C.1

Please Read Instructions on Reverse Side of Yellow copy

Please print in ink or type

Arkansas State Claims Commission

MAY 17 2016

RECEIVED

BEFORE THE STATE CLAIMS COMMISSION

Of the State of Arkansas

☒ Mr.
☐ Mrs.
☐ Ms.
☐ Miss

Donald Oswald and Karen Oswald, ~~his wife~~, Claimants

vs.

State of Arkansas, Respondent

Ark. Highway Dept.

Do Not Write in These Spaces

Claim No. 16-0752-CC

Date Filed May 17, 2016 (Month) (Day) (Year)

Amount of Claim $ 375,500.00

Fund AHTD

Property Damage (v)
Personal Injury
Pain & Suffering

COMPLAINT

Donald and Karen Oswald (Name), the above named Claimant, of 205 E. Oak (Street or R.F.D. & No.), Bono (City), AR (State) 72416 (Zip Code) (Daytime Phone No.), County of Craighead, represented by Attorney Noyl Houston (Legal Counsel, if any, for Claim) of PO Box 3076 (Street and No.), Jonesboro (City), AR (State) 72403 (Zip Code), (870) 935-3730 (Phone No.), (870) 935-0006 (Fax No.), says:

State agency involved: Arkansas Highway and Transportation Department Amount sought: $375,500.00

Month, day, year and place of incident or service: March 3, 2014, US Hwy. 63, Bono, Craighead County, AR

Explanation:

SEE "ATTACHMENT A" attached hereto and incorporated by reference herein for description of claim:

"ATTACHMENTS B-F" Re: Insurance payments and documentation are also attached hereto and incorporated by reference herein.

As parts of this complaint, the claimant makes the statements, and answers the following questions, as indicated: (1) Has claim been presented to any state department or officer thereof? No. (Yes or No); when? _____ (Month) (Day) (Year); to whom? _____ (Department); and that the following action was taken thereon: _____

and that $ _____ was paid thereon: (2) Has any third person or corporation an interest in this claim? No.; if so, state name and address _____ (Name) _____ (Street or R.F.D. & No.) _____ (City) _____ (State) _____ (Zip Code)

and that the nature thereof is as follows: _____; and was acquired on _____, in the following manner: _____

THE UNDERSIGNED states on oath that he or she is familiar with the matters and things set forth in the above complaint, and that he or she verily believes that they are true.

Donald Oswald
(Print Claimant/Representative Name)
Donald Oswald, Claimant

By: Noyl Houston
DONALD AND KAREN OSWALD, CLAIMANTS
Noyl Houston, Attorney
PO Box 3076, Jonesboro, AR 72403

Karen Oswald
Karen Oswald, Claimant
(SEAL)

SWORN TO and subscribed on this 13th day of May, 2016
(Date) (Month) (Year)

Lisa M. Westmoreland
(Notary Public)

OFFICIAL SEAL - #12692133
Lisa M. Westmoreland
CRAIGHEAD COUNTY
EXPIRES: 11-19-2025

My Commission Expires: November 19, 2025
(Month) (Day) (Year)

SF1- R[illegible]

ATTACHMENT "A"

TO

Complaint of Claimants, Donald Oswald and Karen Oswald

FACTS

At approximately 5:59 p.m. on March 3, 2014, Donald Oswald ("Oswald") was southbound on U.S. Highway 63 enroute to the hospital because his mother-in-law had broken her hip. The highway was icy from sleet. An Arkansas Highway and Transportation Department ("AHTD") snowplow truck operated by Jeff Armstrong was northbound on Highway 63 traveling down "Bono Hill" at excessive speed, too fast for the conditions, lost control, and veered suddenly across the centerline, into the oncoming (southbound) lanes, hitting the small pickup operated by Oswald in the left rear quarter panel, causing it to spin violently, resulting in severe and permanent injuries to his neck, back, shoulder, arms and wrists as hereinafter described, as well as damage (total loss) to his pickup.

LIABILITY

As Armstrong was employed by AHTD (collectively, "AHTD"), and he was acting within the scope of his employment at the time of such collision, his negligence is imputed to AHTD.

