; 652401729 - $59.44; 652396118 - $10.64; 652385115 - $161.69	Payment amount based on $249,121.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 9.60509% among all providers. ***Patient Initials:*** C.S.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1984
9/30/2016	**107617518**	**$15,650.05**	11/02/14 - 02/11/15	ACCT: 99900322476 - $15,385.50; 649583564 - $5.31; 649761649 - $121.06; 649787869 - $5.31; 650101529 - $122.65; 650101404 - $5.11; 649761586 - $5.11	Payment amount based on $408,535.63 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 4.78846% among all providers. ***Patient Initials:*** S.H.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1954
9/30/2016	**107617515**	**$18,519.48**	01/05/14	ACCT: 99900295388	Payment amount based on $29,323.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 78.94467% among all providers. ***Patient Initials:*** S.A.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1960

9/30/2016	**107617516**	**$8,322.20**	01/05/14	ACCT: 646473695	Payment amount based on $10,402.75 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016				***Patient Initials:*** A.J.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1988
9/30/2016	**107617514**	**$19,311.56**	12/21/15 - 01/09/16	ACCT: 99900359562	Payment amount based on $286,504.03 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 8.42552% among all providers.	***Patient Initials:*** E.R.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1951
8/26/2016	**107592843**	**$3,849.85**	11/14/15	ACCT: 99900356504	Payment amount based on $4,812.31 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** J.C.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1994
9/9/2016	**107601455**	**$18,977.58**	09/08/15 - 09/21/15	ACCT: 99900349965 - $13,073.78; 652555217 - $2,740.36; 652588850 - $835.58; 652636411 - $2,327.86	Payment amount based on $55,587.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016			Total Bills exceed maximum award. Payment is prorated at 42.67541% among all providers.	***Patient Initials:*** I.G.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1968
8/3/2016	**107573708**	**$12,796.73**	03/06/15 - 03/08/15	ACCT: 99900331778	Payment amount based on $125,279.94 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016			Total Bills exceed maximum award. Payment is prorated at 12.76813% among all providers.	***Patient Initials:*** W.K.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1998
7/20/2016	**107563770**	**$18,239.16**	01/18/16 AND 02/09/16	ACCT: 99900361846 - $17,817.66; 653886067 - $421.50	Payment amount based on $143,456.34 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 15.89261% among all providers.	***Patient Initials:*** J.K.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1996
7/20/2016	**107563772**	**$16,454.60**	03/09/16 - 04/14/16	ACCT: 99900366315 - $15,188.21; 654373023 - $362.38; 654574601 - $378.54; 654697699 - $525.46	Payment amount based on $53,954.75 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 38.12129% among all providers.	***Patient Initials:*** M.B.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1988
7/20/2016	**107563771**	**$17,784.88**	02/18/16 - 03/17/16	ACCT: 99900364309	Payment amount based on $985,350.93 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 2.25616% among all providers.	***Patient Initials:*** J.R.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1986

7/20/2016	**107563768**	**$13,119.83**	04/02/13 - 11/12/13	ACCT: 643716713 - $38.59; 643887005 - $38.59; 645124075 - $12,926.88; 645467223 - $38.59; 645471210 - $38.59; 645622956 - $38.59	Payment amount based on $47,092.50 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 34.82462% among all providers.	***Patient Initials:***	J.J.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1979
7/20/2016	**107563769**	**$20,000.00**	08/16/13 - 08/17/13	ACCT: 99900283763	Payment amount based on $50,752.20 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 49.25895% among all providers.	***Patient Initials:***	E.A.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1999
6/27/2016	**107550431**	**$114.56**	4/7/16	ACCT: 1003525589	Payment amount based on $143.20 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/30/2016				***Patient Initials:***	T.G.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1969
6/20/2016	**107544914**	**$114.46**	02/02/16 - 04/12/16	ACCT: 653962691 - $43.96; 653996301 - $19.58; 654100848 - $11.75; 65.975838 - $19.58; 654258883 - $19.58	Payment amount based on $146.11 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 97.91947% among all providers.	***Patient Initials:***	K.L.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1956
6/20/2016	**107544913**	**$11,654.96**	09/27/15 - 10/05/15 AND 11/02/15	ACCT: 99900351960 - $11,619.41; 653087645 - $35.55	Payment amount based on $80,755.13 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 18.0406% among all providers.	***Patient Initials:***	J.G.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1986
6/20/2016	**107544912**	**$19,065.20**	08/04/15	ACCT: 99900346414	Payment amount based on $42,564.50 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 55.98916% among all providers.	***Patient Initials:***	H.G.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1953
6/20/2016	**107544911**	**$15,577.87**	07/12/15 - 07/25/15	ACCT: 99900344030	Payment amount based on $196,471.75 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 9.911015% among all providers.	***Patient Initials:***	G.C.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1989
5/27/2016	**107528352**	**$2,296.00**	07/01/14	ACCT: 648194063	Payment amount based on $2,870.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/30/2016				***Patient Initials:***	A.C.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	2000

4/28/2016	**107504690**	**$19,207.19**	10/09/15 - 10/27/15	ACCT: 99900353421 - $19,066.05; 652940466 - $21.54; 653005655 - $119.60	Payment amount based on $123,501.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 19.44024% among all providers. ***Patient Initials:*** Q.J.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1991
4/28/2016	**107504691**	**$17,281.47**	11/29/15 - 12/05/15	ACCT: 99900357645	Payment amount based on $74,830.14 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.86783% among all providers. ***Patient Initials:*** C.S.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1978
4/28/2016	**107504692**	**$16,207.96**	12/16/15 - 12/26/15	ACCT: 99900359067	Payment amount based on $334,073.48 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.064521% among all providers. ***Patient Initials:*** N.G.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1965
4/28/2016	**107504688**	**$7,719.20**	05/20/15 - 05/22/15	ACCT: 651419460	Payment amount based on $9,649.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** J.G.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2013
4/28/2016	**107504689**	**$18,976.31**	10/13/14 - 10/17/14 AND 10/24/14	ACCT: 649311658 - $35.57; 99900320547 - $18,940.74	Payment amount based on $73,888.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 32.10316% among all providers. ***Patient Initials:*** J.A.
	Mail To Address:	PO BOX 277362 ATLANTA GA 30384-7362			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1964

HEALTHQUEST

Office of State Finance VendorID: 0000409477

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
10/19/2016	**107630424**	**$1,224.00**	07/14/15 - 06/17/16	ACCT: 75010903	Payment amount based on $1,530.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/22/2016			***Patient Initials:*** C.P.
	Mail To Address:	58 TIMBER CREEK DRIVE CORDOVA TN 38018-4233			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1984

MEDICAL CENTER OF PLANO

Office of State Finance VendorID: 0000055069

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/21/2016	**107653125**	**$13,404.93**	12/20/15	ACCT: 022916279	Payment amount based on $86,128.49 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 19.45485% among all providers. ***Patient Initials:*** A.W.
	Mail To Address:	PO BOX 740782 CINCINNATI OH 45274-0782			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1963

VIRTUAL RADIOLOGIC PROFESSIONALS — *Office of State Finance VendorID:* 0000202477

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/26/2016	**107592903**	**$504.80**	5/22/16	ACCT: 6675468	Payment amount based on $631.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				*Patient Initials:* P.J.
	Mail To Address:	PO BOX 88087 CHICAGO IL 60680			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1964

HILLCREST HOSPITAL SOUTH — *Office of State Finance VendorID:* 0000055086

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
6/20/2016	**107544948**	**$409.85**	03/23/16	ACCT: N1608100381	Payment amount based on $3,150.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 16.26405% among all providers.	*Patient Initials:* L.H.
	Mail To Address:	PO BOX 2796 TULSA OK 74182		BUSINESS OFFICE	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1977

SW MEDICAL CENTER — *Office of State Finance VendorID:* 0000055101

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
5/6/2016	**107511129**	**$844.48**	10/9/15 - 10/16/15	ACCT: 151406584	Payment amount based on $1,055.60 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/9/2016				*Patient Initials:* D.P.
	Mail To Address:	PO BOX 409179 ATLANTA GA 30384-9179			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1997

SOUTHWESTERN SURGICAL AFFILIATES — *Office of State Finance VendorID:* 0000055101

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
5/6/2016	**107511130**	**$40.00**	2/22/16	ACCT: 81607A1821	Payment amount based on $50.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/9/2016				*Patient Initials:* D.P.
	Mail To Address:	ATTN: 8679K BELFAST ME 04915		PO BOX 14000	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1997

SOUTHWESTERN MEDICAL CENTER — *Office of State Finance VendorID:* 0000055101

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
7/25/2016	**107567051**	**$4,092.48**	03/03/16	ACCT: 151645652	Payment amount based on $5,115.60 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				*Patient Initials:* L.C.
	Mail To Address:	PO BOX 740757 CINCINNATI OH 45274			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1975

5/6/2016	**107511131**	**$120.00**	10/19/13	ACCT: 150239549	Payment amount based on $150.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/9/2016 ***Patient Initials:*** H.A.

Mail To Address: PO BOX 740757 CINCINNATI OH 45274

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

WOODWARD REGIONAL MEDICAL CENTER ***Office of State Finance VendorID:*** 0000056261

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
4/22/2016	**107500233**	**$388.39**	10/23/15	ACCT: 231068601	Payment amount based on $485.49 patient balance after insurance and insurance adjustments.

Approx Mail Date: 4/25/2016 ***Patient Initials:*** J.H.

Mail To Address: PO BOX 849110 DALLAS TX 75284-9110

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1954

SUNRISE HOSPITAL ***Office of State Finance VendorID:*** 0000404121

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
5/4/2016	**107508682**	**$421.76**	03/18/15 AND 3/22/15	ACCT: 110747435 - $305.76; 110755797 - $116.00	Payment amount based on $527.20 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/7/2016 ***Patient Initials:*** C.B.

Mail To Address: 3186 MARYLAND PARKWAY LAS VEGAS NV 89109-2317

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1962

SELECT PHYSICAL THERAPY ***Office of State Finance VendorID:*** 0000336784

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
		$96.00	03/24/16 - 05/12/16	ACCT: 240212795	Payment amount based on $120.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 12/30/16 Expected to be mailed by 1/13/17 ***Patient Initials:*** A.G.

Mail To Address: 221 E COMANCHE MC ALESTER OK 74501

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

DENTISTRY BY DESIGN ***Office of State Finance VendorID:*** 0000254911

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
11/30/2016	**107657807**	**$5,048.00**	08/16/16 AND 11/15/16	ACCT: 36014	Payment amount based on $6,310.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/3/2016 ***Patient Initials:*** C.G.

Mail To Address: 7215 E. RENO AVE. MIDWEST CITY OK 73110

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1971

QUARTZ MOUNTAIN MEDICAL CTR ***Office of State Finance VendorID:*** 0000251605

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

5/27/2016	**107528375**	**$7,584.00**	10/10/15	ACCT: 256746	Payment amount based on $9,480.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/30/2016				***Patient Initials:***	A.P.
	Mail To Address:	1 WICKERSHAM DR. MANGUM OK 73554-0280			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1975

QUEST MHSA — ***Office of State Finance VendorID:*** 0000342559

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
10/11/2016	**107624049**	**$328.00**	11/11/15, 11/18/15, 5/11/16, 5/18/16, 5/25/16	ACCT: M.M.	Payment amount based on $410.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/14/2016				***Patient Initials:***	M.M.
	Mail To Address:	PO BOX 309 ANTLERS OK 74523			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1971
8/26/2016	**107592856**	**$393.60**	12/2/15, 12/9/15, 4/27/16, 5/4/16, 6/1/16, 6/29/16	ACCT: M.M.	Payment amount based on $492.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				***Patient Initials:***	M.M.
	Mail To Address:	PO BOX 309 ANTLERS OK 74523			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1971
5/24/2016	**107524715**	**$918.40**	12/16/15 - 12/30/15, 1/20/16 - 4/13/16	ACCT: M.M.	Payment amount based on $1,148.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/27/2016				***Patient Initials:***	M.M.
	Mail To Address:	PO BOX 309 ANTLERS OK 74523			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1971

MERCY HOSPITAL FORT SMITH — ***Office of State Finance VendorID:*** 0000055597

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
4/28/2016	**107504714**	**$3.30**	04/22/12	ACCT: 74121130297	Payment amount based on $14.58 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.34055% among all providers.	***Patient Initials:***	A.B.
	Mail To Address:	PO BOX 6460 CHESTERFIELD MO 63006-6460			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1990

OZARK ORTHO & SPORTS MEDICAL — ***Office of State Finance VendorID:*** 0000055627

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
9/30/2016	**107617512**	**$18.86**	03/27/14 - 10/07/14	ACCT: 186345	Payment amount based on $35.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 67.34457% among all providers.	***Patient Initials:***	L.D.
	Mail To Address:	PO BOX 1608 FAYETTEVILLE AR 72702-1608			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1971

5/6/2016	**107511106**	**$898.40**	6/3/14	ACCT: 188991	Payment amount based on $1,123.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/9/2016			***Patient Initials:*** T.B.
	Mail To Address:	PO BOX 1608 FAYETTEVILLE AR 72702-1608			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1994

THE LAB OF PATH, PA — ***Office of State Finance VendorID:*** 0000408321

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/9/2016	**107601545**	**$60.00**	03/11/16	ACCT: 1627428	Payment amount based on $75.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** M.S.
	Mail To Address:	1915 E. BEEBE CAPPS EXPY SEARCY AR 72143-5012			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1976

WASHINGTON REGIONAL MEDICAL CENTER — ***Office of State Finance VendorID:*** 0000173394

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/30/2016	**107617621**	**$3,719.76**	03/11/14	ACCT: 14070-00557	Payment amount based on $6,904.34 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 67.34457% among all providers. ***Patient Initials:*** L.D.
	Mail To Address:	PO BOX 1887 FAYETTEVILLE AR 72702			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1971

FT SMITH ORAL & MAXILLOFACIAL — ***Office of State Finance VendorID:*** 0000403964

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/28/2016	**107504632**	**$39.68**	04/28/12	ACCT: 028204	Payment amount based on $175.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.34055% among all providers. ***Patient Initials:*** A.B.
	Mail To Address:	2713 S 74TH ST STE 201 FORT SMITH AR 72903-5171			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990

LIFENET — ***Office of State Finance VendorID:*** 0000055753

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
6/8/2016	**107534987**	**$1,167.44**	2/2/16	ACCT: 6875	Payment amount based on $1,459.30 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/11/2016			***Patient Initials:*** S.J.
	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:*** 1955
6/7/2016	**107534007**	**$1,133.40**	05/02/15	ACCT: 15-24756	Payment amount based on $1,416.75 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/10/2016			***Patient Initials:*** A.E.
	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:*** 1995

UNITY HEALTH — *Office of State Finance VendorID:* 0000408320

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
9/9/2016	107601562	$5,599.20	03/11/16	ACCT: 1627428	Payment amount based on $6,999.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				*Patient Initials:* M.S.
	Mail To Address:	WHITE COUNTY MEDICAL CENTER SEARCY AR 72143	3214 E. RACE AVE.		Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1976

CHRISTIAN COUNSELING — *Office of State Finance VendorID:* 0000249446

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573574	$268.80	10/13/15, 10/28/15, 12/22/15	ACCT: S.M.	Payment amount based on $336.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				*Patient Initials:* S.M.
	Mail To Address:	412 N TELEPHONE ROAD MOORE OK 73160			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1975

KIMBERLY NGUYEN, D.M.D. — *Office of State Finance VendorID:* 0000370083

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/17/2016	107584302	$80.00	02/05/14	ACCT: T.B.	Payment amount based on $100.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/20/2016				*Patient Initials:* T.B.
	Mail To Address:	7520 E. HARRY WICHITA KS 67207			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1979

HILLCREST MEDICAL CENTER — *Office of State Finance VendorID:* 0000056219

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
5/24/2016	107524626	$269.89	6/19/13	ACCT: 1317001049	Payment amount based on $337.36 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				*Patient Initials:* P.C.
	Mail To Address:	DEPT 572 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1992
4/28/2016	107504641	$8,792.10	04/12/15 - 04/15/15	ACCT: 1510200049	Payment amount based on $10,990.13 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				*Patient Initials:* R.C.
	Mail To Address:	DEPT 572 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* N/A

HUTCHINS-MAPLES FUNERAL HOME — *Office of State Finance VendorID:* 0000064578

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

11/30/2016	**107657832**	**$7,500.00**	07/23/16	ACCT: D.L.	Payment amount based on $7,500.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/3/2016 ***Patient Initials:*** D.L.

Mail To Address: PO BOX 1108 BRISTOW OK 74010-1108 ***Patient Birth Year:*** 1998

MEMORIAL PARK CEMETERY ***Office of State Finance VendorID:*** 0000173871

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
5/27/2016	**107528332**	**$843.06**	02/16/16	ACCT: M.H.	Payment amount based on $843.06 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/30/2016 ***Patient Initials:*** M.H.

Mail To Address: 6405 MEMORIAL DRIVE ENID OK 73701-9804 ***Patient Birth Year:*** 1994

JACKSON COUNTY MEMORIAL HOSPITAL ***Office of State Finance VendorID:*** 0000056211

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
1/23/2017	**107688809**	**$4,345.79**	08/18/16	ACCT: J00007231261	Payment amount based on $5,432.24 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/26/2017 ***Patient Initials:*** J.T.

Mail To Address: PO BOX 8190 ALTUS OK 73522-8190 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1959

11/1/2016	**107638876**	**$40.00**	5/2/16	ACCT: J00006921345	Payment amount based on $50.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/4/2016 ***Patient Initials:*** C.C.

Mail To Address: PO BOX 8190 ALTUS OK 73522-8190 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1999

8/26/2016	**107592804**	**$4,075.61**	06/08/15	ACCT: J00005941989	Payment amount based on $5,094.51 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2016 ***Patient Initials:*** R.S.

Mail To Address: PO BOX 8190 ALTUS OK 73522-8190 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1941

JACKSON CO MEM HOSPITAL ***Office of State Finance VendorID:*** 0000056211

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
8/3/2016	**107573636**	**$647.12**	4/22/16	ACCT: 00006923321	Payment amount based on $808.90 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/6/2016 ***Patient Initials:*** K.S.

Mail To Address: PO BOX 8190 ALTUS OK 73522 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1988

DEACONESS HOSPITAL ***Office of State Finance VendorID:*** 0000056214

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

5/6/2016	**107511037**	**$100.00**	03/09/15	ACCT: 4477208	Payment amount based on $125.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/9/2016			***Patient Initials:*** M.L.
	Mail To Address:	5501 N PORTLAND AVE OKLAHOMA CITY OK 73112-2074			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1971

HILLCREST HEALTHCARE SYSTEM ***Office of State Finance VendorID:*** 0000056219

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
10/11/2016	**107624005**	**$518.43**	10/15/15	ACCT: A1528800071	Payment amount based on $648.04 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** M.S.
	Mail To Address:	DEPT 572 TULSA OK 74182		110 W 7th SUITE 2400	Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987
10/11/2016	**107624004**	**$4,364.19**	8/16/15 - 8/26/15	ACCT: A1522800411 $3,170.05; A1523800844 $1,194.14	Payment amount based on $5,455.24 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** A.D.
	Mail To Address:	DEPT 572 TULSA OK 74182		110 W 7th SUITE 2400	Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1980
		($6,229.46)	11/01/10	ACCT: 1030200598 (REFUNDED BY HILLCREST AND REDISTRIBUTED)	Payment amount based on ($7,786.83) patient balance after insurance and insurance adjustments.
	Approx Mail Date:	Requested from OSF 4/15/11 Expected to be mailed by 4/29/11			***Patient Initials:*** M.P.
	Mail To Address:	DEPT 572 TULSA OK 74182		110 W 7th SUITE 2400	Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987
4/28/2016	**107504642**	**$294.30**	11/17/15	ACCT: A1532101225	Payment amount based on $367.88 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** R.H.
	Mail To Address:	DEPT 572 TULSA OK 74182		110 W 7th SUITE 2400	Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1980

MERCY HEALTH CENTER ***Office of State Finance VendorID:*** 0000056220

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
10/11/2016	**107624027**	**$937.86**	11/8/15	ACCT: E1503141808	Payment amount based on $1,172.33 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** B.R.
	Mail To Address:	P O BOX 504292 ST LOUIS MO 63150-4292			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990

MERCY HEALTH CENTER ***Office of State Finance VendorID:*** 0000056220

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

1/19/2017	**107686484**	**$2,216.94**	07/19/15	ACCT: OKMC Emergency Phys 3855452 - $388.80; OKMC Hand Surgery Edmond - 3897067 - $1,828.14	Payment amount based on $2,771.18 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/22/2017				***Patient Initials:***	J.A.
	Mail To Address:	PO BOX 505017 ST LOUIS MO 63150-5017			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1995
12/23/2016	**107675541**	**$2,952.50**	06/10/16	ACCT: 53161620142	Payment amount based on $3,690.63 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/26/2016				***Patient Initials:***	P.M.
	Mail To Address:	PO BOX 505017 ST LOUIS MO 63150-5017			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1966
11/16/2016	**107649951**	**$152.50**	10/25/15	ACCT: 507152980025	Payment amount based on $381.26 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/19/2016				***Patient Initials:***	K.R.
	Mail To Address:	PO BOX 505017 ST LOUIS MO 63150-5017			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1966
9/30/2016	**107617493**	**$8,412.83**	02/20/16 - 02/21/16	ACCT: 53160510209	Payment amount based on $11,605.99 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 90.6088% among all providers.	***Patient Initials:***	N.V.
	Mail To Address:	PO BOX 505017 ST LOUIS MO 63150-5017			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1997
8/26/2016	**107592822**	**$992.32**	06/27/15	ACCT: 53151780197	Payment amount based on $1,240.40 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				***Patient Initials:***	K.J.
	Mail To Address:	PO BOX 505017 ST LOUIS MO 63150-5017			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1998
8/3/2016	**107573688**	**$3,468.24**	12/24/15 - 12/25/15	ACCT: 53153580823	Payment amount based on $4,335.30 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016				***Patient Initials:***	B.S.
	Mail To Address:	PO BOX 505017 ST LOUIS MO 63150-5017			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1979
7/20/2016	**107563739**	**$4,602.46**	08/21/15	ACCT: 53152331285	Payment amount based on $4,602.46 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016				***Patient Initials:***	C.G.
	Mail To Address:	PO BOX 505017 ST LOUIS MO 63150-5017				***Patient Birth Year:***	1971
6/27/2016	**107550415**	**$399.62**	1/26/16	ACCT: 53160261723 $372.80; 1108970258 $26.82	Payment amount based on $499.53 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/30/2016				***Patient Initials:***	E.P.
	Mail To Address:	PO BOX 505017 ST LOUIS MO 63150-5017			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1990

MERCY EMS ***Office of State Finance VendorID:*** 0000056220

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

5/24/2016	**107524679**	**$564.42**	10/9/15	ACCT: 8177179	Payment amount based on $705.53 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				***Patient Initials:*** M.M.
	Mail To Address:	PO BOX 268984 OKLAHOMA CITY OK 73126-8984			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1996

ST. JOHN MEDICAL CENTER — ***Office of State Finance VendorID:*** 0000056221

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
12/23/2016	**107675574**	**$5,808.80**	12/12/15	ACCT: J0085753151	Payment amount based on $7,261.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				***Patient Initials:*** J.C.
	Mail To Address:	1923 S. UTICA AVE TULSA OK 74182-0606		DEPT. 606	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1948
7/20/2016	**107563826**	**$874.44**	11/9/15	ACCT: S0071579514	Payment amount based on $1,093.05 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** L.A.
	Mail To Address:	1923 S. UTICA AVE TULSA OK 74182-0606		DEPT. 606	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1961

ST. JOHN SAPULPA — ***Office of State Finance VendorID:*** 0000056221

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
5/24/2016	**107524747**	**$1,151.44**	10/20/15	ACCT: S0071565459	Payment amount based on $1,439.30 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				***Patient Initials:*** J.T.
	Mail To Address:	PO BOX 1368 SAPULPA OK 74067-1368			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1980
5/24/2016	**107524746**	**$1,721.48**	7/5/15	ACCT: S0071487784	Payment amount based on $2,151.85 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				***Patient Initials:*** T.B.
	Mail To Address:	PO BOX 1368 SAPULPA OK 74067-1368			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1957

ST JOHN MEDICAL CENTER — ***Office of State Finance VendorID:*** 0000056221

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/23/2017	**107688932**	**$10,472.37**	07/03/16	ACCT: J0087071251	Payment amount based on $53,589.06 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 24.4275% among all providers.	***Patient Initials:*** B.H.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1977
1/23/2017	**107688931**	**$1,538.46**	04/26/15 - 04/27/15	ACCT: 00842-28109	Payment amount based on $1,923.08 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017				***Patient Initials:*** A.S.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1994

1/19/2017	**107686539**	**$3,038.42**	07/28/15	ACCT: J008481824	Payment amount based on $3,798.03 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/22/2017				***Patient Initials:***	E.M.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	N/A
1/20/2017	**107687735**	**$7,044.80**	6/11/14	Trauma Svs 00821-60027	Payment amount based on $8,806.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/23/2017				***Patient Initials:***	A.R.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1991
1/19/2017	**107686538**	**$232.20**	09/01/15 - 09/04/15	ACCT: J0085055569	Payment amount based on $290.25 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/22/2017				***Patient Initials:***	A.G.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1983
12/23/2016	**107675575**	**$15,990.48**	04/07/16 - 04/10/16	ACCT: J0086505215	Payment amount based on $36,679.05 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 54.4946% among all providers.	***Patient Initials:***	M.B.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1977
11/21/2016	**107653210**	**$8,192.72**	03/26/16	ACCT: J0009737891	Payment amount based on $10,240.90 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016				***Patient Initials:***	V.T.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1989
11/30/2016	**107657916**	**$1,531.30**	11/29/14	ACCT: J0083268514	Payment amount based on $1,914.13 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				***Patient Initials:***	B.D.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1987
11/21/2016	**107653211**	**$17,668.73**	05/02/16	ACCT: J0086670917	Payment amount based on $22,085.91 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016				***Patient Initials:***	M.B.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1970
11/15/2016	**107648882**	**$1,008.00**	08/18/15	ACCT: J0084954357	Payment amount based on $1,260.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/18/2016				***Patient Initials:***	G.M.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1960
11/1/2016	**107638907**	**$765.29**	7/1/16 - 7/2/16	ACCT: J0087069168	Payment amount based on $956.61 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/4/2016				***Patient Initials:***	R.A.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1996

10/11/2016	**107624066**	**$1,754.48**	11/26/15, 12/9/15	ACCT: #J0085654292 $960.00, #J0085702891 $794.48	Payment amount based on $2,193.10 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** D.M.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1936
8/26/2016	**107592875**	**$266.83**	12/5/14	ACCT: J0005973565	Payment amount based on $333.54 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** K.N.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1981
8/26/2016	**107592874**	**$6,678.88**	11/29/15	ACCT: J0085663267	Payment amount based on $8,348.60 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** R.N.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1969
8/26/2016	**107592873**	**$1,013.80**	01/19/15	ACCT: J0012974267	Payment amount based on $1,267.25 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** J.A.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1993
6/27/2016	**107550458**	**$220.00**	10/16/15	ACCT: S0071562697	Payment amount based on $275.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/30/2016			***Patient Initials:*** H.T.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1995
6/20/2016	**107544959**	**$9,004.16**	11/30/15 - 12/01/15	ACCT: J0013607023	Payment amount based on $11,255.20 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			***Patient Initials:*** H.F.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1997
6/20/2016	**107544958**	**$7,115.40**	06/18/15	ACCT: J0084563293	Payment amount based on $8,894.25 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			***Patient Initials:*** C.C.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1960
6/20/2016	**107544957**	**$16,247.43**	04/26/15 - 05/18/15	ACCT: J0084227706 -$14,968.81; J0084337366 - $93.93; J0084326046 - $1,184.69	Payment amount based on $76,432.75 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 26.57145% among all providers. ***Patient Initials:*** K.B.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1969
6/20/2016	**107544956**	**$11,980.64**	08/22/14 - 08/28/14	ACCT: 0082619208	Payment amount based on $14,975.80 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			***Patient Initials:*** E.T.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1965