AHTD is guilty of negligence which was the proximate cause of the collision described above and of the injuries and damages to Claimants, such negligence being hereinafter described in the following particulars:

A. Driving at a speed that was greater than was reasonable and prudent under the circumstances;

B. Failing to keep its truck under proper control;

C. Failing to yield the right-of-way to the oncoming vehicle operated by Oswald;

D. Improperly crossing the center line into the path of Oswald's vehicle;

E. Operating its truck in violation of the following Arkansas statutes:

1) A.C.A. 27-51-201 (Driving at a Speed Greater than is Reasonable and Prudent under Existing

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Conditions);

2) A.C.A. 27-51-501 (Driving Left of Center);

3) A.C.A. 27-51-104 (Careless and Prohibited Driving); and

F. It was otherwise negligent.

PERSONAL INJURY

That as a direct and proximate result of the negligence of ATHD as described above, Oswald suffered severe and permanent injuries to his neck, back, shoulder, arms and wrists, including, but not limited to, the following:

A. Cervical radiculopathy at C3-4 with cord compression resulting in neck pain radiating into his arms and hands requiring cervical discectomy with fusion at C3-C4, as well as bulging discs at C4-5 and C5-6;

B. Either entrapment, or aggravation of previously asymptomatic entrapment, of median and ulnar nerves in Oswald's arms and wrists with resulting numbness requiring surgery on both wrists; and

C. Aggravation of pre-existing low back condition with bulging disc at L4-L5, annular tear, and radiculopathy resulting in radiating low back pain into Oswald's buttocks and legs, among other things.

That in addition to the above injuries, Oswald has suffered permanent injury to his neck, back and upper extremities with residual consequences thereof; that Oswald has had considerable medical expenses to date, and he will have additional medical expense in the future with periodic therapy and analgesics; that Oswald has undergone tremendous pain, suffering and mental anguish, and he will undergo pain, suffering and mental anguish in the future, all to Oswald's damage in at least the sum of $350,000.00, which should be awarded him from AHTD.

Additionally, Oswald's wife, Karen Oswald, has suffered a loss of consortium due to a partial loss of the services, society, companionship of her husband due to the severe and permanent injuries to him, and as a result of which she has suffered damages in the sum

of $25,000.00, which should be awarded her from AHTD.

PROPERTY DAMAGE

That additionally, as the payment to Oswald by State Farm, his insurance carrier, for the total loss of his pickup proximately caused by the negligence of AHTD was reduced by the $500.00 policy deductible, such $500.00 deductible should be awarded him from AHTD.

EXHAUSTION OF REMEDIES

Oswald has exhausted his remedies against insurers, as follows:

A. The AHTD driver, Jeff Armstrong, was excluded from coverage by policy language for operating his employer's vehicle. See letter dated August 7, 2014, of Safeco Insurance. Attached hereto as "Attachment B";

B. Oswald had insurance on his pickup with State Farm Insurance Company (paid for by him) which paid him the following:

1. Comprehensive coverage on vehicle paid $1,985.00 for the total loss of his truck ($3,085.00 less $500.00 deductible and $600.00 for salvage). See letter dated April 29, 2016, from State Farm adjuster, Sartini Sounthavanh, attached hereto as "Attachment C".

2. $5,000.00 limit of medical payments coverage was exhausted. See letter dated April 11, 2014 and payments log from State Farm adjuster Melody Suthers attached hereto, collectively, as "Attachment "D".

3. $25,000.00 limit of uninsured motorist coverage was paid. See August 29, 2014, letter from St. Farm adjuster, Janice Shed, confirming $25,000.00 UM limit offer with State Farm checks totaling $25,000.00 attached hereto, collectively, as "Attachment E". From such proceeds Medicaid was reimbursed the $9,032.37 in benefits paid, attorney's fees of $8,333.33, and costs to date of $351.46, were paid, leaving a reserve balance for additional costs and medical expenses of $7,282.94.

C. Arkansas Medicaid has paid $9,032.37 toward Oswald's medical expenses. A copy of the September 4, 2014 and May 13, 2016

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letters from Arkansas DHS with demand for $5,641.78 in Medicaid payments, and an additional $3,390.59 in Medicaid payments, respectively, with payment logs, are attached hereto, collectively, as "Attachment F". Medicaid payments are also shown on medical bills provided contemporaneously herewith.

Of the $75,129.90 in medical expenses, $14,896.99 in medical bills remain unpaid by insurance (St. Farm or Medicaid, including adjustments for Medicaid) as noted on the List of Medical Expenses filed contemporaneously herewith.

Claimants pray for recovery of their $500.00 deductible for the total loss of their vehicle; Claimant Donald Oswald prays for $350,000.00 for personal injury; and Claimant Karen Oswald prays for $25,000.00 for loss of consortium.

Safeco Insurance
A Liberty Mutual Company

Safeco Insurance Company of Illinois
Safeco Insurance
PO Box 515097
Los Angeles, CA 90051

Mailing Address:
PO Box 515097
Los Angeles, CA 90051

Phone: (636) 326-8631
Fax: (888) 268-8840

August 7, 2014

Houston Law Firm
Po Box 3076
Jonesboro, AR 72403

Insured Name:	Jeff Armstrong & Sherry Armstrong
Policy Number:	F2063313
Loss Date:	March 3, 2014
Claim Number:	551657665037
Your Client:	Don Oswald

Dear Mr. Houston:

We want to let you know we have completed our investigation of Don Oswald's injury claim.

Under Mr. Armstrong's policy form SA-1852/AREP 5/11, coverage for liability is excluded since he was maintain or using a vehicle while employed or otherwise engaged in any business (trade, professions, or occupation. He is employed by the Arkansas Department of Transportation and while clearing the ice and snow from the road while driving a vehicle owned by the DOT. Per Part A, Exclusions A.8:

8. Any **insured** maintaining or using any vehicle while that **insured** is employed or otherwise engaged in any **business** (other than farming or ranching) not described in exclusions **A.6.** or **A.7.** This exclusion **(A.8.)** does not apply to the maintenance or use of a:
   a. private passenger auto;
   b. pickup, motorhome or van that:
      (1) you own; or
      (2) you do not own while used as a temporary substitute for **your covered auto** which is out of normal use because of its:
         (a) breakdown;
         (b) repair;
         (c) servicing;
         (d) loss; or
         (e) destruction; or
      c. **trailer** used with a vehicle described in **A.8.a.** or **A.8.b.** above.

ATTACHMENT "B"

The investigation we conducted found there is no coverage under this policy for this accident since Mr. Armstrong was driving his employer's vehicle in the course of business that was not listed on the policy Therefore, we are unable to pay for his damages.

If you believe there is additional information or circumstances we didn't include in our evaluation or have any questions about this decision, please contact me at the information below. I'd be more than happy to discuss this matter with you.

Sincerely,

Robert Miller
Safeco Insurance
Safeco Insurance Company of Illinois
(636) 326-8631 Fax: (888) 268-8840
Robert.Miller@Safeco.com

Providing Insurance and Financial Services
Home Office, Bloomington, IL

April 29, 2016

Don Oswald
PO Box 15
Bono AR 72416-0015

State Farm Claims
PO Box 52250
Phoenix AZ 85072-2250

RE: Claim Number: 04-419D-693
Date of Loss: March 03, 2014
Our Insured: Don Oswald
Vehicle: 1994 Toyo STANDARD 4X2
VIN: 4TARN81A2RZ241304
Mileage: 251559 (observed at the time of inspection)

Dear Don Oswald:

Your policy provides for payment of the actual cash value of your vehicle, less any applicable deductible. Actual cash value is determined by the market value, age, mileage and the condition of your vehicle at the time the loss occurred.

To assist us in determining actual cash value, we consider information obtained by our representatives, information provided by you, vehicle valuation services, and other sources. If you have additional information you wish us to consider, or if you believe we have not correctly determined the actual cash value of your vehicle, please contact us.

The amount payable to you was determined as follows:

Actual Cash Value	$3,075.00
Plus: Taxes	$0.00
Title Transfer:	$10.00
Less: Deductible	$500.00
Payment to Lienholder (if applicable)	$0.00
Owner Retained Salvage	$600.00
Total Net Payable to You:	$1,985.00

As a State Farm® policyholder, you can enjoy the benefits of online registration. Benefits include checking the status of your claim online; managing your insurance information and accounts; and staying connected to State Farm. Just go to **statefarm.com®** to get registered. All you need to complete the process is your State Farm policy or account number, your email address, and about five minutes. If you are already registered, thank you!

ATTACHMENT "C"

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Thank you for choosing State Farm for your insurance needs.