5/27/2016	**107528403**	**$7,600.24**	03/09/15 - 03/10/15	ACCT: J0010696862	Payment amount based on $9,500.30 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/30/2016			***Patient Initials:*** A.R.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1985
5/27/2016	**107528404**	**$5,495.20**	05/08/15	ACCT: J0084305804	Payment amount based on $6,869.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/30/2016			***Patient Initials:*** R.W.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1988
4/28/2016	**107504735**	**$10,612.72**	10/02/15 - 10/03/15	ACCT: J0085288253	Payment amount based on $13,265.90 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** R.C.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1971
4/28/2016	**107504734**	**$241.26**	06/02/14	ACCT: 895803	Payment amount based on $301.58 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** A.J.
	Mail To Address:	DEPT 606 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1971

INTEGRIS BAPTIST REGIONAL HEALTH CENTER ***Office of State Finance VendorID:*** 0000056242

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/30/2016	**107617460**	**$343.30**	06/08/15	ACCT: 480124754.1	Payment amount based on $1,401.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 30.61857% among all providers. ***Patient Initials:*** Q.A.
	Mail To Address:	DEPT #96-0410 OKLAHOMA CITY OK 73196-0410			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1967

SUNBEAM FAMILY SERVICES ***Office of State Finance VendorID:*** 0000072335

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/22/2016	**107500222**	**$144.00**	10/22/15 AND 10/29/15	ACCT: S.B.	Payment amount based on $180.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	4/25/2016			***Patient Initials:*** J.P.
	Mail To Address:	1100 NW 14th St OKLAHOMA CITY OK 73106			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1988

JANE PHILLIPS MEDICAL CENTER ***Office of State Finance VendorID:*** 0000056279

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
8/3/2016	**107573643**	**$354.00**	04/06/14	ACCT: 70069416	Payment amount based on $442.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/6/2016			***Patient Initials:*** B.A.
	Mail To Address:	DEPT 2878 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2014

8/3/2016	**107573642**	**$1,200.00**	9/13/15	ACCT: 0051024678	Payment amount based on $1,500.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/6/2016			***Patient Initials:*** T.W.
	Mail To Address:	DEPT 2878 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1998

BASS BAPTIST HEALTH CENTER ***Office of State Finance VendorID:*** 0000072365

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
1/20/2017	**107687569**	**$1,908.30**	4/29/16	632876011	Payment amount based on $2,385.38 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/23/2017			***Patient Initials:*** C.C.
	Mail To Address:	PO BOX 960239 OKLAHOMA CITY OK 73196-0239			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1971
11/1/2016	**107638875**	**$204.84**	1/9/16	ACCT: 621675005	Payment amount based on $256.05 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/4/2016			***Patient Initials:*** S.M.
	Mail To Address:	PO BOX 960239 OKLAHOMA CITY OK 73196-0239			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990
6/20/2016	**107544870**	**$17,309.98**	11/05/15 AND 11/12/15	ACCT: 706706001 - $16,882.23; 706706002 - $355.57; 980306A6762 - $72.18	Payment amount based on $29,258.70 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 73.95226% among all providers. ***Patient Initials:*** S.L.
	Mail To Address:	PO BOX 960239 OKLAHOMA CITY OK 73196-0239			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1981

ST. ANTHONY HOSPITAL ***Office of State Finance VendorID:*** 0000072415

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
7/25/2016	**107567038**	**$9,920.86**	08/10/15	ACCT: 40152220024	Payment amount based on $12,401.08 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/28/2016			***Patient Initials:*** D.R.
	Mail To Address:	PO BOX 269009 OKLAHOMA CITY OK 73126-9009			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1958

ST. ANTHONY HOSPITAL ***Office of State Finance VendorID:*** 0000072415

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
6/20/2016	**107544935**	**$1,750.30**	07/27/15	ACCT: 40152084564	Payment amount based on $2,187.88 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			***Patient Initials:*** E.B.
	Mail To Address:	PO BOX 505135 ST. LOUIS MO 63150-5135			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1984

5/27/2016	**107528388**	**$35.11**	09/07/15	ACCT: 40152500426	Payment amount based on $43.89 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				***Patient Initials:*** S.H.
	Mail To Address:	PO BOX 505135 ST. LOUIS MO 63150-5135			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1966
4/6/2016	**107486745**	**$72.25**	7/10/15	ACCT: 40151910030	Payment amount based on $90.31 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/9/2016				***Patient Initials:*** D.R.
	Mail To Address:	PO BOX 505135 ST. LOUIS MO 63150-5135			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1979

ST ANTHONY HOSPITAL ***Office of State Finance VendorID:*** 0000072415

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
12/16/2016	**107670850**	**$1,380.50**	06/05/15	ACCT: 40151562891	Payment amount based on $1,725.63 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/19/2016				***Patient Initials:*** S.S.
	Mail To Address:	PO BOX 505135 ST LOUIS MO 63150			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1984
8/26/2016	**107592863**	**$963.53**	01/11/16	ACCT: 40160115097	Payment amount based on $1,204.41 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** H.W.
	Mail To Address:	PO BOX 505135 ST LOUIS MO 63150			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1991
5/6/2016	**107511122**	**$374.05**	1/24/15	ACCT:40150240034	Payment amount based on $467.56 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/9/2016				***Patient Initials:*** J.H.
	Mail To Address:	PO BOX 505135 ST LOUIS MO 63150			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1978
5/4/2016	**107508668**	**$2,609.42**	10/23/15	ACCT: 40152963812	Payment amount based on $3,261.78 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/7/2016				***Patient Initials:*** P.A.
	Mail To Address:	PO BOX 505135 ST LOUIS MO 63150			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1964

SSM HEALTH ***Office of State Finance VendorID:*** 0000072415

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/20/2017	**107687716**	**$518.06**	5/26/16	24161472163	Payment amount based on $647.58 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				***Patient Initials:*** W.M.
	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.	***Patient Birth Year:*** 1964
9/9/2016	**107601498**	**$123.00**	04/05/16	ACCT: 40160640818	Payment amount based on $153.75 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** B.B.
	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.	***Patient Birth Year:*** 1989

8/3/2016	**107573740**	**$200.00**	7/2/15	ACCT: 40151821216	Payment amount based on $250.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				***Patient Initials:*** B.P.
	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.	***Patient Birth Year:*** 1989
7/20/2016	**107563808**	**$2,144.35**	01/12/16	ACCT: 40160110769	Payment amount based on $4,298.08 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 62.36396% among all providers.	***Patient Initials:*** B.B.
	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.	***Patient Birth Year:*** 1989

ST. JOHN SAPULPA

Office of State Finance VendorID: 0000056348

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/27/2016	**107550460**	**$317.60**	1/5/16	ACCT: S0071618145	Payment amount based on $397.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** K.C.
	Mail To Address:	DEPT 2594 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1990
6/27/2016	**107550459**	**$94.40**	10/7/15	ACCT: 0071556051	Payment amount based on $118.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** M.J.
	Mail To Address:	DEPT 2594 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1957
5/24/2016	**107524749**	**$1,711.72**	10/07/15	ACCT: S0000131392	Payment amount based on $2,139.65 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				***Patient Initials:*** M.J.
	Mail To Address:	DEPT 2594 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1957

ST. FRANCIS HOSPITAL

Office of State Finance VendorID: 0000056512

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
4/29/2016	**107506181**	**$869.78**	5/12/14	ACCT: 950487	Payment amount based on $1,087.23 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/2/2016				***Patient Initials:*** A.M.
	Mail To Address:	6600 S YALE AVE TULSA OK 74136-3319		SUITE 500	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1972

ST FRANCIS HEALTH SYSTEM

Office of State Finance VendorID: 0000056512

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/21/2016	**107653199**	**$7,258.57**	5/30/15	3384875	Payment amount based on $9,073.21 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				***Patient Initials:*** D.H.
	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:*** 1963

11/18/2016	**107651897**	**$636.00**	12/4/15	ACCT: 1466097	Payment amount based on $795.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				***Patient Initials:*** E.T.
	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:*** 1966
11/18/2016	**107651898**	**$806.56**	4/28/16, 5/2/16	ACCT: 602432201 $168.96, 602443086 $637.60	Payment amount based on $1,008.20 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				***Patient Initials:*** R.E.
	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:*** 1960
6/27/2016	**107550449**	**$195.46**	1/12/16	ACCT:602046257	Payment amount based on $244.33 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** K.C.
	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:*** 1990
6/20/2016	**107544936**	**$2,294.78**	02/06/15 - 01/26/16	ACCT: 919896	Payment amount based on $17,636.94 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 16.26405% among all providers.	***Patient Initials:*** L.H.
	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:*** 1977
6/20/2016	**107544937**	**$283.84**	07/22/15 - 10/09/15	ACCT: 1801388	Payment amount based on $354.80 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** C.C.
	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:*** 1960
6/7/2016	**107534053**	**$1,166.11**	07/19/15	ACCT: 43449	Payment amount based on $1,457.64 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** B.D.
	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:*** 1995
6/7/2016	**107534052**	**$3,845.76**	10/27/15	ACCT: 735634	Payment amount based on $4,807.20 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** G.G.
	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:*** 1985
6/7/2016	**107534051**	**$2,857.29**	09/03/15	ACCT: 601615241	Payment amount based on $3,571.61 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** C.P.
	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:*** 1998
6/7/2016	**107534050**	**$4,336.98**	10/26/14	ACCT: 377916	Payment amount based on $5,421.23 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** J.M.
	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:*** 1987

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
1/23/2017	**107688916**	**$13,832.36**	04/29/15	ACCT: 443866463	Payment amount based on $17,290.45 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017				*Patient Initials:*	I.B.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1985
1/23/2017	**107688917**	**$3,221.38**	04/26/15 - 05/18/15	ACCT: 601174966 - $2,542.96; 477684599 - $117.96; 601187556 - $404.59; 477725787 - $38.20; 601191185 - $117.67	Payment amount based on $4,026.71 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017				*Patient Initials:*	A.S.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1994
1/9/2017	**107680037**	**$251.84**	02/26/26	ACCT: 3438111	Payment amount based on $314.80 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/12/2017				*Patient Initials:*	H.R.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1992
12/16/2016	**107670851**	**$11,247.46**	04/18/15 - 05/12/15	ACCT: 601149292	Payment amount based on $104,999.20 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/19/2016			Total Bills exceed maximum award. Payment is prorated at 13.38993% among all providers.	*Patient Initials:*	C.B.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1980
11/30/2016	**107657906**	**$4,893.58**	10/22/15	ACCT: 3414169	Payment amount based on $6,116.98 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				*Patient Initials:*	A.M.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1966
11/30/2016	**107657907**	**$1,171.12**	02/18/16 - 02/27/16	ACCT: 602187156	Payment amount based on $1,463.90 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				*Patient Initials:*	T.W.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1995
11/21/2016	**107653200**	**$3,712.30**	01/21/16 - 02/02/16	ACCT: 602084848	Payment amount based on $4,640.38 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016				*Patient Initials:*	J.H.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1960
11/30/2016	**107657905**	**$2,675.61**	02/28/16	ACCT: 602219232	Payment amount based on $3,617.39 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				*Patient Initials:*	C.T.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1979

9/30/2016	**107617573**	**$10,565.58**	06/18/13	ACCT: 952250618	Payment amount based on $13,206.98 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			***Patient Initials:*** F.P.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1962
7/25/2016	**107567039**	**$1,488.19**	05/24/14 - 05/25/14	ACCT: 952450	Payment amount based on $1,860.24 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/28/2016			***Patient Initials:*** L.S.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1968
5/27/2016	**107528389**	**$3,093.20**	05/16/15	ACCT: 601245785	Payment amount based on $3,866.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/30/2016			***Patient Initials:*** C.C.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1979
4/28/2016	**107504719**	**$8,557.54**	10/10/15 AND 11/21/15	ACCT: 772096	Payment amount based on $10,696.93 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** R.H.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1980
4/28/2016	**107504718**	**$12,650.87**	07/12/15 - 08/31/15	ACCT: 601431108 - $4,782.54; 601456581 - $595.52; 601445650 - $6,961.71; 601560690 - $311.10	Payment amount based on $22,772.74 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 69.44086% among all providers. ***Patient Initials:*** C.M.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1991
4/28/2016	**107504716**	**$7,771.34**	05/01/15 - 05/02/15	ACCT: 60119775200	Payment amount based on $9,714.18 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** J.R.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1968
4/28/2016	**107504717**	**$400.00**	05/20/15	ACCT: 601259198	Payment amount based on $500.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** J.G.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2013
4/28/2016	**107504715**	**$16,377.41**	12/14/12 - 01/23/13	ACCT: 952185881	Payment amount based on $301,493.19 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.79013% among all providers. ***Patient Initials:*** P.W.
	Mail To Address:	PO BOX 706161 TULSA OK 74170-6161			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987

ASSOCIATED ANESTHESIOLOGIST ***Office of State Finance VendorID:*** 0000056444

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

11/30/2016	**107657749**	**$849.15**	02/19/16	ACCT: 297107	Payment amount based on $1,061.44 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/3/2016				***Patient Initials:*** T.W.
	Mail To Address:	6839 S CANTON AVE TULSA OK 74136-3402			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995
11/21/2016	**107652979**	**$1,936.00**	6/9/15	284474	Payment amount based on $2,420.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				***Patient Initials:*** D.H.
	Mail To Address:	6839 S CANTON AVE TULSA OK 74136-3402			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1963
11/18/2016	**107651823**	**$700.00**	5/2/16	ACCT: 447709100	Payment amount based on $875.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				***Patient Initials:*** R.E.
	Mail To Address:	6839 S CANTON AVE TULSA OK 74136-3402			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1960
6/20/2016	**107544780**	**$409.85**	02/10/15 - 01/25/16	ACCT: 278637	Payment amount based on $3,149.98 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 16.26405% among all providers.	***Patient Initials:*** L.H.
	Mail To Address:	6839 S CANTON AVE TULSA OK 74136-3402			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1977
4/28/2016	**107504557**	**$611.08**	07/20/15	ACCT: 836163	Payment amount based on $1,100.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 69.44086% among all providers.	***Patient Initials:*** C.M.
	Mail To Address:	6839 S CANTON AVE TULSA OK 74136-3402			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1991
4/28/2016	**107504556**	**$704.00**	12/14/12 - 04/30/13	ACCT: 617838	Payment amount based on $12,960.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.79013% among all providers.	***Patient Initials:*** P.W.
	Mail To Address:	6839 S CANTON AVE TULSA OK 74136-3402			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1987

SOUTHERN OK AMBULANCE SERVICE ***Office of State Finance VendorID:*** 0000056450

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
12/23/2016	**107675571**	**$2,648.00**	06/09/16 - 06/10/16	ACCT: PAT-043781	Payment amount based on $3,310.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				***Patient Initials:*** P.M.
	Mail To Address:	PO BOX 1387 ARDMORE OK 73402-1387			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1966

AFFILIATED ANESTHESIOLOGISTS ***Office of State Finance VendorID:*** 0000056467

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/19/2017	**107686331**	**$1,368.00**	07/19/15	ACCT: AAL101826	Payment amount based on $1,710.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** J.A.
	Mail To Address:	DEPT 96-0431 OKLAHOMA CITY OK 73196-0431			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995

11/15/2016	**107648823**	**$280.80**	07/25/16	ACCT: AAL133101	Payment amount based on $351.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/18/2016			***Patient Initials:*** B.B.
	Mail To Address:	DEPT 96-0431 OKLAHOMA CITY OK 73196-0431			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1989

OK RADIOLOGY GROUP ***Office of State Finance VendorID:*** 0000056502

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/16/2016	**107670843**	**$136.00**	06/05/15	ACCT: 118086	Payment amount based on $170.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/19/2016			***Patient Initials:*** S.S.
	Mail To Address:	PO BOX 26064 OKLAHOMA CITY OK 73126-0064			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1984
11/15/2016	**107648876**	**$60.00**	02/25/16	ACCT: 216430	Payment amount based on $75.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/18/2016			***Patient Initials:*** S.T.
	Mail To Address:	PO BOX 26064 OKLAHOMA CITY OK 73126-0064			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1969
8/26/2016	**107592857**	**$24.00**	01/11/16	ACCT: 40160115097	Payment amount based on $30.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** H.W.
	Mail To Address:	PO BOX 26064 OKLAHOMA CITY OK 73126-0064			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1991
5/27/2016	**107528377**	**$11.52**	09/07/15	ACCT: 160875	Payment amount based on $14.40 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/30/2016			***Patient Initials:*** S.H.
	Mail To Address:	PO BOX 26064 OKLAHOMA CITY OK 73126-0064			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1966
5/4/2016	**107508658**	**$296.00**	04/27/15	ACCT: 319871-01	Payment amount based on $370.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/7/2016			***Patient Initials:*** C.J.
	Mail To Address:	PO BOX 26064 OKLAHOMA CITY OK 73126-0064			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1955

LUGINBUEL FUNERAL HOME ***Office of State Finance VendorID:*** 0000174508

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
6/20/2016	**107544884**	**$7,500.00**	11/24/15	ACCT: J.W.B.	Payment amount based on $8,448.06 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			***Patient Initials:*** J.B.
	Mail To Address:	332 N SCRAPER ST VINITA OK 74301-3212			***Patient Birth Year:*** 1946

UROLOGIC SPECIALISTS OF OK ***Office of State Finance VendorID:*** 0000174514

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

6/20/2016	**107544981**	**$23.38**	04/27/15	ACCT: 1-314591	Payment amount based on $110.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 26.57145% among all providers. ***Patient Initials:*** K.B.
	Mail To Address:	DEPT 294 PO BOX 21568 TULSA OK 74121-1568			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1969

INTEGRIS GROVE HOSPITAL — ***Office of State Finance VendorID:*** 0000056517

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/21/2016	**107653093**	**$582.88**	1/18/15	Ambulance (Dept. 96-0409), Acct. #4820*25077.1	Payment amount based on $728.60 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			***Patient Initials:*** J.W.
	Mail To Address:	PO BOX 960399 OKLAHOMA CITY OK 73196-0399			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1960
11/21/2016	**107653094**	**$7,495.04**	1/18/15 - 1/19/-15	90611006	Payment amount based on $9,368.80 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			***Patient Initials:*** J.W.
	Mail To Address:	PO BOX 960399 OKLAHOMA CITY OK 73196-0399			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1960

TULSA ADJUSTMENT BUREAU — ***Office of State Finance VendorID:*** 0000174559

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/30/2016	**107617597**	**$452.56**	03/12/14	ACCT: ORA1203983	Payment amount based on $840.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 67.34457% among all providers. ***Patient Initials:*** L.D.
	Mail To Address:	PO BOX 52039 TULSA OK 74152-0039			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1971

OKLAHOMA RADIOLOGY GROUP — ***Office of State Finance VendorID:*** 0000275626

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
5/4/2016	**107508634**	**$136.00**	10/23/15	ACCT: 178221	Payment amount based on $170.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/7/2016			***Patient Initials:*** P.A.
	Mail To Address:	P O BOX 26064 OKLAHOMA CITY OK 73126-0064			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1964

LOWELL-TIMS FUNERAL HOME — ***Office of State Finance VendorID:*** 0000060844

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
10/11/2016	**107624023**	**$7,500.00**	5/16/16	ACCT: J.G.	Payment amount based on $7,500.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** J.G.
	Mail To Address:	1100 E TAMARACK RD ALTUS OK 73521-1232			***Patient Birth Year:*** 1963

SHAWNEE MEDICAL CENTER CLINIC — *Office of State Finance VendorID:* 0000072739

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
7/20/2016	107563813	$27.86	03/14/13	ACCT: 2090462	Payment amount based on $100.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 34.82462% among all providers.	*Patient Initials:*	J.J.
	Mail To Address:	PO BOX 849 SHAWNEE OK 74802-0849			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1979

EAST OKLAHOMA ORTHOPEDIC CENTER — *Office of State Finance VendorID:* 0000072747

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
4/28/2016	107504614	$12.06	12/14/12	ACCT: 494950	Payment amount based on $222.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.79013% among all providers.	*Patient Initials:*	P.W.
	Mail To Address:	PO BOX 22063 DEPT 555 TULSA OK 74121-2063			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1987

SURGERY, INC — *Office of State Finance VendorID:* 0000192709

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
9/9/2016	107601532	$114.40	5/29/15	ACCT: 177524CCJ	Payment amount based on $143.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	9/12/2016				*Patient Initials:*	L.F.
	Mail To Address:	P.O. BOX 35307 TULSA OK 74153-0307			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1964
8/26/2016	107592887	$99.20	01/19/15	ACCT: 175306	Payment amount based on $124.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				*Patient Initials:*	J.A.
	Mail To Address:	P.O. BOX 35307 TULSA OK 74153-0307			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1993
5/4/2016	107508683	$350.58	09/08/15	ACCT: 179202C8I	Payment amount based on $438.23 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/7/2016				*Patient Initials:*	R.H.
	Mail To Address:	P.O. BOX 35307 TULSA OK 74153-0307			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1967

TULSA RADIOLOGY ASSOCIATES — *Office of State Finance VendorID:* 0000056693

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
1/23/2017	107688953	$178.03	07/03/16	ACCT: 855239	Payment amount based on $911.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 24.4275% among all providers.	*Patient Initials:*	B.H.
	Mail To Address:	PO BOX 4939 TULSA OK 74159-0939			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1977

1/19/2017	**107686557**	**$316.00**		07/28/15		ACCT: 681078	Payment amount based on $395.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017						***Patient Initials:*** E.M.
	Mail To Address:	PO BOX 4939					Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** N/A
		TULSA		OK	74159-0939			
1/19/2017	**107686556**	**$341.60**		02/04/16		ACCT: TRA455037	Payment amount based on $427.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017						***Patient Initials:*** F.L.
	Mail To Address:	PO BOX 4939					Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1992
		TULSA		OK	74159-0939			
12/23/2016	**107675582**	**$362.40**		12/12/15		ACCT: TRA765900	Payment amount based on $453.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016						***Patient Initials:*** J.C.
	Mail To Address:	PO BOX 4939					Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1948
		TULSA		OK	74159-0939			
12/23/2016	**107675864**	**$18.50**		4/9/16		Acct; TRA836660	Payment amount based on $23.13 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016						***Patient Initials:*** T.B.
	Mail To Address:	PO BOX 4939					Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1955
		TULSA		OK	74159-0939			
11/30/2016	**107657939**	**$149.60**		11/29/14		ACCT: 566108	Payment amount based on $187.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/3/2016						***Patient Initials:*** B.D.
	Mail To Address:	PO BOX 4939					Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1987
		TULSA		OK	74159-0939			
11/15/2016	**107648894**	**$44.34**		08/18/15		ACCT: TRA694341	Payment amount based on $55.43 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/18/2016						***Patient Initials:*** G.M.
	Mail To Address:	PO BOX 4939					Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1960
		TULSA		OK	74159-0939			
11/1/2016	**107638921**	**$96.80**		6/25/16		ACCT: 853548	Payment amount based on $121.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/4/2016						***Patient Initials:*** R.A.
	Mail To Address:	PO BOX 4939					Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1996
		TULSA		OK	74159-0939			
10/11/2016	**107624080**	**$39.20**		10/7/15		ACCT: TRA724373	Payment amount based on $49.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016						***Patient Initials:*** J.B.
	Mail To Address:	PO BOX 4939					Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1986
		TULSA		OK	74159-0939			
8/26/2016	**107592896**	**$20.18**		11/29/15		ACCT: TRA282796	Payment amount based on $25.23 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016						***Patient Initials:*** R.N.
	Mail To Address:	PO BOX 4939					Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1969
		TULSA		OK	74159-0939			

7/20/2016	**107563859**	**$341.60**	01/02/16	ACCT: TRA776806	Payment amount based on $427.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** J.E.
	Mail To Address:	PO BOX 4939 TULSA OK 74159-0939			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1982
7/20/2016	**107563858**	**$48.00**	11/9/15	ACCT: TRA746443	Payment amount based on $60.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** L.A.
	Mail To Address:	PO BOX 4939 TULSA OK 74159-0939			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1961
6/27/2016	**107550478**	**$3.91**	1/5/16	ACCT: TRA778935	Payment amount based on $4.89 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** K.C.
	Mail To Address:	PO BOX 4939 TULSA OK 74159-0939			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1990
6/20/2016	**107544976**	**$371.20**	11/29/15 AND 11/30/15	ACCT: 1879411	Payment amount based on $464.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** H.F.
	Mail To Address:	PO BOX 4939 TULSA OK 74159-0939			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1997
6/20/2016	**107544975**	**$412.80**	06/17/15 - 06/18/15	ACCT: 1742015	Payment amount based on $516.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** C.C.
	Mail To Address:	PO BOX 4939 TULSA OK 74159-0939			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1960
6/20/2016	**107544974**	**$281.23**	04/26/15 - 04/28/15	ACCT: TRA301988	Payment amount based on $1,323.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 26.57145% among all providers.	***Patient Initials:*** K.B.
	Mail To Address:	PO BOX 4939 TULSA OK 74159-0939			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1969
5/27/2016	**107528425**	**$336.80**	05/08/15	ACCT: TRA633939	Payment amount based on $421.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				***Patient Initials:*** R.W.
	Mail To Address:	PO BOX 4939 TULSA OK 74159-0939			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1988
5/24/2016	**107524781**	**$165.00**	12/15/14	ACCT: 150930238	Payment amount based on $206.25 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				***Patient Initials:*** Y.S.
	Mail To Address:	PO BOX 4939 TULSA OK 74159-0939			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995
4/28/2016	**107504753**	**$412.80**	10/02/15 - 10/03/15	ACCT: TRA722041	Payment amount based on $516.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				***Patient Initials:*** R.C.
	Mail To Address:	PO BOX 4939 TULSA OK 74159-0939			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1971

ORTHOPEDIC ASSOCIATES, INC. *Office of State Finance VendorID:* 0000056699

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
9/30/2016	107617513	$1,890.25	10/18/15 - 11/23/15	ACCT: 91068	Payment amount based on $3,604.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 65.56089% among all providers.	*Patient Initials:*	K.L.
	Mail To Address:	3301 NW 50TH ST OKLAHOMA CITY OK 73112-5627			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1970
7/20/2016	107563764	$18.47	08/05/15	ACCT: 88744	Payment amount based on $224.60 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 10.27708% among all providers.	*Patient Initials:*	M.L.
	Mail To Address:	3301 NW 50TH ST OKLAHOMA CITY OK 73112-5627			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1975

TULSA X-RAY LABORATORY, INC. *Office of State Finance VendorID:* 0000056723

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
1/20/2017	107687777	$265.60	5/14/16	Z2GF069	Payment amount based on $332.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/23/2017				*Patient Initials:*	W.H.
	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:*	2001
11/21/2016	107653232	$866.85	06/17/16	ACCT: 321472-QTXRL	Payment amount based on $1,132.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 95.72122% among all providers.	*Patient Initials:*	J.R.
	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:*	1974
4/28/2016	107504755	$231.06	08/28/15	ACCT: TXRL-249389	Payment amount based on $332.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 86.99495% among all providers.	*Patient Initials:*	N.B.
	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:*	1984
4/28/2016	107504754	$9.19	09/18/15	ACCT: 254678	Payment amount based on $67.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 17.14525% among all providers.	*Patient Initials:*	E.G.
	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:*	1955

TULSA X-RAY LABORATORY, INC. *Office of State Finance VendorID:* 0000056723

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
10/19/2016	107630531	$74.40	08/16/15	ACCT: 19741-QTXRL	Payment amount based on $93.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/22/2016				*Patient Initials:*	J.B.
	Mail To Address:	P.O. BOX 3290 INDIANAPOLIS IN 46260-3290			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1976