Sincerely,

Santini Sounthavanh
Claim Representative
(800) 869-4136 Ext. 6156923742
Fax: (855) 666-0964

State Farm Mutual Automobile Insurance Company

Providing Insurance and Financial Services
Home Office, Bloomington, IL

StateFarm®

April 11, 2014

Don Oswald
PO Box 15
Bono AR 72416-0015

State Farm Claims
P.O. Box 661001
Dallas TX 75266-1001

RE: Claim Number: 04-419D-693
Date of Loss: March 03, 2014
Our Insured: Don Oswald
Injured Party: Don Oswald

Dear Don Oswald:

We are writing to you to provide status on the handling of your Medical Payments Coverage claim.

The Medical Payments Coverage limits have been exhausted on behalf of Don Oswald. Maximum benefits payable per individuals are $5,000.00, and final payment was made on April 11, 2014. Enclosed is a Payment Log which lists payment(s) made.

If there is other insurance coverage available, you may wish to consider submitting your future bills to that company.

If you have any questions, please contact us.

Sincerely,

Melody Suthers
Claim Processor
(866) 227-0010 Ext. 8162468056
Fax: (800) 726-4093

State Farm Mutual Automobile Insurance Company

Enclosure: Payment Log

ATTACHMENT "D"

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Payment Log
04-11-2014

Payment/ Recovery Date	Payment/ Recovery Number	Payee	Billed Amount	Date Bill Received	Date From	Date To	Coverage Description	Paid Amount
04-11-14	122072989J	NEA BAPTIST MEMORIAL	$5,733.00	04-08-14	03-25-14	03-25-14	Medical Payment	$4,163.45
04-10-14	122071117J	DR'S ANATOMIC PATHOLOGY	$5.25	04-08-14	03-25-14	03-25-14	Medical Payment	$2.55
03-18-14	122042168J	EMERSON AMBULANCE SERVICE INC	$834.00	03-12-14	03-03-14	03-03-14	Medical Payment	$834.00

Providing Insurance and Financial Services
Home Office, Bloomington, IL

StateFarm®

August 29, 2014

Houston Law Firm
PO Box 3076
Jonesboro AR 72403-3076

State Farm Claims
P. O. Box 661001
Dallas TX 75266-1001

RE: Claim Number: 04-419D-693
Date of Loss: March 03, 2014
Our Insured: Don Oswald
Your Client(s): Don Oswald

Dear Mr. Houston:

We are extending an offer to Mr. Oswald for policy limits of $25,000 for his Underinsured Motorist Claim. Our records reflect Mr. Oswald receives Medicaid benefits and St Bernard's file a medical lien.

Please contact me to discuss at your earliest convenience.

Sincerely,

Janice Shed
Claim Representative
(877) 494-2450
Fax: (888) 650-1919

State Farm Mutual Automobile Insurance Company

ATTACHMENT "E"

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STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY
CENTRAL
CZ INJURY OFFICE P22069PCL22

JPMORGAN CHASE BANK, NA 56-1544/441
COLUMBUS, OH 43240

1 22 254721 J

CLAIM NO 04-419D-693
LOSS DATE 03-03-2014

INSURED OSWALD, DON & LINDA K

DATE 09-12-2014
MM DD YYYY

**********EXACTLY
NETEEN THOUSAND THREE HUNDRED FIFTY-EIGHT AND 22/100 DOLLARS

$****19,358.22

Pay to the
Order of: DON OSWALD & HOUSTON LAW FIRM, HIS ATTORNEY

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

VOID IF GREEN COLORED BACKGROUND IS MISSING

SECURED DOCUMENT WATERMARK APPEARS ON BACK, HOLD AT 45° ANGLE FOR VIEWING

⑈ 2217254721⑈ ⑆044115443⑆ 627119630⑈

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY
CENTRAL
CZ INJURY OFFICE P22069PCL22

JPMORGAN CHASE BANK, NA 56-1544/441
COLUMBUS, OH 43240

1 22 254717 J

CLAIM NO 04-419D-693
LOSS DATE 03-03-2014

INSURED OSWALD, DON & LINDA K

DATE 09-12-2014
MM DD YYYY

****EXACTLY FIVE THOUSAND SIX HUNDRED FORTY-ONE AND 78/100 DOLLARS

$*****5,641.78

Pay to the
Order of: ARKANSAS DEPARTMENT OF HUMAN SERVICES

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

VOID IF GREEN COLORED BACKGROUND IS MISSING

SECURED DOCUMENT WATERMARK APPEARS ON BACK, HOLD AT 45° ANGLE FOR VIEWING

⑈ 2217254717⑈ ⑆044115443⑆ 627119639⑈

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Third Party Liability Unit

P.O. Box 1437, Slot S-296 Little Rock, AR 72203-1437
501-537-1070 · Fax: 501-682-1644