10/11/2016	**107624081**	**$670.40**	8/17/15 - 8/26/15	ACCT: 238205-QTXRL	Payment amount based on $838.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				***Patient Initials:*** A.D.
	Mail To Address:	P.O. BOX 3290 INDIANAPOLIS IN 46260-3290			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1980
9/9/2016	**107601557**	**$20.00**	10/11/15	ACCT: 261992-QTXRL	Payment amount based on $50.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** J.H.
	Mail To Address:	P.O. BOX 3290 INDIANAPOLIS IN 46260-3290			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1993
8/26/2016	**107592897**	**$265.60**	01/19/15	ACCT: 15475-QTXTL	Payment amount based on $332.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** J.A.
	Mail To Address:	P.O. BOX 3290 INDIANAPOLIS IN 46260-3290			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1993
7/20/2016	**107563860**	**$147.20**	10/13/15	ACCT: 262713	Payment amount based on $184.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** M.S.
	Mail To Address:	P.O. BOX 3290 INDIANAPOLIS IN 46260-3290			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1963
4/29/2016	**107506208**	**$292.00**	8/5/15	ACCT: 242213QTXRL	Payment amount based on $365.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/2/2016				***Patient Initials:*** L.S.
	Mail To Address:	P.O. BOX 3290 INDIANAPOLIS IN 46260-3290			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1970

WEATHERFORD HOSPITAL AUTHORITY ***Office of State Finance VendorID:*** 0000072809

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
8/3/2016	**107573788**	**$537.05**	6/2/15 - 6/7/15	ACCT: 802686, 802843, 8030277	Payment amount based on $671.31 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				***Patient Initials:*** T.G.
	Mail To Address:	3701 EAST MAIN ST. WEATHERFORD OK 73096-5499			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1998

HOLDENVILLE GENERAL HOSPITAL ***Office of State Finance VendorID:*** 0000056743

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/27/2016	**107550375**	**$732.00**	7/2/15	ACCT: 1284464-01	Payment amount based on $915.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** C.C.
	Mail To Address:	100 MCDOUGAL DRIVE HOLDENVILLE OK 74848			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2015

PAULS VALLEY GENERAL HOSPITAL ***Office of State Finance VendorID:*** 0000010410

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

9/9/2016	**107601465**	**$424.90**	03/22/15	ACCT: 10014242	Payment amount based on $531.13 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** T.B.
	Mail To Address:	PO BOX 368 PAULS VALLEY OK 73075-0368			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1993
9/9/2016	**107601464**	**$3,532.40**	08/30/15	ACCT: 10025128 - $2,945.20; 10025934 - $587.20	Payment amount based on $4,415.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** B.C.
	Mail To Address:	PO BOX 368 PAULS VALLEY OK 73075-0368			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1997
9/9/2016	**107601463**	**$1,650.03**	09/03/15	ACCT: 10025820 - $522.62; 10025473 - $287.81; 10025806 - $839.60	Payment amount based on $2,062.54 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** T.M.
	Mail To Address:	PO BOX 368 PAULS VALLEY OK 73075-0368			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1982
7/20/2016	**107563785**	**$107.69**	01/18/16	ACCT: 10035496	Payment amount based on $847.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 15.89261% among all providers.	***Patient Initials:*** J.K.
	Mail To Address:	PO BOX 368 PAULS VALLEY OK 73075-0368			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1996

PURCELL MUNICIPAL ***Office of State Finance VendorID:*** 0000056820

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/15/2016	**107648875**	**$635.84**	02/25/16	ACCT: 907160560023	Payment amount based on $794.80 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/18/2016				***Patient Initials:*** S.T.
	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:*** 1969
11/15/2016	**107648874**	**$2,734.40**	12/03/15	ACCT: 907153370054	Payment amount based on $3,418.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/18/2016				***Patient Initials:*** G.H.
	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:*** 1959
6/7/2016	**107534041**	**$325.20**	03/22/15	ACCT: 907150810007	Payment amount based on $406.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** D.C.
	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:*** 1968

PURCELL HOSPITAL CLINIC BILLING ***Office of State Finance VendorID:*** 0000056820

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

7/20/2016	**107563795**	**$106.85**	6/30/15	ACCT: 940710025495	Payment amount based on $133.56 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** D.L.
	Mail To Address:	PO BOX 511 PURCELL OK 73080-0511			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995
6/7/2016	**107534042**	**$356.00**	03/22/15	ACCT: 940710007088	Payment amount based on $445.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** D.C.
	Mail To Address:	PO BOX 511 PURCELL OK 73080-0511			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1968

DIAGNOSTIC IMAGING ASSOC INC ***Office of State Finance VendorID:*** 0000072917

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
7/20/2016	**107563637**	**$18.40**	05/02/15	ACCT: 257419-QDIA1	Payment amount based on $23.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** S.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***
1/20/2017	**107687529**	**$241.60**	5/31/15	153363966-00656-07	Payment amount based on $302.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				***Patient Initials:*** L.D.
	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:*** 1982
11/21/2016	**107653045**	**$224.77**	12/12/15	Z2GB5CM	Payment amount based on $613.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 45.835% among all providers.	***Patient Initials:*** D.P.
	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:*** 1996
6/20/2016	**107544842**	**$376.80**	08/10/15	ACCT: 1041399	Payment amount based on $471.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** D.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:*** 1958
6/20/2016	**107544841**	**$19.65**	03/23/16	ACCT: Z2A0CZ0	Payment amount based on $151.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 16.26405% among all providers.	***Patient Initials:*** L.H.
	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:*** 1977
6/7/2016	**107533966**	**$21.25**	08/03/13	ACCT: DIA391260	Payment amount based on $26.56 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** B.T.
	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:*** 1972

4/28/2016	**107504610**	**$76.63**	04/23/12	ACCT: DIA196298	Payment amount based on $338.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.34055% among all providers.	***Patient Initials:***	A.B.
	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:***	1990
4/22/2016	**107500184**	**$169.23**	11/25/12 - 12/02/13	ACCT: DIA296886	Payment amount based on $211.54 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	4/25/2016				***Patient Initials:***	K.T.
	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:***	1950
4/22/2016	**107500183**	**$157.60**	03/01/16	ACCT: Z286361	Payment amount based on $197.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	4/25/2016				***Patient Initials:***	J.H.
	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:***	1954

DIAGNOSTIC IMAGING ASSOCIATES ***Office of State Finance VendorID:*** 0000072917

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
11/30/2016	**107657809**	**$234.40**	06/28/16	ACCT: 228388-QDIA1	Payment amount based on $293.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				***Patient Initials:***	M.V.
	Mail To Address:	PO BOX 3205 INDIANAPOLIS IN 46206-3205			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1994
11/21/2016	**107653046**	**$429.60**	6/30/15	958259-QDIA	Payment amount based on $537.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016				***Patient Initials:***	D.H.
	Mail To Address:	PO BOX 3205 INDIANAPOLIS IN 46206-3205			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1963
10/11/2016	**107623986**	**$20.80**	10/06/15	ACCT: 1132955-QDIA1	Payment amount based on $26.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/14/2016				***Patient Initials:***	J.B.
	Mail To Address:	PO BOX 3205 INDIANAPOLIS IN 46206-3205			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1986
8/3/2016	**107573596**	**$275.20**	5/31/15	ACCT: 969998-QDIA1	Payment amount based on $344.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016				***Patient Initials:***	B.P.
	Mail To Address:	PO BOX 3205 INDIANAPOLIS IN 46206-3205			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1989
6/7/2016	**107533965**	**$99.20**	07/10/14	ACCT: 652707	Payment amount based on $124.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/10/2016				***Patient Initials:***	W.T.
	Mail To Address:	PO BOX 3205 INDIANAPOLIS IN 46206-3205			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	N/A

4/6/2016	**107486620**	**$13.30**	7/10/15	ACCT: 436687-QDIA1	Payment amount based on $16.63 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	4/9/2016				***Patient Initials:***	D.R.
	Mail To Address:	PO BOX 3205 INDIANAPOLIS IN 46206-3205			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1979
4/6/2016	**107486619**	**$279.20**	8/7/15	ACCT: 514419-QDIA1	Payment amount based on $349.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	4/9/2016				***Patient Initials:***	L.S.
	Mail To Address:	PO BOX 3205 INDIANAPOLIS IN 46206-3205			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1964

DIAGNOSTIC IMAGING ASSOCIATES

Office of State Finance VendorID: 0000072917

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
10/11/2016	**107623985**	**$142.40**	1/24/16	ACCT: 24DBVZ	Payment amount based on $178.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/14/2016				***Patient Initials:***	J.J.
	Mail To Address:	PO BOX 973038 DALLAS TX 75397-3038			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1983

RADIOLOGY CONSULTANTS

Office of State Finance VendorID: 0000056853

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
12/23/2016	**107675566**	**$28.00**	06/10/16	ACCT: 131537	Payment amount based on $35.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/26/2016				***Patient Initials:***	P.M.
	Mail To Address:	PO BOX 95818 OKLAHOMA CITY OK 73143-5818			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1966
11/16/2016	**107649957**	**$128.00**	10/04/15	ACCT: 19164	Payment amount based on $160.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/19/2016				***Patient Initials:***	B.Y.
	Mail To Address:	PO BOX 95818 OKLAHOMA CITY OK 73143-5818			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1974
8/3/2016	**107573728**	**$338.40**	12/24/15	ACCT: 95298	Payment amount based on $423.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016				***Patient Initials:***	B.S.
	Mail To Address:	PO BOX 95818 OKLAHOMA CITY OK 73143-5818			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1979
6/27/2016	**107550443**	**$32.80**	12/4/15	ACCT: 89317	Payment amount based on $41.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/30/2016				***Patient Initials:***	E.M.
	Mail To Address:	PO BOX 95818 OKLAHOMA CITY OK 73143-5818			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1989
5/24/2016	**107524718**	**$55.20**	12/13/14	ACCT: 300537	Payment amount based on $69.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/27/2016				***Patient Initials:***	C.D.
	Mail To Address:	PO BOX 95818 OKLAHOMA CITY OK 73143-5818			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1978

5/24/2016	**107524717**	**$52.53**	10/9/15	ACCT: 73922	Payment amount based on $65.66 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/27/2016			***Patient Initials:*** M.M.
	Mail To Address:	PO BOX 95818 OKLAHOMA CITY OK 73143-5818			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1996

NORMAN RADIOLOGY DBA SOUTHWEST RADIOLOGY ASSOCIATES ***Office of State Finance VendorID:*** 0000056863

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
1/23/2017	**107688855**	**$12.77**	08/04/15 - 08/14/15	ACCT: 343074	Payment amount based on $15.96 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/26/2017			***Patient Initials:*** D.D.
	Mail To Address:	PO BOX 269083 OKLAHOMA CITY OK 73126-9083			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1994
7/25/2016	**107566989**	**$29.60**	10/19/15	ACCT: 580213019	Payment amount based on $37.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/28/2016			***Patient Initials:*** M.C.
	Mail To Address:	PO BOX 269083 OKLAHOMA CITY OK 73126-9083			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987
6/20/2016	**107544895**	**$83.71**	11/17/15	ACCT: 9DDSPZ	Payment amount based on $580.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 18.0406% among all providers. ***Patient Initials:*** J.G.
	Mail To Address:	PO BOX 269083 OKLAHOMA CITY OK 73126-9083			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1986
6/8/2016	**107535004**	**$10.86**	11/10/15	ACCT: 9dkk7b	Payment amount based on $13.58 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/11/2016			***Patient Initials:*** E.T.
	Mail To Address:	PO BOX 269083 OKLAHOMA CITY OK 73126-9083			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2015

KINCANNON-LEE FUNERAL HOME ***Office of State Finance VendorID:*** 0000056907

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
8/26/2016	**107592809**	**$7,500.00**	11/25/15	ACCT: M.M.	Payment amount based on $8,444.69 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** M.M.
	Mail To Address:	3020 N MAIN ST ALTUS OK 73521-1303			***Patient Birth Year:*** 1977

ST. FRANCIS HEALTH SYSTEM ***Office of State Finance VendorID:*** 0000403803

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
10/11/2016	**107624063**	**$573.12**	12/26/15	ACCT: 242211	Payment amount based on $716.40 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** B.B.
	Mail To Address:	PO BOX 732354 DALLAS TX 75373			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990

4/28/2016	**107504732**	**$15,852.29**	11/20/15 - 11/22/15	ACCT: 601884311	Payment amount based on $19,815.36 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/1/2016 ***Patient Initials:*** J.S.

Mail To Address: PO BOX 732214 DALLAS TX 75373

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

4/29/2016	**107506194**	**$32.90**	5/18/15, 6/23/15	ACCT: #477727901 $12.90; #477829002 $20.00	Payment amount based on $41.13 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/2/2016 ***Patient Initials:*** K.M.

Mail To Address: PO BOX 732214 DALLAS TX 75373

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1999

STILLWATER MEDICAL CENTER ***Office of State Finance VendorID:*** 0000175255

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
8/26/2016	**107592885**	**$3,888.00**	10/24/15	ACCT: 2425680	Payment amount based on $4,860.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2016 ***Patient Initials:*** F.R.

Mail To Address: PO BOX 268905 OKLAHOMA CITY OK 73126-8905

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2014

STILLWATER MEDICAL CENTER ***Office of State Finance VendorID:*** 0000175255

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/30/2016	**107657921**	**$3,473.12**	10/24/15	ACCT: 2425711	Payment amount based on $4,341.40 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/3/2016 ***Patient Initials:*** T.J.

Mail To Address: 1323 W. 6TH AVE. STILLWATER OK 77997

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1996

11/30/2016	**107657920**	**$1,744.00**	10/24/15	ACCT: 2425710	Payment amount based on $2,180.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/3/2016 ***Patient Initials:*** J.J.

Mail To Address: 1323 W. 6TH AVE. STILLWATER OK 77997

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1971

11/1/2016	**107638911**	**$908.80**	4/21/16	ACCT: 2495551	Payment amount based on $1,136.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/4/2016 ***Patient Initials:*** C.W.

Mail To Address: 1323 W. 6TH AVE. STILLWATER OK 77997

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

9/9/2016	**107601529**	**$672.35**	5/20/16	ACCT: 2506196	Payment amount based on $840.44 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/12/2016 ***Patient Initials:*** C.T.

Mail To Address: 1323 W. 6TH AVE. STILLWATER OK 77997

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1975

7/25/2016	**107567056**	**$1,972.80**	10/24/15 - 10/26/15	ACCT: 2425700	Payment amount based on $2,466.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				***Patient Initials:*** K.C.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995
7/20/2016	**107563831**	**$1,222.40**	10/24/15	ACCT: V00002425695	Payment amount based on $1,528.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				***Patient Initials:*** M.C.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1967
6/27/2016	**107550463**	**$273.67**	1/2/16	ACCT: 2451848	Payment amount based on $342.09 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** C.S.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1993
6/27/2016	**107550462**	**$890.40**	3/3/16	ACCT: V00002476046	Payment amount based on $1,113.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** D.H.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1982
6/20/2016	**107544965**	**$12,828.62**	10/24/15 - 03/21/16	ACCT: 2425692 - $5,283.32; 2434785 - $280.90; 2436911 - $48.00; 2451668 - $2,385.60; 2462842 - $2,918.40; 90939 - $1,912.40	Payment amount based on $16,035.78 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** A.C.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2003
6/8/2016	**107535052**	**$105.72**	2/2/16	ACCT: 2464235	Payment amount based on $132.15 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				***Patient Initials:*** S.J.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1955
6/8/2016	**107535051**	**$305.60**	10/24/15	ACCT: 2425701	Payment amount based on $382.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				***Patient Initials:*** L.W.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1955
6/7/2016	**107534062**	**$2,865.16**	05/03/15	ACCT: 2359403	Payment amount based on $3,581.45 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** A.E.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995
6/8/2016	**107535050**	**$522.20**	10/24/15	ACCT: 2425703	Payment amount based on $652.75 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				***Patient Initials:*** A.R.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1984

5/24/2016	**107524758**	**$640.00**	11/22/15 - 11/27/15	ACCT: 2437316 $580.00, 2439180 $60.00	Payment amount based on $800.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/27/2016			***Patient Initials:*** C.B.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1992
5/24/2016	**107524757**	**$1,493.00**	10/24/15	ACCT: 2425716	Payment amount based on $1,866.25 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/27/2016			***Patient Initials:*** T.W.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1981
5/24/2016	**107524756**	**$4,148.00**	10/24/15	ACCT: 2425707	Payment amount based on $5,185.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/27/2016			***Patient Initials:*** Y.W.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1953
5/27/2016	**107528413**	**$380.00**	06/30/14	ACCT: 2242882	Payment amount based on $475.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/30/2016			***Patient Initials:*** A.C.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2000
5/6/2016	**107511134**	**$847.24**	6/26/15	ACCT: 2379377	Payment amount based on $1,059.05 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/9/2016			***Patient Initials:*** A.S.
	Mail To Address:	1323 W. 6TH AVE. STILLWATER OK 77997			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1963

STILLWATER MEDICAL CENTER ***Office of State Finance VendorID:*** 0000175255

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
8/26/2016	**107592886**	**$236.80**	10/24/15	ACCT: 87391	Payment amount based on $296.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** F.R.
	Mail To Address:	PO BOX 721766 NORMAN OK 73070			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2014
7/20/2016	**107563832**	**$14,849.42**	10/24/15 - 03/08/16	ACCT: SEE ATTACHED BREAKDOWN	Payment amount based on $23,720.88 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 78.25079% among all providers. ***Patient Initials:*** K.H.
	Mail To Address:	PO BOX 721766 NORMAN OK 73070			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1985
6/20/2016	**107544964**	**$20,000.00**	10/24/15 - 10/29/15	ACCT: 90821 - $1,378.11; 2425691 - $18,621.89	Payment amount based on $39,368.18 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 63.50308% among all providers. ***Patient Initials:*** D.Z.
	Mail To Address:	PO BOX 721766 NORMAN OK 73070			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1980

5/24/2016	**107524759**	**$284.00**	12/2/15	ACCT: 1264258	Payment amount based on $355.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				***Patient Initials:*** C.B.
	Mail To Address:	PO BOX 721766 NORMAN OK 73070			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1992

LOVE CO MERCY HLT CENTER — ***Office of State Finance VendorID:*** 0000175284

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/8/2016	**107535001**	**$988.56**	1/24/15	ACCT: 52150240004	Payment amount based on $1,235.70 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				***Patient Initials:*** L.C.
	Mail To Address:	300 WANDA ST MARIETTA OK 73448-1200			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1962

RADIOLOGY SERVICES OF ARDMORE — ***Office of State Finance VendorID:*** 0000056950

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
12/23/2016	**107675567**	**$350.40**	06/10/16	ACCT: AG1620003	Payment amount based on $438.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				***Patient Initials:*** P.M.
	Mail To Address:	PO BOX 518 ARDMORE OK 73402			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1966
9/9/2016	**107601482**	**$26.50**	4/21/15	ACCT: AF1110513	Payment amount based on $33.13 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** G.L.
	Mail To Address:	PO BOX 518 ARDMORE OK 73402			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1996
9/9/2016	**107601484**	**$19.91**	03/22/15	ACCT: P10014242	Payment amount based on $24.89 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** T.B.
	Mail To Address:	PO BOX 518 ARDMORE OK 73402			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1993
9/9/2016	**107601483**	**$124.80**	08/30/15	ACCT: P10025128	Payment amount based on $156.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** B.C.
	Mail To Address:	PO BOX 518 ARDMORE OK 73402			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1997

BROWN'S FUNERAL HOME — ***Office of State Finance VendorID:*** 0000329490

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/20/2016	**107544818**	**$7,500.00**	01/09/16	ACCT: M.M.	Payment amount based on $7,502.58 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** M.M.
	Mail To Address:	800 W 13TH ST ATOKA OK 74525-3426				***Patient Birth Year:*** 1983

5/27/2016	**107528223**	**$4,141.01**	12/30/15	ACCT: K.Y.M.	Payment amount based on $4,141.01 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/30/2016				***Patient Initials:***	K.M.
	Mail To Address:	800 W 13TH ST ATOKA OK 74525-3426				***Patient Birth Year:***	1968

HUBER-BENSON FUNERAL HOME — ***Office of State Finance VendorID:*** 0000056996

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
12/23/2016	**107675650**	**$1,530.00**	11/24/2015	ACCT: 2015-85	Payment amount based on $1,530.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/26/2016				***Patient Initials:***	I.L.
	Mail To Address:	100 S BARKER AVE EL RENO OK 73036-2810				***Patient Birth Year:***	2013

ORTHOPEDIC SPORTS MEDICAL CENTER — ***Office of State Finance VendorID:*** 0000057045

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
6/20/2016	**107544907**	**$104.85**	11/26/15	ACCT: 226191	Payment amount based on $200.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 65.53194% among all providers.	***Patient Initials:***	R.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:***	1992

RADIOLOGY CONSULTANTS OF TULSA, INC. — ***Office of State Finance VendorID:*** 0000057079

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
1/23/2017	**107688904**	**$447.47**	04/26/15	ACCT: RCT436857	Payment amount based on $559.34 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017				***Patient Initials:***	A.S.
	Mail To Address:	PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1994
11/30/2016	**107657898**	**$133.25**	02/18/16 - 02/27/16	ACCT: RCT542589	Payment amount based on $166.56 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				***Patient Initials:***	T.W.
	Mail To Address:	PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1995
11/30/2016	**107657897**	**$93.84**	02/28/16	ACCT: RCT544185	Payment amount based on $117.30 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				***Patient Initials:***	C.T.
	Mail To Address:	PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1979
11/21/2016	**107653193**	**$561.80**	5/30 - 6/9/15	500316	Payment amount based on $702.25 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016				***Patient Initials:***	D.H.
	Mail To Address:	PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1963

6/27/2016	**107550444**	**$21.50**	1/11/16 - 1/12/16	ACCT: 115723	Payment amount based on $26.88 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** K.C.
	Mail To Address:	PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1990
6/20/2016	**107544930**	**$30.93**	02/06/15 - 01/25/16	ACCT: 217411	Payment amount based on $237.70 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 16.26405% among all providers.	***Patient Initials:*** L.H.
	Mail To Address:	PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1977
6/7/2016	**107534044**	**$42.80**	07/19/15	ACCT: RCT507888	Payment amount based on $53.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** B.D.
	Mail To Address:	PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995
6/7/2016	**107534043**	**$199.60**	09/03/15	ACCT: RCT515240	Payment amount based on $249.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** C.P.
	Mail To Address:	PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1998
5/27/2016	**107528376**	**$21.40**	05/16/15	ACCT: 152251852	Payment amount based on $26.75 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				***Patient Initials:*** C.C.
	Mail To Address:	PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1979
4/28/2016	**107504708**	**$1,094.40**	11/20/15 - 11/21/15	ACCT: RCT52420	Payment amount based on $1,368.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				***Patient Initials:*** J.S.
	Mail To Address:	PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1958
4/28/2016	**107504707**	**$196.93**	07/12/15	ACCT: 506823	Payment amount based on $354.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 69.44086% among all providers.	***Patient Initials:*** C.M.
	Mail To Address:	PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1991
4/28/2016	**107504706**	**$165.41**	12/14/12 - 08/20/13	ACCT: 343734	Payment amount based on $3,045.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.79013% among all providers.	***Patient Initials:*** P.W.
	Mail To Address:	PO BOX 4975 TULSA OK 74159-0975			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1987

NEUROLOGICAL ASSOCIATES OF TULSA ***Office of State Finance VendorID:*** 0000057111

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

5/27/2016	**107528336**	**$176.80**	05/17/15	----------	Payment amount based on $221.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				***Patient Initials:*** C.C.
	Mail To Address:	PO BOX 21228 TULSA OK 74121		DEPT 62	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1979

CRISWELL FUNERAL HOME, INC. — ***Office of State Finance VendorID:*** 0000057122

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
5/17/2016	**107518787**	**$3,753.00**	06/18/15	ACCT: K.W.	Payment amount based on $3,753.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/20/2016				***Patient Initials:*** K.W.
	Mail To Address:	PO BOX 1300 ADA OK 74821-1300				***Patient Birth Year:*** 1985

BARTLESVILLE AMBULANCE — ***Office of State Finance VendorID:*** 0000057150

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
9/9/2016	**107601239**	**$1,076.00**	4/26/15	ACCT: 31196	Payment amount based on $1,345.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** S.E.
	Mail To Address:	PO BOX 1051 BARTLESVILLE OK 74005-1051			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1993

MEMORIAL HOSPITAL — ***Office of State Finance VendorID:*** 0000057172

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/21/2016	**107652963**	**$5,866.93**	5/29/15	4013283	Payment amount based on $7,333.66 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016				***Patient Initials:*** D.H.
	Mail To Address:	PO BOX 272 STILWELL OK 74960-0272			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1963

MCALESTER REGIONAL HLTH CTR — ***Office of State Finance VendorID:*** 0000057252

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
8/26/2016	**107592820**	**$498.44**	3/3/16	ACCT: V00014868921	Payment amount based on $623.05 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** S.W.
	Mail To Address:	PO BOX 1228 MCALESTER OK 74502-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1961
6/20/2016	**107544888**	**$1,621.80**	1/3/16	ACCT: V00014736060	Payment amount based on $2,027.25 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** M.M.
	Mail To Address:	PO BOX 1228 MCALESTER OK 74502-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1983

MCALESTER REGIONAL HEALTH CENTER — *Office of State Finance VendorID:* 0000057252

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
1/9/2017	107680001	$335.02	03/04/16	ACCT: V00014872352	Payment amount based on $418.78 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 1/12/2017
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 Initials: H.R.
Patient Birth Year: 1992

McALESTER REGIONAL HEALTH CENTER — *Office of State Finance VendorID:* 0000057252

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
9/9/2016	107601421	$1,471.20	10/14/14	ACCT: V00013737986	Payment amount based on $1,839.00 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 9/12/2016
Mail To Address: PAYMENT PROCESSING CENTER - AVADYN PO BOX 219714, KANSAS CITY MO 64121
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: C.A.
Patient Birth Year: 1962

SMITH-PARKS FUNERAL HOME — *Office of State Finance VendorID:* 0000057285

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
5/4/2016	107508641	$3,750.00	06/27/15	ACCT: K.D.K.	Payment amount based on $8,259.00 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 5/7/2016
Mail To Address: PO BOX 196, HARRAH OK 73045-0196
Patient Initials: K.K.
Patient Birth Year: 1974

PARKS BROTHERS FUNERAL HOME — *Office of State Finance VendorID:* 0000057285

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
5/4/2016	107508642	$7,500.00	11/02/15	ACCT: A.J.H.	Payment amount based on $9,450.75 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 5/7/2016
Mail To Address: 617 MANVEL AVE, CHANDLER OK 74834
Patient Initials: A.H.
Patient Birth Year: 1998

TEMPLE & SON FUNERAL HOME, INC. — *Office of State Finance VendorID:* 0000057298

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/21/2016	107653219	$405.00	10/20/15	ACCT: O.F.	Payment amount based on $405.00 patient balance after insurance and insurance adjustments.	

Approx Mail Date: 11/24/2016
Mail To Address: PO BOX 11301, OKLAHOMA CITY OK 73136-0301
Patient Initials: O.F.
Patient Birth Year: 1982

6/20/2016	**107544967**	**$7,242.06**	02/20/16	ACCT: S.B.	Payment amount based on $7,242.06 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			***Patient Initials:*** S.B.
	Mail To Address:	PO BOX 11301 OKLAHOMA CITY OK 73136-0301			***Patient Birth Year:*** 1956

DUNCAN EMERGENCY PHYSICIANS ***Office of State Finance VendorID:*** 0000057308

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/23/2016	**107675707**	**$123.59**	08/20/16	Acct: 40507345-47-1835	Payment amount based on $154.49 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***Patient Initials:*** K.W.
	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:*** 1977
11/18/2016	**107651850**	**$784.00**	3/4/16	ACCT: 51116005-47-1835	Payment amount based on $980.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/21/2016			***Patient Initials:*** K.B.
	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:*** 1962

DUNCAN REGIONAL HOSPITAL ***Office of State Finance VendorID:*** 0000057308

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/18/2016	**107651851**	**$782.08**	3/4/16	ACCT: 565574135	Payment amount based on $977.60 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/21/2016			***Patient Initials:*** K.B.
	Mail To Address:	PO BOX 100 DUNCAN OK 73534		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1962
11/18/2016	**107651849**	**$98.73**	8/11/16	ACCT: D00033631553 $89.03, 51078134-47-1835 $9.70	Payment amount based on $123.41 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/21/2016			***Patient Initials:*** S.C.
	Mail To Address:	PO BOX 100 DUNCAN OK 73534		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1958
11/18/2016	**107651848**	**$503.15**	7/18/16 - 8/12/16	ACCT: 61624058-47-1835 $45.86; D00033549628 $120.75; D00033599137 $173.47; D00033627254 $163.06	Payment amount based on $628.94 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/21/2016			***Patient Initials:*** E.P.
	Mail To Address:	PO BOX 100 DUNCAN OK 73534		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1930
11/1/2016	**107638861**	**$50.02**	1/24/2016	ACCT: D00032965342	Payment amount based on $62.53 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/4/2016			***Patient Initials:*** T.T.
	Mail To Address:	PO BOX 100 DUNCAN OK 73534		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1963

5/27/2016	**107528267**	**$5,868.70**	10/18/15 - 10/19/15	ACCT: D00032654746	Payment amount based on $7,335.88 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/30/2016			***Patient Initials:*** T.B.
	Mail To Address:	PO BOX 100 DUNCAN OK 73534			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1962
4/28/2016	**107504611**	**$262.80**	12/16/15	ACCT: D00032847561	Payment amount based on $5,416.73 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.064521% among all providers. ***Patient Initials:*** N.G.
	Mail To Address:	PO BOX 100 DUNCAN OK 73534			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1965

DUNCAN REGIONAL HOSPITAL ***Office of State Finance VendorID:*** 0000057308

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/23/2016	**107675706**	**$410.15**	8/20/16, 10/14/16	Acct; D00033661126 $381.94, D00033852762 $28.21	Payment amount based on $512.69 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***Patient Initials:*** K.W.
	Mail To Address:	P.O. BOX 248821 OKLAHOMA CITY OK 73124-8821			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1977

ST. JOHN EMERGENCY PHYSICIANS ***Office of State Finance VendorID:*** 0000261370

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/30/2016	**107657915**	**$105.84**	11/29/14	ACCT: 2209133	Payment amount based on $132.30 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/3/2016			***Patient Initials:*** B.D.
	Mail To Address:	DEPT 334 TULSA OK 74104-6520		PO BOX 21228	Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987

STEVEN D. MELTZNER, D.M.D. ***Office of State Finance VendorID:*** 0000057371

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/23/2016	**107675497**	**$1,520.00**	06/10/16	ACCT: MORPE00	Payment amount based on $1,900.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***Patient Initials:*** P.M.
	Mail To Address:	4140 W MEMORIAL RD STE 201 OKLAHOMA CITY OK 73120-8300			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1966
11/16/2016	**107649921**	**$5,920.00**	04/26/15 - 06/16/15	ACCT: CLAWI001-10019 - $5,640.00; 10026 - $280.00	Payment amount based on $7,400.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/19/2016			***Patient Initials:*** W.C.
	Mail To Address:	4140 W MEMORIAL RD STE 201 OKLAHOMA CITY OK 73120-8300			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987

9/30/2016	**107617419**	**$8,383.13**	02/21/16 - 04/20/16	ACCT: 10195	Payment amount based on $11,565.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 90.6088% among all providers.	***Patient Initials:***	N.V.
	Mail To Address:	4140 W MEMORIAL RD STE 201 OKLAHOMA CITY OK 73120-8300			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1997

INTEGRIS BAPTIST MEDICAL CENTER ***Office of State Finance VendorID:*** 0000057438

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
		$51.84	4/1/16 - 4/30/16	Acct: 10046159015	Payment amount based on $64.80 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				***Patient Initials:***	M.H.
	Mail To Address:	PO BOX 268907 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1955
11/30/2016	**107657834**	**$1,191.46**	12/18/15 - 07/24/16	ACCT: 17472945005 - $884.74; 101963713 - $160.00; 101925800 - $25.11; 601067 - $121.61	Payment amount based on $1,489.33 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				***Patient Initials:***	S.H.
	Mail To Address:	PO BOX 268907 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1974
11/15/2016	**107648849**	**$4,705.22**	09/11/15	ACCT: 23307246001	Payment amount based on $5,881.53 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/18/2016				***Patient Initials:***	L.G.
	Mail To Address:	PO BOX 268907 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1956
9/30/2016	**107617459**	**$17,711.14**	10/17/15	ACCT: 23344520001	Payment amount based on $33,768.49 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 65.56089% among all providers.	***Patient Initials:***	K.L.
	Mail To Address:	PO BOX 268907 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1970
8/26/2016	**107592801**	**$314.85**	01/13/16	ACCT: 23425386002	Payment amount based on $393.56 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				***Patient Initials:***	H.W.
	Mail To Address:	PO BOX 268907 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1991
7/25/2016	**107566938**	**$1,804.24**	09/27/15	ACCT: 23307246002	Payment amount based on $2,255.30 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/28/2016				***Patient Initials:***	L.G.
	Mail To Address:	PO BOX 268907 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1956
7/25/2016	**107566939**	**$577.05**	03/19/15	ACCT: 121022422003	Payment amount based on $721.31 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/28/2016				***Patient Initials:***	M.D.
	Mail To Address:	PO BOX 268907 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1978

7/20/2016	**107563685**	**$353.72**	01/01/16	ACCT: 23416195001	Payment amount based on $708.98 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 62.36396% among all providers.	***Patient Initials:*** B.B.
	Mail To Address:	PO BOX 268907 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1989
7/20/2016	**107563684**	**$114.84**	01/24/15	ACCT: 23067287002	Payment amount based on $150.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 95.70235% among all providers.	***Patient Initials:*** E.W.
	Mail To Address:	PO BOX 268907 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1976
5/27/2016	**107528297**	**$4,765.18**	09/15/15	ACCT: 23305828001	Payment amount based on $5,956.48 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				***Patient Initials:*** S.H.
	Mail To Address:	PO BOX 268907 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1966

INTEGRIS BAPTIST MEDICAL CTR

Office of State Finance VendorID: 0000057438

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
		$945.80	11/12/14	Acct#21887231002	Payment amount based on $1,182.25 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				***Patient Initials:*** R.L.
	Mail To Address:	PO BOX 268907 OKLAHOMA CITY OK 73126-8907			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1980

EMSA - EASTERN DIVISION

Office of State Finance VendorID: 0000057454

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/19/2017	**107686424**	**$1,107.20**	07/28/15	ACCT: 15-15119367	Payment amount based on $1,384.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** E.M.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** N/A
1/19/2017	**107686423**	**$1,078.40**	10/02/15	ACCT: 15-15158389	Payment amount based on $1,348.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** R.C.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1971
1/19/2017	**107686422**	**$1,126.40**	07/16/16	ACCT: 16-16114711	Payment amount based on $1,408.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** J.C.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1981
12/23/2016	**107675504**	**$577.21**	04/07/16	ACCT: 16-16056028	Payment amount based on $1,324.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 54.4946% among all providers.	***Patient Initials:*** M.B.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1977

11/30/2016	**107657818**	**$1,145.60**	02/28/16	ACCT: 16-16032968	Payment amount based on $1,432.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				***Patient Initials:***	C.T.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1979
11/30/2016	**107657817**	**$1,088.00**	11/29/14	ACCT: 14-14186497	Payment amount based on $1,360.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				***Patient Initials:***	B.D.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1987
11/21/2016	**107653053**	**$803.79**	1/16/16	Incident #16010552	Payment amount based on $1,432.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 70.1626% among all providers.	***Patient Initials:***	C.T.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1988
9/30/2016	**107617423**	**$1,068.80**	06/18/13	ACCT:13-13068866	Payment amount based on $1,336.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016				***Patient Initials:***	F.P.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1962
9/9/2016	**107601314**	**$1,049.60**	7/4/14	ACCT: 14-14102584	Payment amount based on $1,312.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	9/12/2016				***Patient Initials:***	W.T.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1988
8/26/2016	**107592779**	**$75.13**	11/29/15	ACCT: 15-15191400	Payment amount based on $93.91 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				***Patient Initials:***	R.N.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1969
7/20/2016	**107563646**	**$1,078.40**	3/15/15	ACCT: 15-15042340	Payment amount based on $1,348.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016				***Patient Initials:***	D.C.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1961
6/20/2016	**107544849**	**$603.79**	08/04/15	ACCT: 15-15123422	Payment amount based on $1,348.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 55.98916% among all providers.	***Patient Initials:***	H.G.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1953
6/20/2016	**107544848**	**$1,212.80**	06/17/15	ACCT: 15-15095859	Payment amount based on $1,516.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016				***Patient Initials:***	C.C.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1960

6/20/2016	**107544847**	**$296.75**	04/26/15	ACCT: 15-15065080	Payment amount based on $1,396.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 26.57145% among all providers.	***Patient Initials:*** K.B.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1969
6/7/2016	**107533973**	**$1,116.80**	07/10/14	ACCT: 14-14105898	Payment amount based on $1,396.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** W.T.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** N/A
6/7/2016	**107533972**	**$1,097.60**	07/19/15	ACCT: 15-15114077	Payment amount based on $1,372.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** B.D.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995
4/29/2016	**107506108**	**$40.00**	5/12/14	ACCT: 14-14073516	Payment amount based on $50.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/2/2016				***Patient Initials:*** A.M.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1972
4/28/2016	**107504615**	**$748.85**	07/12/15	ACCT: 15-15110436	Payment amount based on $1,348.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 69.44086% among all providers.	***Patient Initials:*** C.M.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1991
4/29/2016	**107506107**	**$1,107.20**	1/23/15	ACCT: 1515012545	Payment amount based on $1,384.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/2/2016				***Patient Initials:*** M.P.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1978

EMSA - WESTERN DIVISION - OKC ***Office of State Finance VendorID:*** 0000057454

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/23/2017	**107688773**	**$897.83**	05/02/16	ACCT: 16-16070266	Payment amount based on $1,360.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 82.52151% among all providers.	***Patient Initials:*** A.A.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1956
1/23/2017	**107688774**	**$51.91**	07/28/16	ACCT: 16-16121526	Payment amount based on $1,396.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 4.64847% among all providers.	***Patient Initials:*** A.T.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1972

1/23/2017	**107688771**	**$59.88**	01/10/16	ACCT: 16-16005164	Payment amount based on $1,336.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 5.60263% among all providers.	***Patient Initials:***	J.O.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1990
1/23/2017	**107688772**	**$401.55**	10/26/15	ACCT: 15-15171953	Payment amount based on $1,324.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 37.91102% among all providers.	***Patient Initials:***	M.J.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1984
1/23/2017	**107688770**	**$915.94**	07/17/15 AND 07/24/15	ACCT: 15-15113084 - $768.80; 15-15117435 - $147.14	Payment amount based on $1,144.93 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017				***Patient Initials:***	D.D.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1994
12/23/2016	**107675502**	**$1,088.00**	11/25/15	ACCT: 15-15188455	Payment amount based on $1,360.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/26/2016				***Patient Initials:***	M.I.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1974
12/23/2016	**107675503**	**$1,107.20**	12/12/15	ACCT: 15-15197731	Payment amount based on $1,384.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/26/2016				***Patient Initials:***	J.C.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1948
12/23/2016	**107675501**	**$252.09**	11/29/15	ACCT: 15-15-190462	Payment amount based on $1,348.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 23.37654% among all providers.	***Patient Initials:***	J.F.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1961
12/23/2016	**107675500**	**$368.71**	10/26/15	ACCT: 15-15172011	Payment amount based on $1,336.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 34.49727% among all providers.	***Patient Initials:***	K.H.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1995
11/16/2016	**107649923**	**$1,136.00**	10/04/15	ACCT: 15-15159262	Payment amount based on $1,420.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/19/2016				***Patient Initials:***	B.Y.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1974
11/1/2016	**107638864**	**$1,107.20**	12/24/13	ACCT: 13-13175810	Payment amount based on $1,384.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/4/2016				***Patient Initials:***	S.T.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1972

10/11/2016	**107623989**	**$200.00**	11/26/15	ACCT: 15-15188799	Payment amount based on $250.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/14/2016				***Patient Initials:***	D.M.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1936
9/30/2016	**107617426**	**$53.48**	11/02/14	ACCT: 14-14170981	Payment amount based on $1,396.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 4.78846% among all providers.	***Patient Initials:***	S.H.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1954
9/30/2016	**107617425**	**$106.35**	08/11/15	ACCT: 15-15127817	Payment amount based on $1,384.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 9.60509% among all providers.	***Patient Initials:***	C.S.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1984
9/30/2016	**107617424**	**$93.29**	12/21/15	ACCT: 15-15203096	Payment amount based on $1,384.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 8.42552% among all providers.	***Patient Initials:***	E.R.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1951
9/9/2016	**107601315**	**$1,126.40**	09/02/15	ACCT: 15-15140299	Payment amount based on $1,408.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	9/12/2016				***Patient Initials:***	P.S.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1973
8/26/2016	**107592780**	**$1,116.80**	11/8/15	ACCT: 1515178916	Payment amount based on $1,396.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				***Patient Initials:***	B.R.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1990
8/26/2016	**107592778**	**$1,116.80**	06/27/15	ACCT: 15-15102020	Payment amount based on $1,396.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				***Patient Initials:***	K.J.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1998
9/9/2016	**107601316**	**$517.57**	09/08/15	ACCT: 15-15144294	Payment amount based on $1,516.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	9/12/2016			Total Bills exceed maximum award. Payment is prorated at 42.67541% among all providers.	***Patient Initials:***	I.G.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1968
4/28/2016	**107504616**	**$204.04**	10/09/15	ACCT: 15-15162442	Payment amount based on $1,312.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 19.44024% among all providers.	***Patient Initials:***	Q.J.
	Mail To Address:	PO BOX 21228 DEPT 5 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1991

EMSA — *Office of State Finance VendorID:* 0000057454

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
4/6/2016	107486629	$71.30	7/10/15	ACCT: 15-15108872	Payment amount based on $89.13 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/9/2016				*Patient Initials:* D.R.
	Mail To Address:	PO BOX 21228 TULSA OK 74121-1228		DEPT 64	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1979

SEQUOYAH MEMORIAL HOSPITAL — *Office of State Finance VendorID:* 0000057609

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
4/28/2016	107504722	$524.38	04/16/12 AND 04/23/12	ACCT: 54145-0005 - $104.18; 54145-0006 - $420.20	Payment amount based on $2,312.85 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.34055% among all providers.	*Patient Initials:* A.B.
	Mail To Address:	213 E. REDWOOD SALLISAW OK 74955			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1990

ROGAN FUNERAL HOME — *Office of State Finance VendorID:* 0000057634

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
7/25/2016	107567033	$6,295.00	12/19/15	ACCT: J.D.R.	Payment amount based on $6,295.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				*Patient Initials:* J.R.
	Mail To Address:	404 S BROADWAY ST HUGO OK 74743-6232				*Patient Birth Year:* 1987

MCCURTAIN COUNTY EMS — *Office of State Finance VendorID:* 0000057681

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
12/23/2016	107675535	$632.64	02/04/16	ACCT: 7762	Payment amount based on $790.80 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				*Patient Initials:* S.B.
	Mail To Address:	827 EAST LINCOLN ROAD IDABEL OK 74745			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1962

INTEGRIS SOUTHWEST MEDICAL CTR — *Office of State Finance VendorID:* 0000057735

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
1/23/2017	107688807	$3,784.00	08/28/15 - 08/31/15 AND 09/01/15 - 09/30/15	ACCT: 727300002 - $258.40; 727300003 - $3,525.60	Payment amount based on $4,730.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017				*Patient Initials:* D.D.
	Mail To Address:	PO BOX 268908 OKLAHOMA CITY OK 73126-8908			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1994

9/30/2016	**107617461**	**$3,204.04**	02/20/16	ACCT: 286881207	Payment amount based on $4,420.15 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 90.6088% among all providers.	***Patient Initials:*** N.V.
	Mail To Address:	PO BOX 268908 OKLAHOMA CITY OK 73126-8908			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1997
8/3/2016	**107573632**	**$153.52**	8/25/15	ACCT: 684998008	Payment amount based on $191.90 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				***Patient Initials:*** C.S.
	Mail To Address:	PO BOX 268908 OKLAHOMA CITY OK 73126-8908			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1990

PEDIATRICS OF BARTLESVILLE — ***Office of State Finance VendorID:*** 0000176996

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
5/24/2016	**107524704**	**$93.32**	9/15/14	ACCT: 7042A8867	Payment amount based on $116.65 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				***Patient Initials:*** T.W.
	Mail To Address:	3400 FRANK PHILLIPS, SUITE 302 BARTLESVILLE OK 74006			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1998

ST. MARY'S HOSPITAL — ***Office of State Finance VendorID:*** 0000078683

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/23/2017	**107688935**	**$13,557.78**	09/14/16	ACCT: 311319198	Payment amount based on $55,630.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 30.46392% among all providers.	***Patient Initials:*** L.B.
	Mail To Address:	305 S 5TH ST ENID OK 73701-5832			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1980

CREOKS BEHAVIORAL HEALTH — ***Office of State Finance VendorID:*** 0000073808

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/15/2016	**107648838**	**$1,397.47**	09/03/13 - 06/30/14	ACCT: 006472277	Payment amount based on $1,746.84 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/18/2016				***Patient Initials:*** F.D.
	Mail To Address:	2109 S. HWY 69 WAGONER OK 74467			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1969

MUSKOGEE CO. EMS — ***Office of State Finance VendorID:*** 0000058026

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/23/2017	**107688850**	**$1,710.40**	04/29/15	ACCT: 2015-6757-4A - $598.40; 2015-6763-5A - $1,112.00	Payment amount based on $2,138.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017				***Patient Initials:*** I.B.
	Mail To Address:	200 CALLAHAN ST MUSKOGEE OK 74403-5126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1985

12/23/2016	**107675785**	**$809.60**	6/1/16	ACCT: 72230	Payment amount based on $1,012.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***Patient Initials:*** S.A.
	Mail To Address:	200 CALLAHAN ST MUSKOGEE OK 74403-5126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1981
11/15/2016	**107648869**	**$92.94**	08/18/15	ACCT: 32899	Payment amount based on $116.18 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/18/2016			***Patient Initials:*** G.M.
	Mail To Address:	200 CALLAHAN ST MUSKOGEE OK 74403-5126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1960

MIDWEST RADIOLOGY ASSOCIATES ***Office of State Finance VendorID:*** 0000058096

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
8/17/2016	**107584321**	**$22.40**	02/17/16	ACCT: 384588C41	Payment amount based on $28.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/20/2016			***Patient Initials:*** E.H.
	Mail To Address:	2527 CRANBERRY HWY WAREHAM MA 02571-1046			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990
4/29/2016	**107506158**	**$7.94**	2/5/16	ACCT: 457311 C41	Payment amount based on $9.93 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/2/2016			***Patient Initials:*** A.S.
	Mail To Address:	2527 CRANBERRY HWY WAREHAM MA 02571-1046			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1956

CREEK CO. EMERGENCY AMBULANCE ***Office of State Finance VendorID:*** 0000058163

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
6/27/2016	**107550342**	**$52.34**	1/5/16	ACCT: 161065	Payment amount based on $65.43 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/30/2016			***Patient Initials:*** K.C.
	Mail To Address:	123 E. HOBSON SAPULPA OK 74066			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990

SWEARINGEN FUNERAL HOME ***Office of State Finance VendorID:*** 0000177818

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/9/2016	**107601535**	**$1,910.00**	03/25/15	ACCT: S.G.	Payment amount based on $1,910.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** S.G.
	Mail To Address:	1001 N. MILT PHILLIPS AVE. SEMINOLE OK 74868			***Patient Birth Year:*** 1984

SWEARINGEN FUNERAL HOME OF KONOWA ***Office of State Finance VendorID:*** 0000177818

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

11/30/2016	**107657925**	**$4,675.00**	03/27/15	ACCT: J.B.	Payment amount based on $4,675.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/3/2016 ***Patient Initials:*** J.B.

Mail To Address: 217 N. BROADWAY ***Patient Birth Year:*** 1988
KONOWA OK 74849

DIAGNOSTIC PATHOLOGY SERVICES, INC. ***Office of State Finance VendorID:*** 0000058330

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
4/22/2016	**107500158**	**$8.00**	04/13/15	ACCT: 04F37799603	Payment amount based on $10.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 4/25/2016 ***Patient Initials:*** L.M.

Mail To Address: PO BOX 849893 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1997
DALLAS TX 75284

BROADWAY CLINIC ***Office of State Finance VendorID:*** 0000058473

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
11/16/2016	**107649967**	**$836.00**	10/08/15	ACCT: 19944	Payment amount based on $1,045.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/19/2016 ***Patient Initials:*** B.Y.

Mail To Address: 1801 N BROADWAY AVE Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1974
OKLAHOMA CITY OK 73103-3446

OKLAHOMA DIAGNOSTIC IMAGING ***Office of State Finance VendorID:*** 0000058497

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
12/16/2016	**107670829**	**$512.00**	08/17/16	ACCT: 162560	Payment amount based on $640.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/19/2016 ***Patient Initials:*** S.H.

Mail To Address: PO BOX 268822 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1966
OKLAHOMA CITY OK 73126

ENID PATHOLOGY CONSULTANTS ***Office of State Finance VendorID:*** 0000058501

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
1/23/2017	**107688776**	**$23.15**	09/14/16	ACCT: BROLE012	Payment amount based on $95.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/26/2017 Total Bills exceed maximum award. Payment is prorated at 30.46392% among all providers. ***Patient Initials:*** L.B.

Mail To Address: PO BOX 1232 Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1980
ENID OK 73702-1232

BENCHMARK MONUMENT ***Office of State Finance VendorID:*** 0000328803

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

10/11/2016	**107623957**	**$5,908.75**	6/18/16	ACCT: D.W.	Payment amount based on $5,908.75 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** D.W.
	Mail To Address:	1735 EAST 11TH STREET TULSA OK 74104			***Patient Birth Year:*** 1979
8/26/2016	**107592754**	**$3,642.92**	03/27/15	ACCT: M.S.	Payment amount based on $3,642.92 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** M.S.
	Mail To Address:	1735 EAST 11TH STREET TULSA OK 74104			***Patient Birth Year:*** 1980

MCCLAIN-GRADY CO. EMS — ***Office of State Finance VendorID:*** 0000058533

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
7/20/2016	**107563733**	**$74.53**	07/31/15	ACCT: PAT008188	Payment amount based on $906.55 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 10.27708% among all providers. ***Patient Initials:*** M.L.
	Mail To Address:	PO BOX 430 BLANCHARD OK 73010-0430			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1975

DOROTHY PHELPS, LPC — ***Office of State Finance VendorID:*** 0000178578

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/9/2016	**107601467**	**$1,129.33**	05/03/15 - 01/27/16	ACCT: D.E.	Payment amount based on $1,411.66 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** D.E.
	Mail To Address:	MARRIAGE & FAMILY CONSULTANT, INC. 1400 BRYAN DRIVE, STE 305 DURANT OK 74701-2155			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1997

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

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/21/2016	**-107653019**	**($162.90)**	05/22/16	ACCT: 2886	Payment amount based on ($599.40) patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/24/2016			Total Bills exceed maximum award. Payment is prorated at 33.97059% among all providers. ***Patient Initials:*** E.B.
	Mail To Address:	PO BOX 567 HUGO OK 74743-0567			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987
11/21/2016	**107653019**	**$162.90**	05/22/16	ACCT: 2886	Payment amount based on $599.40 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 33.97059% among all providers. ***Patient Initials:*** E.B.
	Mail To Address:	PO BOX 567 HUGO OK 74743-0567			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987
10/11/2016	**107623967**	**$2,086.40**	10/7/15	ACCT: 2618	Payment amount based on $2,608.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/14/2016			***Patient Initials:*** J.B.
	Mail To Address:	PO BOX 567 HUGO OK 74743-0567			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1986

JACKSON COUNTY EMS — *Office of State Finance VendorID:* 0000058782

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
1/23/2017	107688808	$2,412.80	08/18/16	ACCT: 12839	Payment amount based on $3,016.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017				*Patient Initials:* J.T.
	Mail To Address:	1309 N PARK LN ALTUS OK 73521-4552			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1959

MEDICAL PLAZA IMAGING — *Office of State Finance VendorID:* 0000179205

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
7/20/2016	107563735	$284.34	03/11/15	ACCT: 22926	Payment amount based on $371.39 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 95.70235% among all providers.	*Patient Initials:* E.W.
	Mail To Address:	3330 NW 56TH, SUITE 206 OKLAHOMA CITY OK 73112			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1976

OKLAHOMA SURGICARE — *Office of State Finance VendorID:* 0000058929

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573702	$634.40	11/30/15	ACCT: 81005	Payment amount based on $3,978.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				*Patient Initials:* V.M.
	Mail To Address:	4317 W. MEMORIAL RD OKLAHOMA CITY OK 73134-1720			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1965

LAUREATE PSYCH CLINIC — *Office of State Finance VendorID:* 0000059014

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573667	$222.40	10/26/15	ACCT: 3025972240	Payment amount based on $278.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				*Patient Initials:* J.G.
	Mail To Address:	PO BOX 21228 DEPT 31 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1957

WARREN CLINIC — *Office of State Finance VendorID:* 0000074753

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
6/27/2016	107550485	$152.40	1/11/16, 2/17/16	,#3035421900 $110.80, ACCT:#478533795 $41.60	Payment amount based on $190.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				*Patient Initials:* K.C.
	Mail To Address:	6600 S YALE AVE STE 1400 TULSA OK 74136-3348			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1990

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
1/19/2017	107686543	$315.36	07/28/15	ACCT: 2445690A7661	Payment amount based on $394.20 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/22/2017				Patient Initials:	E.M.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	N/A
1/19/2017	107686541	$16.00	11/17/15 - 12/29/15	ACCT: 2425994A7661	Payment amount based on $20.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/22/2017				Patient Initials:	A.G.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1983
11/15/2016	107648883	$79.68	08/18/16	ACCT: 2446994A7661	Payment amount based on $99.60 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/18/2016				Patient Initials:	G.M.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1960
7/25/2016	107567054	$917.79	06/22/14 - 07/02/14	ACCT: 1930261A7661	Payment amount based on $1,269.10 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/28/2016			Total Bills exceed maximum award. Payment is prorated at 90.39744% among all providers.	Patient Initials:	C.B.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1959
7/20/2015	-107279140	($917.79)	06/22/14 - 07/02/14	ACCT: 1930261A7661 **VOIDED, CHECK ISSUED WITH MULTIPLE VICTIMS ON ONE CHECK**	Payment amount based on ($1,269.10) patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2015			Total Bills exceed maximum award. Payment is prorated at 90.39744% among all providers.	Patient Initials:	C.B.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1959
7/20/2016	107563828	$276.80	01/02/16	ACCT: 2632624A7661	Payment amount based on $346.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016				Patient Initials:	J.E.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1982
6/20/2016	107544962	$599.04	11/29/15 - 12/15/15	ACCT: 2595357A7661	Payment amount based on $748.80 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016				Patient Initials:	H.F.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1997
6/20/2016	107544961	$604.32	07/07/15, 06/18/15 AND 06/18/15	ACCT: 2135020A7661 - $72.48; 2406738A7661 - $248.16; 2390189A7661 - $283.68	Payment amount based on $755.40 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016				Patient Initials:	C.C.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1960

6/20/2016	**107544960**	**$1,492.76**	04/26/15 - 06/24/15	ACCT: 2193963 - $27.27; 2183632 - $1,465.49	Payment amount based on $7,022.39 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 26.57145% among all providers.	***Patient Initials:*** K.B.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1969
5/24/2016	**107524748**	**$79.50**	12/15/14	ACCT: 2220260A7661	Payment amount based on $99.38 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/27/2016				***Patient Initials:*** Y.S.
	Mail To Address:	PO BOX 13292 TULSA OK 74121		PO BOX 21228	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1995
4/28/2016	**107504736**	**$209.76**	10/02/15 - 10/15/15	ACCT: 2487719A7661	Payment amount based on $262.20 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				***Patient Initials:*** R.C.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1971

ST JOHN PHYSICIANS ***Office of State Finance VendorID:*** 0000179816

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/20/2017	**107687736**	**$364.00**	6/11 - 6/12/14	209350 @ $193.76; 180903 @ $86.24; 185374 @ $84.00	Payment amount based on $455.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				***Patient Initials:*** A.R.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1991
1/23/2017	**107688933**	**$84.00**	04/27/15	ACCT: 2344564	Payment amount based on $105.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017				***Patient Initials:*** A.S.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1994
1/19/2017	**107686542**	**$276.80**	02/04/16	ACCT: 2247554V7661	Payment amount based on $346.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** F.L.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1992
11/1/2016	**107638908**	**$119.92**	4/14/15	ACCT: 2335104	Payment amount based on $149.90 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/4/2016				***Patient Initials:*** A.C.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1998
9/9/2016	**107601522**	**$105.84**	9/21/14	ACCT: E2120015	Payment amount based on $132.30 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** L.F.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1954