September 4, 2014

NOYL HOUSTON
HOUSTON LAW FIRM, P.A.
P O BOX 3076
JONESBORO, AR 72403

STATE FARM INSURANCE
P O BOX 661001
DALLAS, TX 75266

RE: Donald Oswald
CASE #: 155357
INSURED: Unknown
CLAIM#: 04-419D-693

Dear Sir or Madam:

We have been notified that you represent the above recipient concerning an accident/incident on March 3, 2014. Donald Oswald is a Medicaid recipient and Medicaid has made payments in the amount of **$5,641.78** in connection with that accident/incident. For your convenience, an itemized listing of the payments is enclosed. **This letter supersedes all previous correspondence from our office to date.**

NOTE: Providers of service have one (1) year from the date of service to bill Medicaid for reimbursement. Please notify this office in advance of settlement to ensure the Medicaid amount is the correct updated amount. If you fail to notify us prior to settlement you may be responsible for additional payments made between the last letter received and the settlement date.

As a condition of Medicaid eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award, which may be obtained against any third party to the Arkansas Department of Human Services to the extent of any amount which may be paid by Medicaid for the benefit of the applicant.

When an action or claim is brought by a medical assistance recipient or his legal representative against a third party who may be liable for injury, disease, disability, or death of a medical assistance recipient, any settlement, judgment, or award obtained is subject to the division's claims for reimbursement of the benefits provided to the recipient under the medical assistance program.

kv

ATTACHMENT "F"

No judgment, award, or settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease, or disability, in which the department has interest, shall be satisfied without first giving the department notice and a reasonable opportunity to establish its interest.

The Department of Human Services has an interest in this matter. Since we have a claim, please provide reasonable notice of all settlement negotiations and hearings so the department can take appropriate actions to protect the interest of the Medicaid Program. If you contend any of the payments listed are for services not attributable to your client's claim, please notify us immediately.

We appreciate your cooperation in this matter. Please do not hesitate to contact us at (501) 537-3424 should you have any questions.

Sincerely,

Kathryn Veasley

Kathryn Veasley, Quality Assurance Coordinator
Division of Medical Services
Administrative Services Section
Third Party Liability Unit