8/26/2016	**107592876**	**$337.60**	3/11/16	ACCT: 1154417368	Payment amount based on $422.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** E.S.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1996
7/20/2016	**107563827**	**$34.82**	9/13/15	ACCT: 1744012V7661	Payment amount based on $43.53 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			***Patient Initials:*** T.W.
	Mail To Address:	PO BOX 13292 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1998

OKLAHOMA OTOLARYNGOLOGY ASSOC. ***Office of State Finance VendorID:*** 0000179890

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
8/3/2016	**107573701**	**$112.07**	08/26/15 AND 10/07/15	ACCT: 2480168B - $88.66; 2528404B - $23.41	Payment amount based on $140.09 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/6/2016			***Patient Initials:*** M.P.
	Mail To Address:	PO BOX 960119 OKLAHOMA CITY OK 73196-0119			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1953

PSYCHIATRIC ASSOCIATES, INC. ***Office of State Finance VendorID:*** 0000059146

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
5/27/2016	**107528365**	**$24.00**	03/01/16	ACCT: 5927	Payment amount based on $30.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/30/2016			***Patient Initials:*** S.H.
	Mail To Address:	6406 N. SANTA FE, SUITE A OKLAHOMA CITY OK 73116-9117			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1966

MAYES EMERGENCY SERVICES TRUST AUTHORITY ***Office of State Finance VendorID:*** 0000057188

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
1/23/2017	**107688841**	**$200.00**	04/25/15	ACCT: 24547857	Payment amount based on $250.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/26/2017			***Patient Initials:*** A.S.
	Mail To Address:	4 REDDEN PRYOR OK 74361-8800			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1994
11/18/2016	**107651882**	**$200.00**	3/2/16	ACCT: 37181000	Payment amount based on $250.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/21/2016			***Patient Initials:*** R.C.
	Mail To Address:	4 REDDEN PRYOR OK 74361-8800			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1964

OMNI MEDICAL GROUP ***Office of State Finance VendorID:*** 0000059226

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

6/20/2016	**107544905**	**$320.64**	06/18/15 - 07/07/15	ACCT: 2135020	Payment amount based on $400.80 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** C.C.
	Mail To Address:	PO BOX 13291 BELFAST ME 04915-4023			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1960

EAGLE PEAK MONUMENTS — ***Office of State Finance VendorID:*** 0000343113

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
8/17/2016	**107584284**	**$4,850.00**	07/26/16	INVOICE: 2016-039	Payment amount based on $6,757.60 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/20/2016				***Patient Initials:*** S.G.
	Mail To Address:	603 N. MISSION SAPULPA OK 74066				***Patient Birth Year:*** 1992

RADIOLOGY ASSOC OF ENID — ***Office of State Finance VendorID:*** 0000059300

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/20/2017	**107687694**	**$252.00**	4/29/16	178017	Payment amount based on $315.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				***Patient Initials:*** C.C.
	Mail To Address:	PO BOX 2824 WICHITA KS 67201			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1971
11/1/2016	**107638899**	**$143.36**	1/9/16	ACCT: 135722	Payment amount based on $179.20 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/4/2016				***Patient Initials:*** S.M.
	Mail To Address:	PO BOX 2824 WICHITA KS 67201			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1990
6/20/2016	**107544929**	**$86.97**	11/12/15 - 12/15/15	ACCT: 192966	Payment amount based on $147.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 73.95226% among all providers.	***Patient Initials:*** S.L.
	Mail To Address:	PO BOX 2824 WICHITA KS 67201			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1981

PALMER AND MARLER FUNERAL HOME — ***Office of State Finance VendorID:*** 0000180327

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/7/2016	**107534035**	**$4,967.18**	01/12/16	ACCT: C.B.	Payment amount based on $4,967.18 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** C.B.
	Mail To Address:	P O BOX 710 CUSHING OK 74023				***Patient Birth Year:*** 1989

MERCER- ADAMS FUNERAL SERVICES — ***Office of State Finance VendorID:*** 0000180668

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

7/25/2016	**107566981**	**$7,500.00**	03/02/16	ACCT: J.G.	Payment amount based on $7,500.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/28/2016
Mail To Address: 3925 N ASBURY AVE
BETHANY OK 73008-3329
Patient Initials: J.G.
Patient Birth Year: 1961

AFFORDABLE CREMATION SERVICE — ***Office of State Finance VendorID:*** 0000247310

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
8/26/2016	**107592732**	**$3,105.00**	05/11/15	ACCT: B.W.	Payment amount based on $3,105.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 8/29/2016
Mail To Address: P O BOX 2226
ELK CITY OK 73648
Patient Initials: B.W.
Patient Birth Year: 1969

THE EYE INSTITUTE — ***Office of State Finance VendorID:*** 0000059547

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
11/30/2016	**107657820**	**$3.20**	06/16/15 - 03/30/16	ACCT: 776940	Payment amount based on $4.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/3/2016
Mail To Address: PO BOX 21228
TULSA OK 74121-1228
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: T.H.
Patient Birth Year: 1984

FIELD AND FIELD CHIROPRACTIC CLINIC INC — ***Office of State Finance VendorID:*** 0000250367

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
4/29/2016	**107506112**	**$890.40**	9/3/14 - 10/3/14	ACCT: C.R.	Payment amount based on $1,113.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/2/2016
Mail To Address: 615 WEST UNIVERSITY
STILLWATER OK 74074
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: C.R.
Patient Birth Year: 1994

COMANCHE CO. HEALTHCARE CORP — ***Office of State Finance VendorID:*** 0000059705

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
1/19/2017	**107686405**	**$476.80**	12/19/14 - 12/30/14	ACCT: 702792 - $160.80; 737971 - $116.00; 714312 - $200.00	Payment amount based on $596.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/22/2017
Mail To Address: 3811 W. GORE BLVD. SUITE 2
LAWTON OK 73505-6328
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: J.K.
Patient Birth Year: 1965

COMANCHE COUNTY HEALTHCARE — ***Office of State Finance VendorID:*** 0000059705

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

6/20/2016	**107544830**	**$609.88**	12/03/15	ACCT: 29655	Payment amount based on $762.35 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** N.D.
	Mail To Address:	PO BOX 785 LAWTON OK 73502-0785			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1984
6/20/2016	**107544829**	**$2,679.10**	09/26/15	ACCT: 77175	Payment amount based on $5,578.84 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 60.02819% among all providers.	***Patient Initials:*** L.B.
	Mail To Address:	PO BOX 785 LAWTON OK 73502-0785			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1966
5/27/2016	**107528241**	**$433.60**	08/27/15 AND 07/09/15	ACCT: 908301 - $250.40; 838037 - $183.20	Payment amount based on $542.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				***Patient Initials:*** M.W.
	Mail To Address:	PO BOX 785 LAWTON OK 73502-0785			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1992
4/28/2016	**107504601**	**$7,240.96**	04/28/15	ACCT: 91766	Payment amount based on $23,119.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 39.14963% among all providers.	***Patient Initials:*** K.H.
	Mail To Address:	PO BOX 785 LAWTON OK 73502-0785			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1982
4/6/2016	**107486609**	**$228.39**	7/3/13 - 12/19/13	ACCT: 112302	Payment amount based on $285.49 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/9/2016				***Patient Initials:*** P.S.
	Mail To Address:	PO BOX 785 LAWTON OK 73502-0785			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1954

CCMH HOME HEALTH CARE

Office of State Finance VendorID: 0000059705

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/20/2016	**107544933**	**$222.25**	09/16/15 - 09/28/15	ACCT: 38573	Payment amount based on $462.81 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 60.02819% among all providers.	***Patient Initials:*** L.B.
	Mail To Address:	12 NW SHERIDAN ROAD LAWTON OK 73505-6304			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1966

GRIFFIN FUNERAL HOME

Office of State Finance VendorID: 0000254477

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/19/2017	**107686438**	**$4,342.00**	09/26/15	ACCT: C.S.	Payment amount based on $4,342.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** C.S.
	Mail To Address:	P O BOX 2475 ARDMORE OK 73402				***Patient Birth Year:*** 1997

11/15/2016	**107648846**	**$5,727.40**	06/11/15	ACCT: S.L.	Payment amount based on $5,727.40 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/18/2016
Mail To Address: P O BOX 2475
ARDMORE OK 73402
Patient Initials: S.L.
Patient Birth Year: 1994

BRUMLEY FUNERAL HOME — ***Office of State Finance VendorID:*** 0000199498

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
1/20/2017	**107687722**	**$4,218.88**	5/11/15	FUNERAL 5/11/15	Payment amount based on $4,218.88 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/23/2017
Mail To Address: 500 NORTH PARK DR.
BROKEN BOW OK 74728
Patient Initials: M.D.
Patient Birth Year: 1968

ALLERGY EAR NOSE AND THROAT INSTITUTE — ***Office of State Finance VendorID:*** 0000075457

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
5/6/2016	**107510996**	**$845.17**	11/20/15	ACCT: 18329	Payment amount based on $1,056.46 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/9/2016
Mail To Address: 4920 SW LEE BLVD.
LAWTON OK 73505-8339
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: M.P.
Patient Birth Year: 1968

ROBERT P WEBB III DDS INC — ***Office of State Finance VendorID:*** 0000181952

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
12/16/2016	**107670887**	**$1,680.00**	05/05/16 AND 06/22/16	ACCT: C.S.	Payment amount based on $2,100.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/19/2016
Mail To Address: 400 E DOWNING
TAHLEQUAH OK
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: C.S.
Patient Birth Year: 1995

EMERGENCY MEDICAL SERVICE — ***Office of State Finance VendorID:*** 0000060114

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*	*Patient Identifiers*
1/20/2017	**107687539**	**$530.40**	4/29/16	I632876011	Payment amount based on $663.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 1/23/2017
Mail To Address: 4401 W MEMORIAL RD STE 121
OKLAHOMA CITY OK 73134-1722
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: C.C.
Patient Birth Year: 1971

11/1/2016	**107638865**	**$637.86**	1/9/16	ACCT: B621675005	Payment amount based on $797.33 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/4/2016
Mail To Address: 4401 W MEMORIAL RD STE 121
OKLAHOMA CITY OK 73134-1722
Acceptance of payment may require a provider write-off. EOB will accompany payment.
Patient Initials: S.M.
Patient Birth Year: 1990

9/9/2016	**107601317**	**$355.20**	02/24/16	ACCT: 1598789002	Payment amount based on $444.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 9/12/2016 ***Patient Initials:*** B.C.

Mail To Address: 4401 W MEMORIAL RD STE 121
OKLAHOMA CITY OK 73134-1722

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

5/17/2016	**107518797**	**$791.20**	09/09/15	ACCT: 731419291	Payment amount based on $989.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 5/20/2016 ***Patient Initials:*** T.D.

Mail To Address: 4401 W MEMORIAL RD STE 121
OKLAHOMA CITY OK 73134-1722

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1975

KEITH BIGLOW FUNERAL DIRECTORS

Office of State Finance VendorID: 0000060171

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/16/2016	**107649940**	**$600.00**	09/09/15	ACCT: M.M.	Payment amount based on $600.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 11/19/2016 ***Patient Initials:*** M.M.

Mail To Address: 549 S 6TH ST
MUSKOGEE OK 74401-7602

Patient Birth Year: 1963

H. JASON LAUGHLIN, D.C.

Office of State Finance VendorID: 0000406734

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
7/20/2016	**107563672**	**$111.25**	03/02/16 - 03/17/16	ACCT: J.K.	Payment amount based on $875.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 7/23/2016

Total Bills exceed maximum award. Payment is prorated at 15.89261% among all providers. ***Patient Initials:*** J.K.

Mail To Address: 222 E. GRAND AVE., STE 301
PONCA CITY OK 74601

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1996

SEYOUNG, KIM DC

Office of State Finance VendorID: 0000218495

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/16/2016	**107670805**	**$2,244.00**	10/21/15 - 08/17/16	ACCT: 10677	Payment amount based on $2,805.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: 12/19/2016 ***Patient Initials:*** E.R.

Mail To Address: 5583 NW EXPRESSWAY
OKLAHOMA CITY OK 73132-5280

Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1971

SOUTHWEST MONUMENT

Office of State Finance VendorID: 0000208371

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
		$5,090.00	11/3/16	Inv. 549849	Payment amount based on $5,694.00 patient balance after insurance and insurance adjustments.

Approx Mail Date: Requested from OSF 1/19/17 Expected to be mailed by 2/2/17 ***Patient Initials:*** I.L.

Mail To Address: 7200 SOUTH WESTERN
OKLAHOMA CITY OK 73139

Patient Birth Year: 2013

CRAIG GENERAL HOSPITAL — *Office of State Finance VendorID:* 0000060257

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/18/2016	107651843	$348.57	4/26/16	ACCT: 3629453	Payment amount based on $435.71 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				*Patient Initials:* A.L.
	Mail To Address:	PO BOX 326 VINITA OK 74301-0326			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1984

SEILING MUNICIPAL HOSPITAL — *Office of State Finance VendorID:* 0000060267

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573744	$200.00	5/31/15	ACCT: 20006261	Payment amount based on $250.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				*Patient Initials:* B.P.
	Mail To Address:	PO BOX 720 SEILING OK 73663-0720			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1989

CINDY A ROGERS MD — *Office of State Finance VendorID:* 0000404043

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
5/17/2016	107518777	$503.20	09/22/15	ACCT: 02419	Payment amount based on $629.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/20/2016				*Patient Initials:* T.D.
	Mail To Address:	PO BOX 1331 ENID OK 73702-1331			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1975

MICHAEL D. ELDER, MD INC — *Office of State Finance VendorID:* 0000339093

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573691	$648.00	11/30/15	ACCT: ELD.177	Payment amount based on $840.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				*Patient Initials:* V.M.
	Mail To Address:	PO BOX 270852 OKLAHOMA CITY OK 73137-0852			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1965

HINTON TURNER FUNERAL HOME — *Office of State Finance VendorID:* 0000259073

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
1/20/2017	107687778	$7,365.00	12/6/15	12/6/15 Funeral	Payment amount based on $7,365.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				*Patient Initials:* G.T.
	Mail To Address:	PO BOX 250 HINTON OK 73047-0250				*Patient Birth Year:* 1964

MISSY ISKI, LPC — *Office of State Finance VendorID:* 0000212434

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/1/2016	107638890	$80.00	8/4/14 - 1/29/15	ACCT: 15659-10327	Payment amount based on $100.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/4/2016				*Patient Initials:* S.T.
	Mail To Address:	4825 SOUTH PEROIA, STE 7 TULSA OK 74105			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1972

HOWARD-HARRIS FUNERAL SERVICE — *Office of State Finance VendorID:* 0000060556

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
6/20/2016	107544868	$7,500.00	02/20/16	ACCT: J.R.	Payment amount based on $8,868.82 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				*Patient Initials:* J.R.
	Mail To Address:	2601 SW 59TH ST OKLAHOMA CITY OK 73119				*Patient Birth Year:* 1937
6/7/2016	107533995	$2,593.96	01/05/16	ACCT: B.D.J.	Payment amount based on $2,593.96 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				*Patient Initials:* B.J.
	Mail To Address:	2601 SW 59TH ST OKLAHOMA CITY OK 73119				*Patient Birth Year:* 1995

NORTHWEST ANESTHESIA — *Office of State Finance VendorID:* 0000060573

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
9/30/2016	107617504	$398.61	10/18/15	ACCT: 343365	Payment amount based on $760.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 65.56089% among all providers.	*Patient Initials:* K.L.
	Mail To Address:	PO BOX 26168 OKLAHOMA CITY OK 73126-0168			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1970
5/27/2016	107528339	$120.32	09/15/15	ACCT: NWA244211	Payment amount based on $150.40 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				*Patient Initials:* S.H.
	Mail To Address:	PO BOX 26168 OKLAHOMA CITY OK 73126-0168			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1966

OKLAHOMA CITY ENT CLINIC, PC — *Office of State Finance VendorID:* 0000060731

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
7/20/2016	107563756	$278.79	1/8/16, 1/12/16, 2/3/16, AND 3/2/16	ACCT: 45607V7457	Payment amount based on $558.79 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 62.36396% among all providers.	*Patient Initials:* B.B.
	Mail To Address:	535 NW 9TH ST., SUITE 300 OKLAHOMA CITY OK 73102			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1989

OKLAHOMA CITY ENT CLINIC — *Office of State Finance VendorID:* 0000400978

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/15/2016	107648872	$6,822.21	09/19/16	ACCT: D.T.H.	Payment amount based on $8,527.76 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/18/2016				*Patient Initials:* D.H.
	Mail To Address:	HEARING & BALANCE CENTER OKLAHOMA CITY OK 73102	535 NW 9TH ST SUITE 305		Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1992

ORTHODONTIC ASSOCIATES — *Office of State Finance VendorID:* 0000376509

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
9/9/2016	107601453	$2,364.00	06/09/16	ACCT: BY43	Payment amount based on $2,955.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				*Patient Initials:* B.B.
	Mail To Address:	10914 HEFNER POINTE DR, SUITE 300 OKLAHOMA CITY OK 73120			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1989

GREER FUNERAL HOME — *Office of State Finance VendorID:* 0000060844

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/30/2016	107657859	$296.05	05/25/16	ACCT: A.P.	Payment amount based on $315.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/3/2016			Total Bills exceed maximum award. Payment is prorated at 93.98496% among all providers.	*Patient Initials:* A.P.
	Mail To Address:	235 S PENNSYLVANIA AVE MANGUM OK 73554-4807			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 2015
11/30/2016	107657858	$315.00	05/25/16	ACCT: W.P.	Payment amount based on $315.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/3/2016				*Patient Initials:* W.P.
	Mail To Address:	235 S PENNSYLVANIA AVE MANGUM OK 73554-4807				*Patient Birth Year:* 1956

HILLCREST MEMORY GARDENS INC — *Office of State Finance VendorID:* 0000174096

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/26/2016	107592794	$1,134.33	02/11/16	ACCT: K.S.	Payment amount based on $1,134.33 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				*Patient Initials:* K.S.
	Mail To Address:	PO BOX 300 SPENCER OK 73084-0300				*Patient Birth Year:* 1991
8/3/2016	107573623	$1,134.08	06/17/16	ACCT: R.L.	Payment amount based on $1,134.08 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				*Patient Initials:* R.L.
	Mail To Address:	PO BOX 300 SPENCER OK 73084-0300				*Patient Birth Year:* 1998

8/3/2016	**107573622**	**$1,862.91**	02/08/16	ACCT: C.C.	Payment amount based on $1,862.91 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/6/2016			***Patient Initials:*** C.C.
	Mail To Address:	PO BOX 300 SPENCER OK 73084-0300			***Patient Birth Year:*** 1984

OU PHYSICIANS GROUP ***Office of State Finance VendorID:*** 0000061010

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
		$64.80	1/1/16	Acct: 280892	Payment amount based on $81.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				***Patient Initials:*** K.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:*** 1991
1/23/2017	**107688887**	**$32.80**	08/19/16	ACCT: 2747420	Payment amount based on $41.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017				***Patient Initials:*** J.T.
	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:*** 1959
1/23/2017	**107688884**	**$623.86**	05/02/16 - 05/04/16	ACCT: 2201935	Payment amount based on $945.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 82.52151% among all providers.	***Patient Initials:*** A.A.
	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:*** 1956
1/23/2017	**107688885**	**$1,084.02**	04/28/16	ACCT: 2722086	Payment amount based on $4,534.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 29.88255% among all providers.	***Patient Initials:*** R.H.
	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:*** 1973
1/23/2017	**107688886**	**$1,010.76**	07/28/16 - 08/03/16	ACCT: 399696	Payment amount based on $27,180.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 4.64847% among all providers.	***Patient Initials:*** A.T.
	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:*** 1972
1/20/2017	**107687667**	**$66.79**	4/11/15 - 5/6/15	Patient #1533681	Payment amount based on $83.49 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				***Patient Initials:*** R.M.
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1948
1/23/2017	**107688882**	**$1,732.18**	01/10/16 - 01/22/16	ACCT: 2510486	Payment amount based on $38,646.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 5.60263% among all providers.	***Patient Initials:*** J.O.
	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:*** 1990

1/23/2017	**107688883**	**$257.19**	10/26/15	ACCT: 1211543	Payment amount based on $848.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 37.91102% among all providers.	***Patient Initials:*** M.J.
	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
1/23/2017	**107688881**	**$1,036.80**	07/17/15 - 04/01/16	ACCT: 1261423	Payment amount based on $1,296.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017				***Patient Initials:*** D.D.
	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:*** 1994
1/20/2017	**107687666**	**$1,357.60**	5/26/16	2728862	Payment amount based on $1,697.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				***Patient Initials:*** W.M.
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1964
1/19/2017	**107686504**	**$32.00**	01/14/16 - 06/22/16	ACCT: 2668483	Payment amount based on $40.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** A.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:*** 1983
12/23/2016	**107675559**	**$1,417.37**	11/25/15 - 01/20/16	ACCT: 2687973	Payment amount based on $1,771.71 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				***Patient Initials:*** M.I.
	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:*** 1974
12/23/2016	**107675560**	**$1,465.50**	06/13/15 - 06/16/15	ACCT: 1915214	Payment amount based on $12,521.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 14.6304% among all providers.	***Patient Initials:*** D.S.
	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:*** 1980
12/23/2016	**107675558**	**$448.46**	11/29/15 - 12/02/15	ACCT: 1807755	Payment amount based on $2,398.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 23.37654% among all providers.	***Patient Initials:*** J.F.
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1961
12/23/2016	**107675557**	**$908.80**	10/26/15 - 11/02/15	ACCT: 1793050	Payment amount based on $3,293.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 34.49727% among all providers.	***Patient Initials:*** K.H.
	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:*** 1995
12/23/2016	**107675555**	**$1,586.59**	08/27/15	ACCT: 229361	Payment amount based on $4,701.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 42.18752% among all providers.	***Patient Initials:*** C.K.
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1977

12/23/2016	**107675556**	**$1,546.19**	09/18/15 - 09/21/15	ACCT: 1509146	Payment amount based on $16,773.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/26/2016			Total Bills exceed maximum award. Payment is prorated at 11.52293% among all providers.	***Patient Initials:***	G.W.
	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:***	1974
11/21/2016	**107653157**	**$301.57**	01/28/15 - 11/11/15	ACCT: 1783988	Payment amount based on $730.91 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 51.57423% among all providers.	***Patient Initials:***	R.S.
	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:***	1963
11/21/2016	**107653159**	**$1,405.87**	01/25/16 - 03/22/16	ACCT: 2700258	Payment amount based on $31,943.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 5.50147% among all providers.	***Patient Initials:***	J.L.
	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:***	1970
11/21/2016	**107653160**	**$847.65**	01/03/16 - 01/05/16	ACCT: 119646	Payment amount based on $1,133.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 93.51787% among all providers.	***Patient Initials:***	S.A.
	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:***	1969
11/21/2016	**107653161**	**$542.78**	06/29/16 - 07/01/16	ACCT: 1775144	Payment amount based on $3,143.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 21.58687% among all providers.	***Patient Initials:***	A.W.
	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:***	1983
11/21/2016	**107653158**	**$154.60**	1/5/16 - 1/30/16	447215	Payment amount based on $2,956.50 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 6.53659% among all providers.	***Patient Initials:***	D.H.
	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:***	1993
11/16/2016	**107649954**	**$1,452.80**	10/25/15 - 10/27/15	ACCT: 2681043	Payment amount based on $3,632.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/19/2016				***Patient Initials:***	K.R.
	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:***	1966
11/1/2016	**107638894**	**$48.80**	1/12/16	ACCT: 1709138	Payment amount based on $61.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/4/2016				***Patient Initials:***	R.J.
	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:***	1988
9/30/2016	**107617528**	**$1,526.86**	03/14/16 - 04/08/16	ACCT: 2711934	Payment amount based on $26,118.65 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 7.307336% among all providers.	***Patient Initials:***	A.J.
	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:***	1985

9/30/2016	**107617527**	**$170.24**	03/22/15 - 04/03/16	ACCT: 2619826	Payment amount based on $15,928.96 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 1.33595% among all providers.	***Patient Initials:***	J.A.
	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:***	1983
9/30/2016	**107617526**	**$140.80**	03/22/16	ACCT: 2692792	Payment amount based on $176.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016				***Patient Initials:***	M.P.
	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:***	1980
9/30/2016	**107617524**	**$680.42**	08/11/15 - 09/08/15	ACCT: 2663809	Payment amount based on $8,855.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 9.60509% among all providers.	***Patient Initials:***	C.S.
	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
9/30/2016	**107617525**	**$1,586.70**	11/02/14 - 03/30/16	ACCT: 214374	Payment amount based on $41,420.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 4.78846% among all providers.	***Patient Initials:***	S.H.
	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:***	1954
9/30/2016	**107617523**	**$447.20**	01/05/14	ACCT: 1948765	Payment amount based on $559.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016				***Patient Initials:***	A.J.
	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:***	1988
9/30/2016	**107617522**	**$595.15**	12/21/15 - 01/09/16	ACCT: 1406826	Payment amount based on $8,829.54 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 8.42552% among all providers.	***Patient Initials:***	E.R.
	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:***	1951
8/26/2016	**107592845**	**$1,098.26**	11/14/15	ACCT: 590861	Payment amount based on $1,372.83 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				***Patient Initials:***	J.C.
	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:***	1994
8/26/2016	**107592844**	**$3.29**	11/25/15	ACCT: 448090	Payment amount based on $4.11 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				***Patient Initials:***	D.H.
	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:***	1992
9/9/2016	**107601456**	**$461.92**	09/08/15	ACCT: 2670561	Payment amount based on $1,353.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	9/12/2016			Total Bills exceed maximum award. Payment is prorated at 42.67541% among all providers.	***Patient Initials:***	I.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:***	1968

8/3/2016	**107573709**	**$598.06**	03/06/15 - 03/07/15	ACCT: 2616418	Payment amount based on $5,855.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016			Total Bills exceed maximum award. Payment is prorated at 12.76813% among all providers.	***Patient Initials:***	W.K.
	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:***	1998
7/20/2016	**107563774**	**$488.00**	4/27/15-9/3/15	ACCT: 2139046	Payment amount based on $610.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016				***Patient Initials:***	D.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:***	2007
7/20/2016	**107563775**	**$167.20**	8/8/14	ACCT: 360763	Payment amount based on $209.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016				***Patient Initials:***	C.B.
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1950
7/20/2016	**107563777**	**$791.07**	01/19/16	ACCT: 2697846	Payment amount based on $6,222.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 15.89261% among all providers.	***Patient Initials:***	J.K.
	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:***	1996
7/20/2016	**107563779**	**$730.40**	03/09/16 - 04/14/16	ACCT: 1211541	Payment amount based on $2,395.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 38.12129% among all providers.	***Patient Initials:***	M.B.
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1988
7/20/2016	**107563778**	**$2,185.36**	02/18/16 - 04/21/16	ACCT: 2706435	Payment amount based on $121,077.50 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 2.25616% among all providers.	***Patient Initials:***	J.R.
	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:***	1986
7/20/2016	**107563776**	**$5,004.99**	03/15/13 - 09/04/13	ACCT: 2452541	Payment amount based on $17,965.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 34.82462% among all providers.	***Patient Initials:***	J.J.
	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:***	1979
6/20/2016	**107544919**	**$16,318.08**	01/21/16 - 03/01/16	ACCT: 1249835	Payment amount based on $20,831.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 97.91947% among all providers.	***Patient Initials:***	K.L.
	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:***	1956
6/20/2016	**107544917**	**$1,517.62**	07/27/15 - 08/05/15	ACCT: 2660119	Payment amount based on $1,897.03 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016				***Patient Initials:***	E.B.
	Mail To Address:	PO BOX 269026 OKLAHOMA CITY OK 73126-9026			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1984

6/20/2016	**107544918**	**$640.36**	09/28/15 - 11/02/15	ACCT: 2674554	Payment amount based on $4,436.96 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 18.0406% among all providers.	***Patient Initials:***	J.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:***	1986
6/20/2016	**107544916**	**$331.01**	08/04/15 - 04/15/16	ACCT: 299428	Payment amount based on $739.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 55.98916% among all providers.	***Patient Initials:***	H.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:***	1953
6/20/2016	**107544915**	**$1,409.19**	07/12/15 - 07/25/15	ACCT: 265060	Payment amount based on $17,773.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 9.911015% among all providers.	***Patient Initials:***	G.C.
	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:***	1989
6/7/2016	**107534034**	**$575.83**	04/06/15 - 04/25/15	ACCT: 264027	Payment amount based on $719.79 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/10/2016				***Patient Initials:***	J.R.
	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
6/7/2016	**107534033**	**$1,079.40**	12/04/13	ACCT: 521415	Payment amount based on $1,349.25 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/10/2016				***Patient Initials:***	B.T.
	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:***	1972
6/8/2016	**107535010**	**$752.89**	12/10/15	ACCT: 731477155	Payment amount based on $941.11 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/11/2016				***Patient Initials:***	E.T.
	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:***	2015
5/27/2016	**107528353**	**$128.00**	07/01/14	ACCT: 2559305	Payment amount based on $160.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/30/2016				***Patient Initials:***	A.C.
	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:***	2000
4/28/2016	**107504694**	**$563.77**	10/09/15 - 10/14/15	ACCT: 280630	Payment amount based on $3,625.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 19.44024% among all providers.	***Patient Initials:***	Q.J.
	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:***	1991
4/28/2016	**107504695**	**$476.67**	11/29/15 - 12/05/15	ACCT: 442222	Payment amount based on $2,064.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.86783% among all providers.	***Patient Initials:***	C.S.
	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:***	1978

4/28/2016	**107504696**	**$1,236.04**	12/16/15 - 12/22/15	ACCT: 2692153	Payment amount based on $25,477.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.064521% among all providers.	*Patient Initials:*	N.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:*	1965
4/28/2016	**107504693**	**$686.49**	10/13/14 - 12/07/15	ACCT: 311303	Payment amount based on $2,673.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 32.10316% among all providers.	*Patient Initials:*	J.A.
	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:*	1964

OU Child Study Center — *Office of State Finance VendorID:* 0000061010

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
11/1/2016	**107638895**	**$270.32**	8/13/15 - 2/10/16	ACCT: 1793404	Payment amount based on $337.90 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/4/2016				*Patient Initials:*	J.M.
	Mail To Address:	1100 NE 13th St Oklahoma City OK 73117			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	2003

OU PHYSICIANS — *Office of State Finance VendorID:* 0000061010

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
7/20/2016	**107563773**	**$11.74**	1/13/2016	ACCT: 1494627	Payment amount based on $14.68 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016				*Patient Initials:*	D.M.
	Mail To Address:	PO BOX 269025 OKLAHOMA CITY OK 73126-9025			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1950

ASSESSMENT, INC. — *Office of State Finance VendorID:* 0000322271

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
11/30/2016	**107657748**	**$896.00**	03/30/16 - 05/13/16	ACCT: M.M. - $560.00; T.M. - $336.00	Payment amount based on $1,120.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/3/2016				*Patient Initials:*	S.M.
	Mail To Address:	2500 MCGEE DR., STE. 104 NORMAN OK 73072			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1989
8/26/2016	**107592741**	**$336.00**	4/26/16, 5/13/16, 5/25/16, 6/1/16	ACCT: N.A.K.	Payment amount based on $420.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				*Patient Initials:*	K.K.
	Mail To Address:	2500 MCGEE DR., STE. 104 NORMAN OK 73072			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1974

WARN, BRETT R. D.D.S. — *Office of State Finance VendorID:* 0000061087

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

9/30/2016	**107617620**	**$235.52**	08/12/15	ACCT: 5488	Payment amount based on $22,037.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 1.33595% among all providers. ***Patient Initials:*** J.A.
	Mail To Address:	502 NW SHERIDAN RD STE 5 LAWTON OK 73505-6505			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1983

SOUTHWEST ORTHOPAEDIC ***Office of State Finance VendorID:*** 0000061138

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/9/2016	**107601519**	**$473.60**	09/11/15 - 12/23/15	ACCT: SOS401921 - $235.20; SOS433072 - $142.40; SOS433072 - $96.00	Payment amount based on $592.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** P.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:*** 1973

GILBERT MEDICAL CENTER ***Office of State Finance VendorID:*** 0000176079

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
7/20/2016	**107563667**	**$23.02**	10/22/15	ACCT: 207614	Payment amount based on $280.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 10.27708% among all providers. ***Patient Initials:*** M.L.
	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:*** 1975

THE PHYSICIANS GROUP ***Office of State Finance VendorID:*** 0000061214

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/23/2016	**107675804**	**$158.51**	7/5/16 - 7/27/16	ACCT: 0413315	Payment amount based on $198.14 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***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
9/9/2016	**107601469**	**$114.74**	04/11/15	ACCT: 0452068	Payment amount based on $143.43 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** T.B.
	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:*** 1993
8/3/2016	**107573712**	**$129.50**	4/8/16	ACCT: 0413315	Payment amount based on $161.88 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/6/2016			***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

REACT-EMS ***Office of State Finance VendorID:*** 0000061247

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

1/20/2017	**107687697**	**$1,603.80**	5/26/16	165970 (583.40) & 165955 (1,020.40)	Payment amount based on $2,004.75 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/23/2017			***Patient Initials:*** W.M.
	Mail To Address:	PO BOX 3700 SHAWNEE OK 74802-3700			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1964
9/9/2016	**107601485**	**$701.40**	09/21/15	ACCT: 15-10039	Payment amount based on $876.75 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** D.H.
	Mail To Address:	PO BOX 3700 SHAWNEE OK 74802-3700			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1982
6/27/2016	**107550446**	**$595.20**	6/3/15	ACCT: 1505087	Payment amount based on $744.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/30/2016			***Patient Initials:*** M.M.
	Mail To Address:	PO BOX 3700 SHAWNEE OK 74802-3700			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1993

REACT-EMS ***Office of State Finance VendorID:*** 0000061247

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/30/2016	**107617564**	**$870.44**	01/05/14	ACCT: 00253913	Payment amount based on $1,378.25 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 78.94467% among all providers. ***Patient Initials:*** S.A.
	Mail To Address:	2316 N AIRPORT DR SHAWNEE OK 74802-3700			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1960
9/30/2016	**107617565**	**$1,102.60**	01/05/14	ACCT: 00253907	Payment amount based on $1,378.25 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			***Patient Initials:*** A.J.
	Mail To Address:	2316 N AIRPORT DR SHAWNEE OK 74802-3700			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1988

ALLIANCE HEALTH MIDWEST ***Office of State Finance VendorID:*** 0000061360

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
		$1,178.89	5/17/15	Acct#490218701	Payment amount based on $1,473.61 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17			***Patient Initials:*** C.H.
	Mail To Address:	PO BOX 405970 ATLANTA GA 30384			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2002
8/3/2016	**107573693**	**$887.00**	12/24/15	ACCT: 8240674	Payment amount based on $1,108.75 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/6/2016			***Patient Initials:*** B.S.
	Mail To Address:	PO BOX 405970 ATLANTA GA 30384			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1979
4/29/2016	**107506159**	**$228.22**	2/5/16	ACCT: 4948169	Payment amount based on $285.28 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/2/2016			***Patient Initials:*** A.S.
	Mail To Address:	PO BOX 405970 ATLANTA GA 30384			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1956

MIDWEST REGIONAL HOSPITAL AMBULANCE

Office of State Finance VendorID: 0000061360

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
7/20/2016	107563744	$420.33	01/24/15	ACCT: 8226523	Payment amount based on $549.01 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 95.70235% among all providers.	*Patient Initials:*	E.W.
	Mail To Address:	PO BOX 405970 ATLANTA GA 30384-5970			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1976

MERCY HOSPITAL ARDMORE

Office of State Finance VendorID: 0000076081

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
12/23/2016	107675540	$7,584.30	06/10/16	ACCT: 5416162003	Payment amount based on $9,480.38 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/26/2016				*Patient Initials:*	P.M.
	Mail To Address:	PO BOX 505017 ST. LOUIS MO 63150-5020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1966
9/9/2016	107601428	$122.85	4/21/15 - 4/22/15	ACCT: 54151110513 $66.40, 54151120356 $56.45	Payment amount based on $153.56 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	9/12/2016				*Patient Initials:*	G.L.
	Mail To Address:	PO BOX 505017 ST. LOUIS MO 63150-5020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1996
8/3/2016	107573687	$541.35	7/17/15	ACCT: 54151980007	Payment amount based on $676.69 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016				*Patient Initials:*	K.L.
	Mail To Address:	PO BOX 505017 ST. LOUIS MO 63150-5020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1997
7/25/2016	107566982	$1,580.96	02/08/14 - 02/11/14	ACCT: 54140390003	Payment amount based on $1,976.20 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/28/2016				*Patient Initials:*	L.L.
	Mail To Address:	PO BOX 505017 ST. LOUIS MO 63150-5020			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1958

EYECARE ASSOCIATES OF SOUTH TULSA

Office of State Finance VendorID: 0000403901

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
4/28/2016	107504625	$100.00	10/20/15	ACCT: 58981	Payment amount based on $125.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016				*Patient Initials:*	R.H.
	Mail To Address:	10010 E. 81ST. ST. SUITE 100 TULSA OK 74133-4558			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1980

SURGERY CENTER OF LAWTON

Office of State Finance VendorID: 0000314055

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

5/6/2016	**107511137**	**$234.14**	11/23/15	ACCT: 0000583	Payment amount based on $292.68 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/9/2016				***Patient Initials:*** M.P.
	Mail To Address:	3617 W GORE BLVD STE D LAWTON OK 73505-6373			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1968

MUSKOGEE LUNG CLINIC — ***Office of State Finance VendorID:*** 0000258894

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
8/26/2016	**107592827**	**$217.52**	5/23/16 - 5/24/16	ACCT: 6012	Payment amount based on $271.90 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** P.J.
	Mail To Address:	TALAT TAWAKLNA MD MUSKOGEE OK 74401		333 S 38TH STE B	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1964

ETHAN LINDSEY, MD — ***Office of State Finance VendorID:*** 0000408623

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
9/9/2016	**107601328**	**$387.03**	1/28/15 - 12/16/15	ACCT: BURBR000	Payment amount based on $483.79 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** B.B.
	Mail To Address:	1117 NW 50TH OKLAHOMA CITY OK 73118			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1977

ANESTHESIA SCHEDULING SERVICES — ***Office of State Finance VendorID:*** 0000062008

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
7/20/2016	**107563554**	**$246.96**	01/12/16	ACCT: ASP65770	Payment amount based on $495.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 62.36396% among all providers.	***Patient Initials:*** B.B.
	Mail To Address:	1111 N LEE AVE STE #236 OKLAHOMA CITY OK 73103-2620			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1989

EMERGENCY PHYSICIANS OF MIDWEST CITY, LLC — ***Office of State Finance VendorID:*** 0000062051

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
		$465.60	5/17/15	Acct #0042664997	Payment amount based on $582.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				***Patient Initials:*** C.H.
	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:*** 2002
9/9/2016	**107601318**	**$2,341.60**	09/21/15 AND 09/23/15	ACCT: 156569189/56 - $1,248.80; 0047452299 - $1,092.80	Payment amount based on $2,927.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** D.H.
	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:*** 1982

4/4/2016	**107484644**	**$215.20**	11/1/14	ACCT: 38420430	Payment amount based on $269.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	4/7/2016				*Patient Initials:*	R.P.
	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:*	1992

CENTER FOR POSITIVE CHANGE — *Office of State Finance VendorID:* 0000184518

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
7/20/2016	**107563605**	**$480.00**	4/10/15 - 5/1/15	ACCT: 11653J2	#Div/0!		
	Approx Mail Date:	7/23/2016				*Patient Initials:*	L.L.
	Mail To Address:	500 N. FINANCIAL TERR. YUKON OK 73099		STE. G		*Patient Birth Year:*	2001

THE ORTHOPAEDIC CTR — *Office of State Finance VendorID:* 0000062172

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
10/19/2016	**107630527**	**$188.00**	08/16/15	ACCT: 211392-01	Payment amount based on $235.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/22/2016				*Patient Initials:*	J.B.
	Mail To Address:	1809 E. 13TH ST. TULSA OK 74104-4431			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1976
4/22/2016	**107500225**	**$136.00**	02/11/15	ACCT: 201084-010006	Payment amount based on $170.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	4/25/2016				*Patient Initials:*	M.G.
	Mail To Address:	1809 E. 13TH ST. TULSA OK 74104-4431			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1966

THE ORTHOPAEDIC CENTER — *Office of State Finance VendorID:* 0000062172

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
9/30/2016	**107617595**	**$508.23**	01/31/16 - 02/23/16	ACCT: 0160205	Payment amount based on $810.76 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 78.35652% among all providers.	*Patient Initials:*	D.L.
	Mail To Address:	PO BOX 21228 DEPT 338 TULSA OK 74121-1228			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1979

ARNOLD MONUMENT COMPANY — *Office of State Finance VendorID:* 0000301649

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
8/26/2016	**107592740**	**$3,048.30**	04/18/16	ACCT: J.V.	Payment amount based on $3,048.30 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				*Patient Initials:*	J.V.
	Mail To Address:	320 E. ELM EL RENO OK 73036				*Patient Birth Year:*	1993

CYNTHIA CHIOCO, PSY.D. — *Office of State Finance VendorID:* 0000364949

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
8/17/2016	107584274	$112.00	09/24/14	ACCT: K.C.	Payment amount based on $140.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/20/2016				*Patient Initials:*	K.C.
	Mail To Address:	OAKVIEW PROFESSIONAL POINT EDMOND OK 73013		3917A E. MEMORIAL	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1996

ORAL & MAXILLOFACIAL ASSOCIATES — *Office of State Finance VendorID:* 0000062333

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
7/20/2016	107563763	$106.60	01/27/15 - 10/22/15	ACCT: 324787	Payment amount based on $139.24 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 95.70235% among all providers.	*Patient Initials:*	E.W.
	Mail To Address:	3601 NW 138TH STE. 100 OKLAHOMA CITY OK 73134			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1976

DR. JACOB MENDENHALL — *Office of State Finance VendorID:* 0000062333

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
12/16/2016	107670831	$52.00	07/26/16	ACCT: 566940	Payment amount based on $65.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	12/19/2016				*Patient Initials:*	S.H.
	Mail To Address:	PO BOX 108811 OKLAHOMA CITY OK 73101			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1966
5/27/2016	107528349	$1,518.32	09/08/15 - 10/27/15	ACCT: 566940	Payment amount based on $1,897.90 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/30/2016				*Patient Initials:*	S.H.
	Mail To Address:	PO BOX 108811 OKLAHOMA CITY OK 73101			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1966

A PLACE FOR CHANGE — *Office of State Finance VendorID:* 0000223330

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
11/1/2016	107638915	$329.85	5/19/16 - 9/1/16	ACCT: N.L.	Payment amount based on $412.31 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/4/2016				*Patient Initials:*	N.L.
	Mail To Address:	17 SOUTH CENTRAL IDABEL OK 74745			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1942
9/9/2016	-107601546	($720.00)	1/12/16 - 6/22/16	ACCT: S.F.L. **VOIDED, ISSUED TO PROVIDER IN ERROR**	Payment amount based on ($900.00) patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	9/12/2016				*Patient Initials:*	S.F.
	Mail To Address:	17 SOUTH CENTRAL IDABEL OK 74745			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1985

9/9/2016	**107601546**	**$720.00**	1/12/16 - 6/22/16	ACCT: S.F.L.	Payment amount based on $900.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** S.F.
	Mail To Address:	17 SOUTH CENTRAL IDABEL OK 74745			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1985
6/27/2016	**107550473**	**$508.52**	1/26/16 - 5/3/16	ACCT: N.L.	Payment amount based on $635.65 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** N.L.
	Mail To Address:	17 SOUTH CENTRAL IDABEL OK 74745			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1942
4/29/2016	**107506204**	**$854.38**	7/8/15 - 12/15/15	ACCT: N.L.	Payment amount based on $1,067.98 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/2/2016				***Patient Initials:*** N.L.
	Mail To Address:	17 SOUTH CENTRAL IDABEL OK 74745			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1942

SAVILLE CENTER ***Office of State Finance VendorID:*** 0000184870

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
12/23/2016	**107675857**	**$1,440.00**	11/3/15 - 4/18/16	Acct: J..M.	Payment amount based on $1,800.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				***Patient Initials:*** M.M.
	Mail To Address:	P.O. BOX 393 STILLWATER OK 74076			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2009
12/23/2016	**107675854**	**$986.84**	9/9/15 - 7/6/16	ACCT: G.H.	Payment amount based on $1,233.55 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				***Patient Initials:*** G.H.
	Mail To Address:	P.O. BOX 393 STILLWATER OK 74076			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2010
12/23/2016	**107675855**	**$302.56**	9/15/15 - 12/9/15	ACCT: M.H.	Payment amount based on $378.20 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				***Patient Initials:*** M.H.
	Mail To Address:	P.O. BOX 393 STILLWATER OK 74076			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2007
12/23/2016	**107675856**	**$80.00**	11/13/15	ACCT: J.P.	Payment amount based on $100.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				***Patient Initials:*** J.P.
	Mail To Address:	P.O. BOX 393 STILLWATER OK 74076			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2000
12/23/2016	**107675853**	**$1,068.10**	3/27/15 - 12/18/15	ACCT: C.C.	Payment amount based on $1,335.13 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				***Patient Initials:*** C.C.
	Mail To Address:	P.O. BOX 393 STILLWATER OK 74076			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 2010

12/23/2016	**107675852**	**$447.44**	11/3/15-4/18/16	ACCT: J.P.	Payment amount based on $559.30 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***Patient Initials:*** J.P.
	Mail To Address:	P.O. BOX 393 STILLWATER OK 74076			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2001
6/8/2016	**107535056**	**$480.00**	8/21/15 - 10/13/15	ACCT: S.S.	Payment amount based on $600.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/11/2016			***Patient Initials:*** S.S.
	Mail To Address:	P.O. BOX 393 STILLWATER OK 74076			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2004

MY DENTIST - LAWTON ***Office of State Finance VendorID:*** 0000184889

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/9/2016	**107601438**	**$5,256.00**	07/27/16 - 07/28/16	ACCT: M.C. 017137	Payment amount based on $6,570.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** M.C.
	Mail To Address:	2111 NW CACHE ROAD LAWTON OK 73505			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987

MY DENTIST - S. WESTERN ***Office of State Finance VendorID:*** 0000184889

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
7/25/2016	**107566987**	**$1,227.20**	10/07/15	ACCT: 017317	Payment amount based on $1,534.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/28/2016			***Patient Initials:*** M.C.
	Mail To Address:	6616 S. WESTERN OKLAHOMA CITY OK 73139			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987

YOUNG CHIROPRACTIC ***Office of State Finance VendorID:*** 0000348603

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/9/2016	**107601593**	**$1,042.18**	1/6/16 - 8/15/16	ACCT: 03-3864	Payment amount based on $1,302.73 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** T.B.
	Mail To Address:	6020 N ROBINSON OKLAHOMA CITY OK 73118			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1978

TULSA BONE AND JOINT ASSOCIATES ***Office of State Finance VendorID:*** 0000062557

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/9/2016	**107601556**	**$1,099.20**	11/04/15 - 03/11/16	ACCT: 141619	Payment amount based on $1,374.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** J.P.
	Mail To Address:	PO BOX 258813 OKLAHOMA CITY OK 73125-8813			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1980

BERNARD C RHONE, DDS — *Office of State Finance VendorID:* 0000185046

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
		$1,820.00		M.H.	Payment amount based on $2,275.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				*Patient Initials:* M.H.
	Mail To Address:	2124 NE 23RD STREET OKLAHOMA CITY OK 73111			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1955

ALL SAINTS HOME MEDICAL — *Office of State Finance VendorID:* 0000220718

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
1/23/2017	**107688640**	**$39.02**	08/18/15	ACCT: H4905	Payment amount based on $48.78 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017				*Patient Initials:* D.D.
	Mail To Address:	PO BOX 700231 TULSA OK 74170-0231			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1994
1/19/2017	**107686334**	**$1,832.68**	09/04/15 - 12/05/15	ACCT: H6567	Payment amount based on $2,290.85 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				*Patient Initials:* A.G.
	Mail To Address:	PO BOX 700231 TULSA OK 74170-0231			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1983
6/20/2016	**107544775**	**$96.40**	08/19/15 - 10/19/15	ACCT: H4973	Payment amount based on $120.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				*Patient Initials:* E.B.
	Mail To Address:	PO BOX 700231 TULSA OK 74170-0231			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1984
4/28/2016	**107504549**	**$96.66**	10/02/15	ACCT: I0799	Payment amount based on $120.83 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				*Patient Initials:* R.C.
	Mail To Address:	PO BOX 700231 TULSA OK 74170-0231			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1971
4/28/2016	**107504548**	**$134.65**	06/02/14	ACCT: D6195	Payment amount based on $168.31 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				*Patient Initials:* A.J.
	Mail To Address:	PO BOX 700231 TULSA OK 74170-0231			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1971
4/28/2016	**107504547**	**$120.04**	01/29/13 - 11/20/13	ACCT: A6823	Payment amount based on $2,209.91 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.79013% among all providers.	*Patient Initials:* P.W.
	Mail To Address:	PO BOX 700231 TULSA OK 74170-0231			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1987

CHARLES LESTER, MD — *Office of State Finance VendorID:* 0000326361

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

11/18/2016	**107651840**	**$35.00**	10/5/16	ACCT: 12453107155	Payment amount based on $87.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/21/2016			***Patient Initials:*** S.D.
	Mail To Address:	101 ROCKEFELLER DR #202 MUSKOGEE OK 74401-5050			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1988
5/24/2016	**107524568**	**$35.00**	4/4/16	ACCT: 12453-101043	Payment amount based on $87.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/27/2016			***Patient Initials:*** S.D.
	Mail To Address:	101 ROCKEFELLER DR #202 MUSKOGEE OK 74401-5050			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1988

JOEL C. RAZOOK MD ***Office of State Finance VendorID:*** 0000062881

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
5/4/2016	**107508605**	**$76.80**	11/20/15	ACCT: B.M.	Payment amount based on $96.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/7/2016			***Patient Initials:*** B.M.
	Mail To Address:	2300 36TH AVE. NW, SUITE 110 NORMAN OK 73072-2922			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1985

MORAD EL-RAHEB MD, INC ***Office of State Finance VendorID:*** 0000063014

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/30/2016	**107617498**	**$181.79**	01/31/16	ACCT: 49804	Payment amount based on $290.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 78.35652% among all providers. ***Patient Initials:*** D.L.
	Mail To Address:	P O BOX 700930 TULSA OK 74170			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1979

AUBREY J HENSHAW DDS ***Office of State Finance VendorID:*** 0000212416

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/28/2016	**107504579**	**$47.61**	07/18/12	ACCT: BU0039	Payment amount based on $210.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.34055% among all providers. ***Patient Initials:*** A.B.
	Mail To Address:	P O BOX 708 SALLISAW OK 74955			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1990

RENAISSANCE DENTAL ***Office of State Finance VendorID:*** 0000397242

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
8/3/2016	**107573731**	**$430.00**	05/28/15 AND 06/09/15	ACCT: 2968	Payment amount based on $537.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/6/2016			***Patient Initials:*** A.T.
	Mail To Address:	12160 E. 96TH ST. N. SUITE 106 OWASSO OK 74055			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1992

OKLAHOMA SURGICAL HOSPITAL — *Office of State Finance VendorID:* 0000063071

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
6/7/2016	107534028	$2,240.00	12/19/14	ACCT: 300542	Payment amount based on $2,800.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				*Patient Initials:* S.K.
	Mail To Address:	2408 E. 81ST ST TULSA OK 74137-4230		SUITE 300	Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1991

BISSLAND CHIOPRACTIC — *Office of State Finance VendorID:* 0000063117

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
10/11/2016	107623958	$1,466.79	4/13/15 - 8/17/15	ACCT: 103279	Payment amount based on $1,833.49 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				*Patient Initials:* D.B.
	Mail To Address:	7506 E. 11TH ST. TULSA OK 74112			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1996

OU PATHOLOGY — *Office of State Finance VendorID:* 0000185546

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
1/23/2017	107688868	$138.91	10/23/15 - 11/11/15 AND 09/01/15	ACCT: 5062-483495 - $33.84; 5062-456368 - $105.07	Payment amount based on $173.64 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017				*Patient Initials:* D.D.
	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:* 1994
1/20/2017	107687664	$100.60	5/26/16	5062*546202	Payment amount based on $125.75 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/23/2017				*Patient Initials:* W.M.
	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:* 1964
1/19/2017	107686498	$177.64	01/07/16 - 01/14/16 AND 02/16/16	ACCT: 504643 - $151.00; 519117 - $26.64	Payment amount based on $222.05 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				*Patient Initials:* A.G.
	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:* 1983
11/21/2016	107653145	$38.90	01/28/15	ACCT: 5062*405705	Payment amount based on $94.28 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 51.57423% among all providers.	*Patient Initials:* R.S.
	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:* 1963

11/21/2016	**107653146**	**$47.07**	01/22/16 - 02/03/16	ACCT: 997000122123	Payment amount based on $1,069.45 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 5.50147% among all providers. ***Patient Initials:*** J.L.
	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:*** 1970
11/21/2016	**107653147**	**$45.43**	06/29/16 - 07/01/16	ACCT: 5062*556083	Payment amount based on $263.05 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 21.58687% among all providers. ***Patient Initials:*** A.W.
	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:*** 1983
9/30/2016	**107617510**	**$49.95**	11/02/14 - 11/13/14	ACCT: 5062*397174	Payment amount based on $1,303.85 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 4.78846% among all providers. ***Patient Initials:*** S.H.
	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:*** 1954
9/30/2016	**107617509**	**$60.47**	01/05/14	ACCT: 5062*293683	Payment amount based on $95.75 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 78.94467% among all providers. ***Patient Initials:*** S.A.
	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:*** 1960
9/9/2016	**107601451**	**$100.60**	09/04/15	ACCT: 5062*470632	Payment amount based on $125.75 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** T.M.
	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:*** 1982
9/9/2016	**107601452**	**$42.93**	09/08/15	ACCT: 5062*471729	Payment amount based on $125.75 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			Total Bills exceed maximum award. Payment is prorated at 42.67541% among all providers. ***Patient Initials:*** I.G.
	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:*** 1968
6/20/2016	**107544904**	**$76.07**	07/16/15 - 07/23/15	ACCT: 04085740	Payment amount based on $959.35 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 9.911015% among all providers. ***Patient Initials:*** G.C.
	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:*** 1989
4/28/2016	**107504684**	**$68.45**	11/29/15 - 11/30/15 AND 12/1/15 - 12/2/15	ACCT: 997000121251 - $47.99; 997000121254 - $20.46	Payment amount based on $296.40 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.86783% among all providers. ***Patient Initials:*** C.S.
	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:*** 1978
4/28/2016	**107504685**	**$40.93**	12/16/15 - 12/22/15	ACCT: 5062*500722	Payment amount based on $843.70 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.064521% among all providers. ***Patient Initials:*** N.G.
	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:*** 1965

4/28/2016	**107504683**	**$74.98**	10/13/14 - 10/17/14	ACCT: 997000120039	Payment amount based on $291.95 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 32.10316% among all providers.	***Patient Initials:***	J.A.
	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:***	1964

THE PATHOLOGY GROUP — ***Office of State Finance VendorID:*** 0000185546

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
8/3/2016	**107573703**	**$48.00**	12/24/15	ACCT: 5166*665293	Payment amount based on $60.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016				***Patient Initials:***	B.S.
	Mail To Address:	PO BOX 269048 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1979

THE PATHOLOGY GROUP — ***Office of State Finance VendorID:*** 0000185546

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
1/19/2017	**107686499**	**$52.80**	07/19/15	ACCT: 5166*590873	Payment amount based on $66.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/22/2017				***Patient Initials:***	J.A.
	Mail To Address:	PO BOX 268984 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1995

BRADY & BRADY, PC — ***Office of State Finance VendorID:*** 0000407429

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
8/17/2016	**107584345**	**$626.00**	08/27/15 - 09/03/15	ACCT: K.H.	Payment amount based on $1,565.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/20/2016				***Patient Initials:***	K.H.
	Mail To Address:	SHARON S. BRADY, PHD LAWTON OK 73505		1401 SW PARK RIDGE BLVD, STE	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1982

THE BRACE PLACE — ***Office of State Finance VendorID:*** 0000063259

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
4/4/2016	**107484705**	**$25.00**	2/3/14 - 2/10/14	ACCT: L.M.	Payment amount based on $25.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	4/7/2016				***Patient Initials:***	L.M.
	Mail To Address:	409 E California Ave Oklahoma City OK 73104		Ste 100		***Patient Birth Year:***	1962

COMMUNITY FUNERAL HOME — ***Office of State Finance VendorID:*** 0000272077

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

8/3/2016	**107573580**	**$5,993.66**	05/31/16	ACCT: L.K.	Payment amount based on $5,993.66 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/6/2016			***Patient Initials:*** L.K.
	Mail To Address:	1624 N PINE GUTHRIE OK 73044			***Patient Birth Year:*** 1966
8/3/2016	**107573578**	**$5,817.66**	05/31/16	ACCT: C.B.	Payment amount based on $5,817.66 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/6/2016			***Patient Initials:*** C.B.
	Mail To Address:	1624 N PINE GUTHRIE OK 73044			***Patient Birth Year:*** 1986
8/3/2016	**107573579**	**$5,817.66**	05/31/16	ACCT: W.C.	Payment amount based on $5,817.66 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/6/2016			***Patient Initials:*** W.C.
	Mail To Address:	1624 N PINE GUTHRIE OK 73044			***Patient Birth Year:*** 1969

NEUROSURGERY CENTER OF SW OK — ***Office of State Finance VendorID:*** 0000063323

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/28/2016	**107504668**	**$1,076.80**	07/05/15 - 07/22/15	ACCT: 13491	Payment amount based on $1,346.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** L.D.
	Mail To Address:	3201 W GORE BLVD STE 303 LAWTON OK 73505-6350			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1950

HEALTHCARE INNOVATIONS OF OK LLC — ***Office of State Finance VendorID:*** 0000307463

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/21/2016	**107653079**	**$98.73**	06/20/16	ACCT: 360806	Payment amount based on $363.30 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 33.97059% among all providers. ***Patient Initials:*** E.B.
	Mail To Address:	6688 N CENTRAL EXPY STE 1300 DALLAS TX 75206-3950			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987

TULSA HOSPITALISTS, INC. — ***Office of State Finance VendorID:*** 0000063457

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/21/2016	**107653231**	**$229.73**	06/17/16	ACCT: RASJE00136309	Payment amount based on $300.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 95.72122% among all providers. ***Patient Initials:*** J.R.
	Mail To Address:	PO BOX 700930 TULSA OK 74170-0930			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1974
4/28/2016	**107504752**	**$364.00**	08/14/15 - 08/15/15	ACCT: 30548	Payment amount based on $455.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** N.M.
	Mail To Address:	PO BOX 700930 TULSA OK 74170-0930			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1994

4/28/2016	**107504751**	**$60.25**	08/03/14 - 08/05/14	ACCT: JOHAV000	Payment amount based on $75.31 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				***Patient Initials:*** A.J.
	Mail To Address:	PO BOX 700930 TULSA OK 74170-0930			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1971
4/28/2016	**107504750**	**$279.81**	09/13/15 - 09/25/15	ACCT: 31420	Payment amount based on $2,040.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 17.14525% among all providers.	***Patient Initials:*** E.G.
	Mail To Address:	PO BOX 700930 TULSA OK 74170-0930			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1955

MEDICAL X-RAY CONSULTANTS PLLC ***Office of State Finance VendorID:*** 0000063461

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/7/2016	**107534015**	**$4.13**	04/06/15 AND 04/23/15	ACCT: 248115	Payment amount based on $5.16 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** J.R.
	Mail To Address:	PO BOX 2419 ADA OK 74821-2419			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1984

STOUT-PHILLIPS FUNERAL HOME ***Office of State Finance VendorID:*** 0000200961

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/30/2016	**107657922**	**$7,500.00**	06/20/16	ACCT: S.A.J.	Payment amount based on $8,049.94 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/3/2016				***Patient Initials:*** S.J.
	Mail To Address:	PO BOX 901 WEWOKA OK 74884-0901				***Patient Birth Year:*** 1999

SMITH-PHILLIPS FUNERAL HOME ***Office of State Finance VendorID:*** 0000200961

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/16/2016	**107649960**	**$500.00**	07/07/16	ACCT: C.J.C.	Payment amount based on $500.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/19/2016				***Patient Initials:*** C.C.
	Mail To Address:	PO BOX 147 ADA OK 74820-0147				***Patient Birth Year:*** 1958
5/25/2016	**107527129**	**$2,874.66**	09/18/15	ACCT: C.J.C. **REPLACES WARRANT 107508681 5/4/16 VCHR 128673 DUE TO WRONG LOCATION**	Payment amount based on $2,874.66 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/28/2016				***Patient Initials:*** C.C.
	Mail To Address:	PO BOX 147 ADA OK 74820-0147				***Patient Birth Year:*** 1958

DENTURES AND DENTAL SERVICES ***Office of State Finance VendorID:*** 0000185820

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

10/11/2016	**107623984**	**$2,544.00**	7/1/16	ACCT: 10910	Payment amount based on $3,180.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/14/2016				***Patient Initials:***	M.O.
	Mail To Address:	4400 NW EXPRESSWAY OKLAHOMA CITY OK 73116		SUITE A	Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1991

OKLAHOMA CITY ANESTHESIA — ***Office of State Finance VendorID:*** 0000063620

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
6/7/2016	**107534025**	**$135.52**	04/09/14	ACCT: 11490	Payment amount based on $169.40 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/10/2016				***Patient Initials:***	B.T.
	Mail To Address:	PO BOX 960391 OKLAHOMA CITY OK 73196			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1972

SEMINOLE MED CTR — ***Office of State Finance VendorID:*** 0000063625

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
6/27/2016	**107550452**	**$212.34**	8/29/13	ACCT: 4013346	Payment amount based on $265.43 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/30/2016				***Patient Initials:***	J.D.
	Mail To Address:	2401 W WRANGLER BLVD SEMINOLE OK 74868-1917			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1978

DR. STEVE SWEENEY — ***Office of State Finance VendorID:*** 0000412155

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
1/23/2017	**107688767**	**$115.54**	05/25/16	ACCT: 3385-1	Payment amount based on $175.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 82.52151% among all providers.	***Patient Initials:***	A.A.
	Mail To Address:	211 S. SOONER RD. MIDWEST CITY OK 73110			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1956

SHAWN SMITH MD — ***Office of State Finance VendorID:*** 0000063750

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
1/23/2017	**107688925**	**$440.75**	07/24/15 - 05/31/16	ACCT: 11702	Payment amount based on $550.94 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017				***Patient Initials:***	D.D.
	Mail To Address:	P O BOX 960261 OKLAHOMA CITY OK 73196-0261			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1994

INTEGRIS CANADIA VALLEY HOSPITAL — ***Office of State Finance VendorID:*** 0000063758

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

8/3/2016	**107573631**	**$347.90**	3/17/16	ACCT: 167876001	Payment amount based on $434.88 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/6/2016			***Patient Initials:*** J.B.
	Mail To Address:	P O BOX 268871 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1991

COMMUNITY LEARNING COUNCIL ***Office of State Finance VendorID:*** 0000208044

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
8/17/2016	**107584269**	**$748.00**	10/12/15 - 11/12/15	ACCT: WJAMI.001 - $364.00; LJAMI.001 - $384.00	Payment amount based on $935.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/20/2016			***Patient Initials:*** J.J.
	Mail To Address:	2525 NW Expressway, Suite 204 OKLAHOMA CITY OK 73112			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1973

THE GRIEF CENTER ***Office of State Finance VendorID:*** 0000235401

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
6/7/2016	**107534067**	**$1,884.00**	06/16/15 - 11/24/15	ACCT: 11236	Payment amount based on $2,355.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/10/2016			***Patient Initials:*** W.S.
	Mail To Address:	4646 S. HARVARD AVE. SUITE 200 TULSA OK 74135			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1989

OCOM NORTH ***Office of State Finance VendorID:*** 0000064132

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/9/2016	**107601447**	**$928.33**	11/23/15	ACCT: 2050162	Payment amount based on $1,160.41 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** P.S.
	Mail To Address:	PO BOX 890609 OKLAHOMA CITY OK 73189			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1973

OUCP DENTAL SERVICE ***Office of State Finance VendorID:*** 0000186126

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
4/28/2016	**107504699**	**$122.25**	10/13/14	ACCT: 15959	Payment amount based on $476.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 32.10316% among all providers. ***Patient Initials:*** J.A.
	Mail To Address:	1200 CHILDRENS AVE, 8F OKLAHOMA CITY OK 73104			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1964

KRISTI SELF MD ***Office of State Finance VendorID:*** 0000382035

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

6/20/2016	**107544879**	**$445.78**	08/07/15 - 08/14/15	ACCT: R1527	Payment amount based on $557.23 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			***Patient Initials:*** E.B.
	Mail To Address:	PO BOX 720596 NORMAN OK 73070-4444			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1984

CROWN HILL FUNERAL HOME — ***Office of State Finance VendorID:*** 0000260963

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
10/19/2016	**107630396**	**$3,983.34**	07/17/15	ACCT: L.I.	Payment amount based on $3,983.34 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/22/2016			***Patient Initials:*** L.I.
	Mail To Address:	1821 E. 66TH ST. N. TULSA OK 74130			***Patient Birth Year:*** 1988

NEW CROWN MANAGEMENT — ***Office of State Finance VendorID:*** 0000260963

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/30/2016	**107657796**	**$5,120.30**	03/25/16	ACCT: C.T.	Payment amount based on $5,120.30 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/3/2016			***Patient Initials:*** C.T.
	Mail To Address:	DBA CROWN HILL FUNERAL HOME 250 E. APACHE TULSA OK 74106			***Patient Birth Year:*** 1970

CITY OF ANADARKO EMS — ***Office of State Finance VendorID:*** 0000064265

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/21/2016	**107653022**	**$105.43**	06/29/16	ACCT: ALLWHE	Payment amount based on $610.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 21.58687% among all providers. ***Patient Initials:*** A.W.
	Mail To Address:	115 W KENTUCKY AVE ANADARKO OK 73005-4014			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1983

CITY OF BROKEN ARROW — ***Office of State Finance VendorID:*** 0000064268

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/23/2016	**107675675**	**$79.58**	4/9/16	Acct: 16-341396	Payment amount based on $99.48 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***Patient Initials:*** T.B.
	Mail To Address:	PO BOX 610 BROKEN ARROW OK 74013-0610			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1955
6/20/2016	**107544825**	**$1,455.38**	11/30/15	ACCT: 151170822	Payment amount based on $1,819.23 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			***Patient Initials:*** H.F.
	Mail To Address:	PO BOX 610 BROKEN ARROW OK 74013-0610			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1997

CHANDLER AMBULANCE SVS.

Office of State Finance VendorID: 0000064269

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
7/20/2016	107563615	$353.12	03/14/13	ACCT: 5004	Payment amount based on $1,267.50 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 34.82462% among all providers.	*Patient Initials:*	J.J.
	Mail To Address:	220 S CLEVELAND AVE CHANDLER OK 74834-2242			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1979

CITY OF CHICKASHA EMS

Office of State Finance VendorID: 0000064271

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
8/26/2016	107592764	$474.40	08/16/15	ACCT: PAT-014545	Payment amount based on $593.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/29/2016				*Patient Initials:*	S.M.
	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:*	1995
6/8/2016	107534931	$474.40	8/16/15	ACCT: PAT-014547	Payment amount based on $593.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/11/2016				*Patient Initials:*	N.M.
	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:*	1995
4/28/2016	107504597	$398.95	11/29/15	ACCT: 00101500905 - $131.52; 00101500906 - $267.43	Payment amount based on $1,727.50 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.86783% among all providers.	*Patient Initials:*	C.S.
	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:*	1978

GUTHRIE FIRE DEPARTMENT

Office of State Finance VendorID: 0000064282

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
1/20/2017	107687489	$917.62	11/22/15	35694209	Payment amount based on $1,147.03 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/23/2017				*Patient Initials:*	K.O.
	Mail To Address:	PO BOX 941608 HOUSTON TX 77094-8608			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1975

CITY OF WAGONER

Office of State Finance VendorID: 0000064307

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
11/15/2016	107648836	$804.80	05/23/13	ACCT: 5969	Payment amount based on $1,006.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/18/2016				*Patient Initials:*	F.D.
	Mail To Address:	P O BOX 406 WAGONER OK 74477-0406			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1969

WOODWARD COUNTY EMS

Office of State Finance VendorID: 0000077040

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573792	$104.58	10/16/15	ACCT: 310310	Payment amount based on $130.73 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				*Patient Initials:* T.D.
	Mail To Address:	PO BOX 771 WOODWARD OK 73802-0771			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1971

MUSKOGEE REGIONAL MEDICAL CENTER

Office of State Finance VendorID: 0000064349

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
12/23/2016	107675786	$432.29	6/1/16	ACCT: 205491871	Payment amount based on $540.36 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	12/26/2016				*Patient Initials:* S.A.
	Mail To Address:	PO BOX 740757 CINCINNATI OH 45274-0757			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1981
11/15/2016	107648870	$15.82	08/18/15	ACCT: 204862882	Payment amount based on $19.78 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/18/2016				*Patient Initials:* G.M.
	Mail To Address:	PO BOX 740757 CINCINNATI OH 45274-0757			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1960
10/11/2016	107624032	$2,836.26	3/6/16	ACCT: 205299605	Payment amount based on $3,545.33 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				*Patient Initials:* J.B.
	Mail To Address:	PO BOX 740757 CINCINNATI OH 45274-0757			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1990
7/20/2016	107563745	$1,198.70	7/29/15	ACCT: 204788046	Payment amount based on $1,498.38 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				*Patient Initials:* T.B.
	Mail To Address:	PO BOX 740757 CINCINNATI OH 45274-0757			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1987

OU MEDICAL CENTER- PRESBY

Office of State Finance VendorID: 0000071817

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/3/2016	107573707	$114.17	3/18/16	ACCT: 654415201	Payment amount based on $142.71 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016				*Patient Initials:* J.B.
	Mail To Address:	PO BOX 740782 CINCINNATI OH 45274-0782			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1991

NORTHEASTERN HEALTH SYSTEM

Office of State Finance VendorID: 0000386462

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

1/23/2017	**107688858**	**$186.72**	07/02/16	ACCT: 20797330	Payment amount based on $955.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 24.4275% among all providers.	***Patient Initials:*** B.H.
	Mail To Address:	PO BOX 1008 TAHLEQUAH OK 74465			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1977
8/26/2016	**107592837**	**$14.54**	12/7/15	ACCT: 20738783	Payment amount based on $18.18 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** S.F.
	Mail To Address:	PO BOX 1008 TAHLEQUAH OK 74465			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1982

NORMAN REGIONAL HOSPITAL ***Office of State Finance VendorID:*** 0000064400

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
10/19/2016	**107630476**	**$4,190.52**	10/31/15	ACCT: N00874370983	Payment amount based on $6,112.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/22/2016				***Patient Initials:*** C.E.
	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:*** 1992
10/19/2016	**107630475**	**$1,566.40**	10/28/14	ACCT: N00871052344	Payment amount based on $1,958.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/22/2016				***Patient Initials:*** K.S.
	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:*** 1969
9/30/2016	**107617503**	**$12,819.60**	12/19/15	ACCT: ,00874825026 - $10,692.40; N00874954209 - $1,244.00; N00874954276 - $883.20	Payment amount based on $16,024.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016				***Patient Initials:*** M.P.
	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:*** 1980
8/26/2016	**107592836**	**$132.00**	7/14/16	ACCT: E001046673	Payment amount based on $165.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** E.T.
	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:*** 2015
8/26/2016	**107592834**	**$117.28**	5/25/15	ACCT: 3382310	Payment amount based on $146.60 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** B.R.
	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:*** 2000
8/26/2016	**107592835**	**$760.80**	12-15-15	ACCT: N008747773331	Payment amount based on $951.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** K.K.
	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:*** 1974

8/26/2016	**107592833**	**$742.00**	11/14/15	ACCT: N00874658871	Payment amount based on $927.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** J.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:*** 1994
8/26/2016	**107592832**	**$1,008.00**	11/26/15 - 11/28/15	ACCT: N00874612561	Payment amount based on $1,260.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** D.H.
	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:*** 1992
8/3/2016	**107573697**	**$186.41**	03/06/15	ACCT: N00872300414	Payment amount based on $1,825.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/6/2016			Total Bills exceed maximum award. Payment is prorated at 12.76813% among all providers.	***Patient Initials:*** W.K.
	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:*** 1998
7/20/2016	**107563750**	**$2,022.86**	07/31/15 - 08/01/15	ACCT: N00873510897	Payment amount based on $24,604.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 10.27708% among all providers.	***Patient Initials:*** M.L.
	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:*** 1975
6/27/2016	**107550425**	**$1,064.18**	4/18/16	ACCT: N00875964356	Payment amount based on $1,330.23 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** D.P.
	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
6/20/2016	**107544896**	**$2,404.02**	09/27/15	ACCT: N00874142921	Payment amount based on $16,657.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 18.0406% among all providers.	***Patient Initials:*** J.G.
	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:*** 1986
6/20/2016	**107544897**	**$17,227.94**	11/22/15 - 11/28/15	ACCT: N00874574643	Payment amount based on $32,861.73 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 65.53194% among all providers.	***Patient Initials:*** R.D.
	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:*** 1992
6/7/2016	**107534023**	**$2,236.40**	03/20/15	ACCT: N00872302328	Payment amount based on $2,795.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** D.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:*** 1968
6/7/2016	**107534022**	**$320.00**	08/02/15	ACCT: N00873584203 - $80.00; N00873516011 - $240.00	Payment amount based on $400.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** E.W.
	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:*** 2013

6/8/2016	**107535006**	**$887.49**	5/24/15	ACCT: N00872893491	Payment amount based on $1,109.36 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/11/2016			***Patient Initials:*** H.B.
	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:*** 1972
6/8/2016	**107535005**	**$526.31**	11/10/15	ACCT: N00874597716 $166.85; N00874466450 $359.46	Payment amount based on $657.89 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/11/2016			***Patient Initials:*** E.T.
	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:*** 2015
5/27/2016	**107528338**	**$4,422.00**	04/26/15, 04/27/15, AND 05/08/15	ACCT: N00872734988 - $1,388.00; N00872639071 - $2,078.00; N00872647392 - $725.60; N00872754636 - $230.40	Payment amount based on $5,527.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/30/2016			***Patient Initials:*** R.M.
	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:*** 1980
5/24/2016	**107524691**	**$374.34**	7/27/15	ACCT: N00873463155	Payment amount based on $467.93 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/27/2016			***Patient Initials:*** E.B.
	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:*** 2006
5/4/2016	**107508629**	**$4,461.60**	11/13/15	ACCT: N00874504581 - $3,827.60; N00874642851 - $634.00	Payment amount based on $5,577.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/7/2016			***Patient Initials:*** B.M.
	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:*** 1985
4/28/2016	**107504670**	**$7,316.80**	12/14/15	ACCT: N00874776904 - $5,912.80; N00874930199 - $1,404.00	Payment amount based on $9,146.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** K.K.
	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:*** 1974

CHOCTAW MEMORIAL HOSPITAL ***Office of State Finance VendorID:*** 0000077143

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
11/21/2016	**107653020**	**$85.07**	06/27/16	ACCT: 10120171	Payment amount based on $313.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 33.97059% among all providers. ***Patient Initials:*** E.B.
	Mail To Address:	1405 E KIRK ST HUGO OK 74743-3603			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1987

10/11/2016	**107623968**	**$3,860.00**	10/6/16 - 10/7/16	ACCT: 10108072	Payment amount based on $4,825.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				***Patient Initials:*** J.B.
	Mail To Address:	1405 E KIRK ST HUGO OK 74743-3603			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1986

COMANCHE COUNTY MEMORIAL HOSPITAL ***Office of State Finance VendorID:*** 0000064418

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/18/2016	**107651841**	**$641.60**	7/5/14	ACCT: 2000267043-0001	Payment amount based on $802.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/21/2016				***Patient Initials:*** S.B.
	Mail To Address:	3401 W GORE BLVD LAWTON OK 73505-6332			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1991
7/25/2016	**107566880**	**$804.00**	03/03/16	ACCT: 2000687393-0001	Payment amount based on $1,005.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				***Patient Initials:*** L.C.
	Mail To Address:	3401 W GORE BLVD LAWTON OK 73505-6332			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1975
7/25/2016	**107566879**	**$7,474.03**	12/18/14 - 12/19/14	ACCT: 2000376389-0001	Payment amount based on $9,342.54 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				***Patient Initials:*** J.K.
	Mail To Address:	3401 W GORE BLVD LAWTON OK 73505-6332			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1965
6/20/2016	**107544833**	**$14,819.37**	11/28/15 - 01/06/16	ACCT: 2000613464 - $245.60; 2000617138 - $11,277.96; 2000639445 - $1,945.60; 2000612824 - $1,350.21	Payment amount based on $18,524.21 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** N.D.
	Mail To Address:	3401 W GORE BLVD LAWTON OK 73505-6332			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1984
6/20/2016	**107544831**	**$16,599.26**	09/16/15 - 03/03/16	ACCT: 2000562126 - $417.32; 2000560734 - $9,571.15; 2000585825 - $222.82; 200585832 - $4,088.65; 200060105 - $400.99; 2000599276 - $623.33; 2000613425 - $290.06; 2000677294 - $984.94	Payment amount based on $34,565.55 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 60.02819% among all providers.	***Patient Initials:*** L.B.
	Mail To Address:	3401 W GORE BLVD LAWTON OK 73505-6332			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1966
5/27/2016	**107528242**	**$5,816.27**	06/28/15	ACCT: 2000504529-0001	Payment amount based on $7,270.34 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				***Patient Initials:*** M.W.
	Mail To Address:	3401 W GORE BLVD LAWTON OK 73505-6332			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1992

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
9/30/2016	107617389	$58.63	03/21/15	ACCT: 2000437718-0001	Payment amount based on $5,486.25 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 1.33595% among all providers.	Patient Initials:	J.A.
	Mail To Address:	PO BOX 129 LAWTON OK 73502-0129			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1983
6/7/2016	107533955	$1,616.00	12/03/15 AND 12/29/15	ACCT: 2000616816-0001 - $1,521.60; 2000633981-0001 - $94.40	Payment amount based on $2,020.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/10/2016				Patient Initials:	C.B.
	Mail To Address:	PO BOX 129 LAWTON OK 73502-0129			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1990
6/7/2016	107533954	$2,969.40	09/13/14 - 09/28/14	ACCT: 2000311362 - $842.78; 2000316878 - $1,189.02; 2000318770 - $468.80; 2000318770 - $16.80; 20003214987 - $452.00	Payment amount based on $3,711.75 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/10/2016				Patient Initials:	T.M.
	Mail To Address:	PO BOX 129 LAWTON OK 73502-0129			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1961
6/7/2016	107533953	$2,251.90	04/02/15 AND 04/03/15	ACCT: 2000447411-0001 - $1,924.20; 2000446569-0001 - $327.70	Payment amount based on $2,814.88 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/10/2016				Patient Initials:	R.B.
	Mail To Address:	PO BOX 129 LAWTON OK 73502-0129			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1975
5/6/2016	107511030	$24.79	11/11/15	ACCT: 200066160-0001	Payment amount based on $30.99 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/9/2016				Patient Initials:	M.P.
	Mail To Address:	PO BOX 129 LAWTON OK 73502-0129			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1968
5/6/2016	107511031	$144.10	7/19/15	ACCT: 2000518499-0001	Payment amount based on $180.13 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/9/2016				Patient Initials:	A.J.
	Mail To Address:	PO BOX 129 LAWTON OK 73502-0129			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1992
4/28/2016	107504604	$11,818.83	04/28/15	ACCT: 2000464043-001	Payment amount based on $37,736.08 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 39.14963% among all providers.	Patient Initials:	K.H.
	Mail To Address:	PO BOX 129 LAWTON OK 73502-0129			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1982
4/28/2016	107504603	$16.47	03/16/16	ACCT: 2000672025-0001	Payment amount based on $339.54 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.064521% among all providers.	Patient Initials:	N.G.
	Mail To Address:	PO BOX 129 LAWTON OK 73502-0129			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year:	1965

4/28/2016	**107504602**	**$13,601.46**	07/05/15 - 07/15/15	ACCT: 2000513016-0001 - $680.00L 2000509031-0001 - $12,291.46	Payment amount based on $17,001.83 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** L.D.
	Mail To Address:	PO BOX 129 LAWTON OK 73502-0129			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1950

LAWTON MEDI-EQUIP ***Office of State Finance VendorID:*** 0000064418

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
6/20/2016	**107544832**	**$122.71**	10/13/15	ACCT: 40277	Payment amount based on $255.53 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 60.02819% among all providers. ***Patient Initials:*** L.B.
	Mail To Address:	924 NW 38TH ST. LAWTON OK 73505			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1966

GRADY MEMORIAL HOSPTAL ***Office of State Finance VendorID:*** 0000064451

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
8/26/2016	**107592789**	**$1,699.95**	08/16/15	ACCT: G000878809	Payment amount based on $2,124.94 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** S.M.
	Mail To Address:	2220 W IOWA AVE CHICKASHA OK 73018			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1995
6/8/2016	**107534964**	**$271.46**	8/16/15	ACCT: G000878808	Payment amount based on $339.33 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/11/2016			***Patient Initials:*** N.M.
	Mail To Address:	2220 W IOWA AVE CHICKASHA OK 73018			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1995
5/6/2016	**107511056**	**$195.07**	9/24/15	ACCT: G000885932 $68.94, G000890029 $126.13	Payment amount based on $243.84 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/9/2016			***Patient Initials:*** D.P.
	Mail To Address:	2220 W IOWA AVE CHICKASHA OK 73018			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1997
4/28/2016	**107504636**	**$1,774.46**	11/29/15	ACCT: G000899623	Payment amount based on $7,683.54 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.86783% among all providers. ***Patient Initials:*** C.S.
	Mail To Address:	2220 W IOWA AVE CHICKASHA OK 73018			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1978

HASKELL CO. HOSPITAL ***Office of State Finance VendorID:*** 0000064460

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

6/7/2016	**107533992**	**$89.49**	08/03/13	ACCT: 162877	Payment amount based on $111.86 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/10/2016			***Patient Initials:*** B.T.
	Mail To Address:	PO BOX 728 STIGLER OK 74462-0728			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1972

DEAN MCGEE EYE INSTITUTE ***Office of State Finance VendorID:*** 0000064505

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/16/2016	**107670766**	**$1,784.00**	02/19/16 AND 05/06/16	ACCT: 0000405400	Payment amount based on $2,230.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/19/2016			***Patient Initials:*** C.C.
	Mail To Address:	PO BOX 27167 SALT LAKE CITY UT 84127-0167			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1985
11/21/2016	**107653042**	**$6.19**	03/12/15	ACCT: 559504	Payment amount based on $15.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 51.57423% among all providers. ***Patient Initials:*** R.S.
	Mail To Address:	PO BOX 27167 SALT LAKE CITY UT 84127-0167			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1963
8/26/2016	**107592773**	**$168.00**	7/25/16	ACCT: 483820	Payment amount based on $210.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	8/29/2016			***Patient Initials:*** A.W.
	Mail To Address:	PO BOX 27167 SALT LAKE CITY UT 84127-0167			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1992

DEAN MCGEE EYE INSTITUTE ***Office of State Finance VendorID:*** 0000064505

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
7/20/2016	**107563631**	**$23.52**	01/29/16	ACCT: 577976	Payment amount based on $185.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 15.89261% among all providers. ***Patient Initials:*** J.K.
	Mail To Address:	PO BOX 26507 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1996
6/20/2016	**107544837**	**$489.60**	04/27/16 - 05/02/16	ACCT: 578486	Payment amount based on $625.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 97.91947% among all providers. ***Patient Initials:*** K.L.
	Mail To Address:	PO BOX 26507 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1956
6/20/2016	**107544836**	**$123.72**	07/29/15	ACCT: 569572	Payment amount based on $154.65 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/23/2016			***Patient Initials:*** E.B.
	Mail To Address:	PO BOX 26507 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1984
6/8/2016	**107534949**	**$87.70**	11-10-15 - 11/30/15	ACCT: 574470	Payment amount based on $109.63 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/11/2016			***Patient Initials:*** E.T.
	Mail To Address:	PO BOX 26507 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2015

5/27/2016	**107528257**	**$168.00**	07/01/14	ACCT: 548439	Payment amount based on $210.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/30/2016			***Patient Initials:*** A.C.
	Mail To Address:	PO BOX 26507 OKLAHOMA CITY OK 73126			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 2000

MC CURTAIN MEMORIAL HOSPITAL ***Office of State Finance VendorID:*** 0000064669

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
12/23/2016	**107675536**	**$5,968.56**	02/04/16	ACCT: 1072626 - $5,377.08; RAD1113038 - $591.48	Payment amount based on $7,460.70 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/26/2016			***Patient Initials:*** S.B.
	Mail To Address:	1301 E. LINCOLN RD IDABEL OK 74745-7300			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1962
11/30/2016	**107657864**	**$128.32**	09/12/15	ACCT: RAD2047644	Payment amount based on $160.40 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	12/3/2016			***Patient Initials:*** R.S.
	Mail To Address:	1301 E. LINCOLN RD IDABEL OK 74745-7300			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1972
11/15/2016	**107648866**	**$6,287.40**	01/03/16 AND 01/04/16	ACCT: 1069903 - $5,587.38; RAD1130971 - $700.02	Payment amount based on $7,859.25 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	11/18/2016			***Patient Initials:*** P.Q.
	Mail To Address:	1301 E. LINCOLN RD IDABEL OK 74745-7300			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1979
6/8/2016	**107535000**	**$438.00**	2/29/15	ACCT: 1062321	Payment amount based on $547.50 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/11/2016			***Patient Initials:*** K.S.
	Mail To Address:	1301 E. LINCOLN RD IDABEL OK 74745-7300			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1991
5/27/2016	**107528328**	**$5,168.54**	06/27/15 OR 07/02/15	ACCT: 1054222 - $4,610.38; RAD1124737 - $421.92; 1054674 - $136.24	Payment amount based on $6,460.68 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/30/2016			***Patient Initials:*** D.C.
	Mail To Address:	1301 E. LINCOLN RD IDABEL OK 74745-7300			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1993

PARKVIEW AMBULANCE ***Office of State Finance VendorID:*** 0000064670

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
7/20/2016	**107563783**	**$29.76**	02/17/16	ACCT: 108980903	Payment amount based on $1,647.75 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 2.25616% among all providers. ***Patient Initials:*** J.R.
	Mail To Address:	PO BOX 129 EL RENO OK 73036-0129			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1986

MERCY HOSPITAL EL RENO

Office of State Finance VendorID: 0000064670

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
7/20/2016	107563782	$1,134.12	9/6/15	ACCT: 106033010	Payment amount based on $1,417.65 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/23/2016				Patient Initials: K.R.
	Mail To Address:	2115 PARKVIEW DR. EL RENO OK 73036-0129			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1975
6/27/2016	107550434	$1,942.82	7/12/16	ACCT: 106245188	Payment amount based on $2,428.53 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				Patient Initials: R.C.
	Mail To Address:	2115 PARKVIEW DR. EL RENO OK 73036-0129			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1990

SHARE MEDICAL CENTER

Office of State Finance VendorID: 0000064693

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
1/23/2017	107688924	$1,660.98	09/17/16 AND 09/18/16	ACCT: V00000791372 - $176.80; V00000791388 - $1,484.18	Payment amount based on $6,815.36 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 30.46392% among all providers.	Patient Initials: L.B.
	Mail To Address:	PO BOX 727 ALVA OK 73717-0727			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1980

B&M MONUMENTS

Office of State Finance VendorID: 0000248799

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/26/2016	107592752	$356.49	03/07/16	ACCT: M.S.	Payment amount based on $356.49 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				Patient Initials: M.S.
	Mail To Address:	PO BOX 1196 LONE GROVE OK 73443				Patient Birth Year: 1985

CLINICAL PATHOLOGY LABORATORIES INC

Office of State Finance VendorID: 0000208045

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
9/30/2016	107617387	$53.52	10/16/15	ACCT: CW425511	Payment amount based on $218.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 30.61857% among all providers.	Patient Initials: Q.A.
	Mail To Address:	P O BOX 141669 AUSTIN TX 78714-1669			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1967
9/9/2016	107601278	$216.00	8/6/15	ACCT: OP279413	Payment amount based on $270.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				Patient Initials: P.B.
	Mail To Address:	P O BOX 141669 AUSTIN TX 78714-1669			Acceptance of payment may require a provider write-off. EOB will accompany payment.	Patient Birth Year: 1943

GIFFORD MONUMENT — *Office of State Finance VendorID:* 0000404589

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
8/4/2016	-107528281	($627.77)	10/21/15	ACCT: M.S. **VOIDED** ISSUED TO WRONG PROVIDER**	Payment amount based on ($627.77) patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/7/2016				*Patient Initials:* M.S.
	Mail To Address:	824 S. CHICKASAW PAULS VALLEY OK 73075				*Patient Birth Year:* 1985
5/27/2016	107528281	$627.77	10/21/15	ACCT: M.S.**VOIDED** ISSUED TO WRONG PROVIDER**	Payment amount based on $627.77 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				*Patient Initials:* M.S.
	Mail To Address:	824 S. CHICKASAW PAULS VALLEY OK 73075				*Patient Birth Year:* 1985

WILSON N. JONES MEMORIAL — *Office of State Finance VendorID:* 0000065088

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
7/25/2016	107567101	$7,432.66	07/05/15	ACCT: 0025429630-0001	Payment amount based on $9,290.83 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				*Patient Initials:* B.K.
	Mail To Address:	500 N HIGHLAND AVE SHERMAN TX 75092-7354			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1978

BROWN'S FUNERAL SERVICE — *Office of State Finance VendorID:* 0000409476

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
10/11/2016	107623960	$2,629.83	3/28/15	ACCT: N.V.	Payment amount based on $2,629.83 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	10/14/2016				*Patient Initials:* N.V.
	Mail To Address:	400 W. QUEEN AVE. COALGATE OK 74538				*Patient Birth Year:* 1975

HEARTPLACE — *Office of State Finance VendorID:* 0000187343

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers
11/21/2016	107653080	$26.46	12/21/15	ACCT: 815009	Payment amount based on $170.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 19.45485% among all providers.	*Patient Initials:* A.W.
	Mail To Address:	PO BOX 842464 DALLAS TX 75284-2464			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:* 1963

AMERICAN MEDICAL RESPONSE — *Office of State Finance VendorID:* 0000065467

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

6/8/2016	**107534906**	**$568.91**	11/26/15	ACCT: 862-15125116-01	Payment amount based on $711.14 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/11/2016				***Patient Initials:*** B.C.
	Mail To Address:	PO BOX 847925 DALLAS TX 75284-7102			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1978
4/28/2016	**107504551**	**$36.75**	12/16/15	ACCT: 001931581-0001	Payment amount based on $757.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 6.064521% among all providers.	***Patient Initials:*** N.G.
	Mail To Address:	PO BOX 847925 DALLAS TX 75284-7102			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1965

US ANESTHESIA PARTNERS — ***Office of State Finance VendorID:*** 0000187669

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
11/21/2016	**107653252**	**$743.55**	06/13/16	ACCT: 350415275	Payment amount based on $2,736.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 33.97059% among all providers.	***Patient Initials:*** E.B.
	Mail To Address:	PO BOX 660267 DALLAS TX 75266			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1987

KEY-WHITMAN EYE CENTER — ***Office of State Finance VendorID:*** 0000367659

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
4/22/2016	**107500198**	**$96.00**	08/31/15	ACCT: 118175-804286	Payment amount based on $120.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	4/25/2016				***Patient Initials:*** L.T.
	Mail To Address:	2801 LEMMON AVE W STE 400 DALLAS TX 75204			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1962

EMERGENCY STAFFING SOLUTIONS — ***Office of State Finance VendorID:*** 0000276638

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
6/7/2016	**107533978**	**$344.00**	08/22/13	ACCT: 0030345186	Payment amount based on $430.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** B.T.
	Mail To Address:	P O BOX 96408 OKLAHOMA CITY OK 73143-345			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1972
4/28/2016	**107504622**	**$240.33**	04/23/12	ACCT: 23805896	Payment amount based on $1,060.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 28.34055% among all providers.	***Patient Initials:*** A.B.
	Mail To Address:	P O BOX 96408 OKLAHOMA CITY OK 73143-345			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1990

AMR AIR AMBULANCE INC. — ***Office of State Finance VendorID:*** 0000405127

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

6/7/2016	**107533921**	**$4,937.82**	04/28/15	ACCT: 33582	Payment amount based on $6,172.28 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/10/2016				*Patient Initials:*	J.R.
	Mail To Address:	8001 S. INTERPORT BLVD. SUITE 150 ENGLEWOOD CO 80112			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1984

RESTHAVEN FUNERAL HOME — *Office of State Finance VendorID:* 0000065883

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
		$380.00	8/2/16	Cust. No: 5894	Payment amount based on $380.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				*Patient Initials:*	M.L.
	Mail To Address:	500 SW 104TH ST OKLAHOMA CITY OK 73139-5528				*Patient Birth Year:*	1989

BROKEN ARROW PHYSICAL THERAPY — *Office of State Finance VendorID:* 0000245688

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
6/20/2016	**107544816**	**$1,876.08**	01/04/16 - 04/06/16	ACCT: 0013005008	Payment amount based on $14,418.95 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 16.26405% among all providers.	*Patient Initials:*	L.H.
	Mail To Address:	3341 S ELM PLACE BROKEN ARROW OK 74012			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1977
4/22/2016	**107500166**	**$1,003.72**	12/05/12 - 04/10/13	ACCT: 0013002590	Payment amount based on $1,254.65 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	4/25/2016				*Patient Initials:*	K.T.
	Mail To Address:	3341 S ELM PLACE BROKEN ARROW OK 74012			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1950

HILLCREST HEALTH CENTER — *Office of State Finance VendorID:* 0000076409

Check Date:	*Check #:*	*Amount:*	*Service Date(s)*	*Provider Reference:*		*Patient Identifiers*	
11/21/2016	**107653085**	**$17,655.98**	06/17/16 AND 06/28/16	ACCT: A1616900011- $17,262.37; A1618000950 - $393.61	Payment amount based on $23,056.51 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 95.72122% among all providers.	*Patient Initials:*	J.R.
	Mail To Address:	DEPT 572 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1974
10/19/2016	**107630431**	**$955.82**	08/16/15	ACCT: A1522800242	Payment amount based on $1,194.78 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/22/2016				*Patient Initials:*	J.B.
	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
9/30/2016	**107617451**	**$16,685.00**	01/31/16 - 02/03/16	ACCT: A1603100022	Payment amount based on $26,617.14 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 78.35652% among all providers.	*Patient Initials:*	D.L.
	Mail To Address:	DEPT 572 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1979

9/9/2016	**107601352**	**$247.64**	7/4/14	ACCT: A1418500012	Payment amount based on $309.55 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	9/12/2016				***Patient Initials:*** W.T.
	Mail To Address:	DEPT 572 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1988
8/26/2016	**107592793**	**$7,199.20**	8/5/15	ACCT: 1521701006	Payment amount based on $8,999.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	8/29/2016				***Patient Initials:*** L.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:*** 1970
6/27/2016	**107550374**	**$7,722.36**	3/29/2015	ACCT: 1508800182	Payment amount based on $9,652.95 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/30/2016				***Patient Initials:*** K.M.
	Mail To Address:	DEPT 572 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1974
6/7/2016	**107533994**	**$3,474.80**	09/16/15 - 09/17/15	ACCT: A1525901300	Payment amount based on $4,343.50 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** T.R.
	Mail To Address:	DEPT 572 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1994
4/28/2016	**107504644**	**$11,698.77**	08/14/15 - 08/15/15	ACCT: A1522600028	Payment amount based on $14,623.46 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				***Patient Initials:*** N.M.
	Mail To Address:	DEPT 572 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1994
4/28/2016	**107504645**	**$16,481.92**	09/01/15 - 09/23/15	ACCT: A1524402001 - $15,580.66; A1525100204 - $901.27	Payment amount based on $23,682.30 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 86.99495% among all providers.	***Patient Initials:*** N.B.
	Mail To Address:	DEPT 572 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1984
4/28/2016	**107504643**	**$2,415.37**	07/29/14, 8/3/14-8/5/14 AND 4/14/15	ACCT: 912749 - $1,064.42; 912749 - $1,1117.58; A1509801046 - $233.37	Payment amount based on $3,019.21 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/1/2016				***Patient Initials:*** A.J.
	Mail To Address:	DEPT 572 TULSA OK 74182			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1971

CENTER FOR PSYCHOLOGICAL DEVELOPMENT ***Office of State Finance VendorID:*** 0000331455

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
7/25/2016	**107566871**	**$274.88**	12/03/15 - 01/21/16	ACCT: 20160217	Payment amount based on $343.60 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	7/28/2016				***Patient Initials:*** B.K.
	Mail To Address:	142 WEST MAIN DURANT OK 74701			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1978

5/27/2016	**107528228**	**$467.30**	01/14/16 - 02/09/16	ACCT: M.D.	Payment amount based on $584.13 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	5/30/2016				***Patient Initials:*** K.M.
	Mail To Address:	142 WEST MAIN DURANT OK 74701			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1968

SOUTHWEST RADIOLOGY ***Office of State Finance VendorID:*** 0000296161

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***
1/19/2017	**107686536**	**$588.00**	12/18/14 - 12/19/14	ACCT: 59000368898 - $438.40; 59000368880 - $35.20; 59000368905 - $114.40	Payment amount based on $735.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	1/22/2017				***Patient Initials:*** J.K.
	Mail To Address:	P O BOX 2309 SECTION #5 LAWTON OK 73502			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1965
6/20/2016	**107544951**	**$148.80**		ACCT: 4398*2000617138 - $29.60; 4398*2000639445 - $30.40; 4398*2000612824 - $88.80	Payment amount based on $186.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016				***Patient Initials:*** N.D.
	Mail To Address:	P O BOX 2309 SECTION #5 LAWTON OK 73502			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1984
6/20/2016	**107544950**	**$87.40**	09/16/15	ACCT: 4398*2000599276 - $17.77; 59000460948 - $36.02; 59000460951 - $33.61	Payment amount based on $182.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 60.02819% among all providers.	***Patient Initials:*** L.B.
	Mail To Address:	P O BOX 2309 SECTION #5 LAWTON OK 73502			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1966
6/7/2016	**107534060**	**$268.00**	12/03/15	ACCT: 59000460442 - $114.40; 59000460456 - $153.60	Payment amount based on $335.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** C.B.
	Mail To Address:	P O BOX 2309 SECTION #5 LAWTON OK 73502			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1990
6/7/2016	**107534059**	**$191.21**	09/13/14 AND 09/21/14	ACCT: 4398*2000316878 - $46.41; 59000400370 - $144.80	Payment amount based on $239.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** T.M.
	Mail To Address:	P O BOX 2309 SECTION #5 LAWTON OK 73502			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1961
6/7/2016	**107534058**	**$48.00**	04/03/15	ACCT: 4398*2000447411	Payment amount based on $60.00 patient balance after insurance and insurance adjustments.	
	Approx Mail Date:	6/10/2016				***Patient Initials:*** R.B.
	Mail To Address:	P O BOX 2309 SECTION #5 LAWTON OK 73502			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:*** 1975

5/27/2016	**107528401**	**$371.20**	06/28/15	ACCT: 4398*2000504529	Payment amount based on $464.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/30/2016			***Patient Initials:*** M.W.
	Mail To Address:	P O BOX 2309 SECTION #5 LAWTON OK 73502			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1992
4/28/2016	**107504728**	**$23.80**	04/28/15	ACCT: 1154585259	Payment amount based on $76.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 39.14963% among all providers. ***Patient Initials:*** K.H.
	Mail To Address:	P O BOX 2309 SECTION #5 LAWTON OK 73502			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1982
4/28/2016	**107504727**	**$496.80**	07/05/15 - 07/13/15	ACCT: 4398*2000509031	Payment amount based on $621.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/1/2016			***Patient Initials:*** L.D.
	Mail To Address:	P O BOX 2309 SECTION #5 LAWTON OK 73502			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1950

SERENITY FUNERALS & CREMATORY ***Office of State Finance VendorID:*** 0000302032

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
1/19/2017	**107686533**	**$3,711.15**	11/12/15	ACCT: J.W.B.	Payment amount based on $3,711.15 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	1/22/2017			***Patient Initials:*** J.B.
	Mail To Address:	4170 E. ADMIRAL PL. TULSA OK 74115			***Patient Birth Year:*** 1944
6/27/2016	**107550453**	**$610.76**	4/10/16	ACCT: J.R.	Payment amount based on $610.76 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	6/30/2016			***Patient Initials:*** J.R.
	Mail To Address:	4170 E. ADMIRAL PL. TULSA OK 74115			***Patient Birth Year:*** 1968

CENTER FOR PSYCHOLOGICAL DEVELOPMENT ***Office of State Finance VendorID:*** 0000335286

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
5/24/2016	**107524565**	**$1,099.52**	8/20/15 - 2/18/16	ACCT: 20160216	Payment amount based on $1,374.40 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/27/2016			***Patient Initials:*** N.D.
	Mail To Address:	1105 MEMORIAL DRIVE STE 202 DENISON TX 75020-2043			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1995

TEXOMA EMERGENCY PHYSICIANS ***Office of State Finance VendorID:*** 0000345985

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
		$137.66	8/18/16	TEP307931	Payment amount based on $172.08 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17			***Patient Initials:*** K.W.
	Mail To Address:	PO BOX 8775 FORT WORTH TX 76124-0775			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1961

Check Date:	Check #:	Amount:	Service Date(s)	Provider Reference:		Patient Identifiers	
		$585.60	7/22/15	Acct#63-E002701295	Payment amount based on $732.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	Requested from OSF 1/19/17 Expected to be mailed by 2/2/17				*Patient Initials:*	S.B.
	Mail To Address:	PO BOX 678216 DALLAS TX 75267-8216			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1994
1/23/2017	**107688902**	**$744.01**	05/02/16	ACCT: 63-E002742631	Payment amount based on $1,127.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 82.52151% among all providers.	*Patient Initials:*	A.A.
	Mail To Address:	PO BOX 678216 DALLAS TX 75267-8216			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1956
1/23/2017	**107688903**	**$34.03**	07/28/16	ACCT: 63-E002754547	Payment amount based on $915.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 4.64847% among all providers.	*Patient Initials:*	A.T.
	Mail To Address:	PO BOX 678216 DALLAS TX 75267-8216			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1972
1/23/2017	**107688901**	**$561.06**	08/25/15	ACCT: 63-E002700552	Payment amount based on $701.33 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017				*Patient Initials:*	D.D.
	Mail To Address:	PO BOX 678216 DALLAS TX 75267-8216			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1994
1/20/2017	**107687692**	**$516.00**	5/26/16	63-E002746275	Payment amount based on $645.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/23/2017				*Patient Initials:*	W.M.
	Mail To Address:	PO BOX 678216 DALLAS TX 75267-8216			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1964
11/21/2016	**107653191**	**$97.78**	01/28/15	ACCT: 3848-QQOU1	Payment amount based on $237.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 51.57423% among all providers.	*Patient Initials:*	R.S.
	Mail To Address:	PO BOX 678216 DALLAS TX 75267-8216			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1963
11/21/2016	**107653192**	**$51.14**	01/22/16	ACCT: 63-E002727825	Payment amount based on $1,162.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	11/24/2016			Total Bills exceed maximum award. Payment is prorated at 5.50147% among all providers.	*Patient Initials:*	J.L.
	Mail To Address:	PO BOX 678216 DALLAS TX 75267-8216			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1970
9/30/2016	**107617562**	**$5.83**	03/21/15	ACCT: 12809-QQOU1	Payment amount based on $545.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 1.33595% among all providers.	*Patient Initials:*	J.A.
	Mail To Address:	PO BOX 678216 DALLAS TX 75267-8216			Acceptance of payment may require a provider write-off. EOB will accompany payment.	*Patient Birth Year:*	1983

9/30/2016	**107617560**	**$262.73**	01/05/14		ACCT: QOU99900295388	Payment amount based on $416.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016				Total Bills exceed maximum award. Payment is prorated at 78.94467% among all providers.	***Patient Initials:***	S.A.
	Mail To Address:	PO BOX 678216 DALLAS	TX	75267-8216		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1960
9/30/2016	**107617561**	**$636.00**	01/05/14		ACCT: QOU00646473695	Payment amount based on $795.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016					***Patient Initials:***	A.J.
	Mail To Address:	PO BOX 678216 DALLAS	TX	75267-8216		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1988
9/9/2016	**107601477**	**$412.80**	6/6/15		ACCT:63-E002694578	Payment amount based on $516.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	9/12/2016					***Patient Initials:***	B.P.
	Mail To Address:	PO BOX 678216 DALLAS	TX	75267-8216		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1989
9/9/2016	**107601478**	**$585.60**	09/04/15		ACCT: 63-E901311319	Payment amount based on $732.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	9/12/2016					***Patient Initials:***	T.M.
	Mail To Address:	PO BOX 678216 DALLAS	TX	75267-8216		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1982
8/3/2016	**107573724**	**$27.64**	4/7/16		ACCT: 63-W000165813	Payment amount based on $34.55 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016					***Patient Initials:***	T.G.
	Mail To Address:	PO BOX 678216 DALLAS	TX	75267-8216		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1969
8/3/2016	**107573725**	**$113.44**	3/18/16		ACCT: 63-E901032730	Payment amount based on $141.80 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	8/6/2016					***Patient Initials:***	J.B.
	Mail To Address:	PO BOX 678216 DALLAS	TX	75267-8216		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1991
6/20/2016	**107544927**	**$332.93**	02/02/16		ACCT: 63-E002727656	Payment amount based on $425.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016				Total Bills exceed maximum award. Payment is prorated at 97.91947% among all providers.	***Patient Initials:***	K.L.
	Mail To Address:	PO BOX 678216 DALLAS	TX	75267-8216		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1956
6/20/2016	**107544925**	**$166.12**	07/27/15		ACCT: 63-E002702099	Payment amount based on $207.65 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016					***Patient Initials:***	E.B.
	Mail To Address:	PO BOX 678216 DALLAS	TX	75267-8216		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1984
6/20/2016	**107544926**	**$105.65**	09/27/15		ACCT: 63E002711268	Payment amount based on $732.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016				Total Bills exceed maximum award. Payment is prorated at 18.0406% among all providers.	***Patient Initials:***	J.G.
	Mail To Address:	PO BOX 678216 DALLAS	TX	75267-8216		Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1986

4/28/2016	**107504705**	**$139.97**	10/13/14	ACCT: Z24FYD9	Payment amount based on $545.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016			Total Bills exceed maximum award. Payment is prorated at 32.10316% among all providers.	***Patient Initials:***	J.A.
	Mail To Address:	PO BOX 678216 DALLAS TX 75267-8216			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1964

FAIRFAX MEDICAL FACILITIES INC — ***Office of State Finance VendorID:*** 0000249922

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
7/20/2016	**107563650**	**$55.69**	02/02/16, 03/01/16 AND 03/02/16	ACCT: 237147 - $27.34; 237358 - $12.71; 233984 - $15.64	Payment amount based on $438.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	7/23/2016			Total Bills exceed maximum award. Payment is prorated at 15.89261% among all providers.	***Patient Initials:***	J.K.
	Mail To Address:	212 NORTH MAIN STREET FAIRFAX OK 74637			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1996

MANE SUPPORT, INC. — ***Office of State Finance VendorID:*** 0000403801

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
4/28/2016	**107504660**	**$420.00**	10/15/15 - 12/17/15	ACCT: 2016-1	Payment amount based on $525.00 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	5/1/2016				***Patient Initials:***	B.C.
	Mail To Address:	2919 DAVIS FORD ROAD MARYVILLE TN 37804-2322			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	2009

ROCKY MOUNTAIN HOLDINGS, LLC — ***Office of State Finance VendorID:*** 0000066696

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***		***Patient Identifiers***	
1/23/2017	**107688950**	**$9,162.88**	07/03/16	ACCT: 16-114811	Payment amount based on $46,888.13 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	1/26/2017			Total Bills exceed maximum award. Payment is prorated at 24.4275% among all providers.	***Patient Initials:***	B.H.
	Mail To Address:	PO BOX 713375 CINCINNATI OH 45271-3375			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1977
9/30/2016	**107617598**	**$580.45**	03/21/15	ACCT: 15-44118	Payment amount based on $54,311.04 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 1.33595% among all providers.	***Patient Initials:***	J.A.
	Mail To Address:	PO BOX 713375 CINCINNATI OH 45271-3375			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1983
6/20/2016	**107544973**	**$2,936.87**	07/12/15	ACCT: 15-114468	Payment amount based on $37,040.49 patient balance after insurance and insurance adjustments.		
	Approx Mail Date:	6/23/2016			Total Bills exceed maximum award. Payment is prorated at 9.911015% among all providers.	***Patient Initials:***	G.C.
	Mail To Address:	PO BOX 713375 CINCINNATI OH 45271-3375			Acceptance of payment may require a provider write-off. EOB will accompany payment.	***Patient Birth Year:***	1989

ANETHESIOLOGY CONSULTANTS — ***Office of State Finance VendorID:*** 0000404122

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

5/4/2016	**107508527**	**$122.70**	03/22/15	ACCT: 718152	Payment amount based on $153.38 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/7/2016			***Patient Initials:*** C.B.
	Mail To Address:	PO BOX 50209 HENDERSON NV 89016-0209			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1962

NEVADA ORTHOPEDIC & SPINE CENTER — ***Office of State Finance VendorID:*** 0000404120

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
5/4/2016	**107508628**	**$125.23**	3/22/15, 4/9/15, 4/30/15	ACCT: 568850	Payment amount based on $156.54 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	5/7/2016			***Patient Initials:*** C.B.
	Mail To Address:	7455 W WASHINGTON AVE, STE 160 LAS VEGAS NV 89128-4356			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1962

BITANOR, INC. — ***Office of State Finance VendorID:*** 0000296320

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/9/2016	**107601245**	**$72.11**	04/11/15 - 04/15/15	ACCT: T.B.	Payment amount based on $90.14 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	9/12/2016			***Patient Initials:*** T.B.
	Mail To Address:	204 S. RIVERSIDE DR. MOORE OK 73160-1237			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1993

UNIVERSITY PHYSICIANS — ***Office of State Finance VendorID:*** 0000409149

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
9/30/2016	**107617612**	**$695.16**	06/08/15 - 06/10/15	ACCT: 15278251 - $526.52; 1700494 - $168.64	Payment amount based on $2,838.00 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	10/3/2016			Total Bills exceed maximum award. Payment is prorated at 30.61857% among all providers. ***Patient Initials:*** Q.A.
	Mail To Address:	PO BOX 808945 KANSAS CITY MO 64180-8945			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1967

CEDARS SINAI MED CTR — ***Office of State Finance VendorID:*** 0000350963

Check Date:	***Check #:***	***Amount:***	***Service Date(s)***	***Provider Reference:***	***Patient Identifiers***
7/20/2016	**107563604**	**$9.97**	4/25/16	acct: 411612730	Payment amount based on $12.46 patient balance after insurance and insurance adjustments.
	Approx Mail Date:	7/23/2016			***Patient Initials:*** M.C.
	Mail To Address:	PO BOX 512717 LOS ANGELES CA 90051			Acceptance of payment may require a provider write-off. EOB will accompany payment. ***Patient Birth Year:*** 1967