KV:pc

Arkansas Title XIX
Recipient Profile Request

From Date of Service: 3/3/2014 12:00:00 AM

To Date of Service: 9/4/2014 12:00:00 AM

mplete Recipient Name and ID - 8085042101 - OSWALD, DONALD

Date of Birth - 5/1/1952

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
123512407 - WAL MART PHARMACY 10-0128	D	0514065313482	1	D ZZZ -	A	-	00406036505 - HYDROCODON-ACETAMINOPHEN 5-325	3/6/14	3/6/14	$24.20	$14.12	$1.00	$0.00	$13.12	20140313	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.
		0514065313482							Total:	$24.20	$14.12	$1.00	$0.00	$13.12			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
123512407 - WAL MART PHARMACY 10-0128	D	0514092303477	1	D ZZZ -	A	-	00228202750 - ALPRAZOLAM 0.25 MG TABLET	4/2/14	4/2/14	$14.53	$9.19	$0.50	$0.00	$8.69	20140410	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.
		0514092303477							Total:	$14.53	$9.19	$0.50	$0.00	$8.69			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
123512407 - WAL MART PHARMACY 10-0128	D	0514092305039	1	D ZZZ -	A	-	00603533715 - PREDNISONE 5 MG TABLET	4/2/14	4/2/14	$16.23	$6.21	$0.50	$0.00	$5.71	20140410	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.
		0514092305039							Total:	$16.23	$6.21	$0.50	$0.00	$5.71			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
123512407 - WAL MART RMACY -128	D	0514092321727	1	D ZZZ -	A	-	53746020301 - OXYCODONE - ACETAMINOP HEN 5-325	4/2/14	4/2/14	$41.77	$25.96	$2.00	$0.00	$23.96	20140410	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.
		0514092321727							Total:	$41.77	$25.96	$2.00	$0.00	$23.96			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
123512407 - WAL MART PHARMACY 10-0128	D	0514133336631	1	D ZZZ -	A	-	00406036505 - HYDROCODO N- ACETAMINOP HEN 5-325	5/13/14	5/13/14	$31.25	$16.99	$1.00	$0.00	$15.99	20140522	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.
		0514133336631							Total:	$31.25	$16.99	$1.00	$0.00	$15.99			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
123512407 - MART MACY 10-0128	D	0514152323358	1	D ZZZ -	A	-	00406036601 - HYDROCODO N- ACETAMINOP H 7.5-325	6/1/14	6/1/14	$28.92	$18.73	$1.00	$0.00	$17.73	20140612	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.
		0514152323358							Total:	$28.92	$18.73	$1.00	$0.00	$17.73			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514153059839	1	99245 1 ZZZ - Patient office consultation, typically 80 minutes	A	7244 - THORACIC OR LUMBOSACRAL NEURITIS OR RADI	-	5/28/14	5/28/14	$301.00	$123.20	$0.00	$0.00	$123.20	20140612	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514153059839							Total:	$301.00	$123.20	$0.00	$0.00	$123.20			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - [illegible] BAPTIST [illegible]IC	J	0514153079801	1	22551 2 ZZZ - ARTHRODESIS, ANTERIOR INTERBODY, INCLUDING DISC SPACE PREPARATION, DISCECTOMY,	A	7234 - BRACHIAL NEURITIS OR RADICULITIS NOS	-	5/30/14	5/30/14	$3,105.00	$2,198.17	$0.00	$0.00	$2,198.17	20140612	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514153079801							Total:	$3,105.00	$2,198.17	$0.00	$0.00	$2,198.17			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514154084921	1	20931 2 ZZZ - SPINAL BONE ALLOGRAFT STRUCT	A	7234 - BRACHIAL NEURITIS OR RADICULITIS NOS	-	5/30/14	5/30/14	$300.00	$142.27	$0.00	$0.00	$142.27	20140612	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514154084921							Total:	$300.00	$142.27	$0.00	$0.00	$142.27			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514155082147	1	69990 2 ZZZ - MICROSURGERY ADD-ON	C	7234 - BRACHIAL NEURITIS OR RADICULITIS NOS	-	5/30/14	5/30/14	$380.00	$248.35	$0.00	$0.00	$0.00	20140619	225 - INVALID NCCI BILLING COMBINATIONS - PROCEDURE MUTUALLY EXCLUSIVE OR INCIDENTAL TO PD/ PENDING PROCEDURE. CMS DOES NOT ALLOW APPEALS.	-
184473002 - NEA BAPTIST CLINIC	J		2	22845 2 ZZZ - ANTERIOR INSTRUM 3 VERTE SEGS	A	7234 - BRACHIAL NEURITIS OR RADICULITIS NOS	-	5/30/14	5/30/14	$2,000.00	$862.61	$0.00	$0.00	$862.61	20140619	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514155082147							**Total:**	**$2,380.00**	**$1,110.96**	**$0.00**	**$0.00**	**$862.61**			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514156113916	1	71020 P ZZZ - X-RAY EXAM OF CHEST	A	5180 - PULMONARY COLLAPSE	-	5/28/14	5/28/14	$21.00	$18.00	$0.00	$0.00	$18.00	20140612	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514156113916							**Total:**	**$21.00**	**$18.00**	**$0.00**	**$0.00**	**$18.00**			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
181611002 - NEA BAPTIST CLINIC	J	0514157059662	1	00600 7 ZZZ - ANESTHESIA FOR PROCEDURES ON CERVICAL SPINE AND CORD; NOT OT ERWISE	A	7234 - BRACHIAL NEURITIS OR RADICULITIS NOS	-	5/30/14	5/30/14	$1,680.00	$503.16	$0.00	$0.00	$503.16	20140612	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514157059662							**Total:**	**$1,680.00**	**$503.16**	**$0.00**	**$0.00**	**$503.16**			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514163086186	1	72020 P ZZZ - XRAY EXAM OF SPINE	A	7233 - CERVICOBRACHIAL SYNDROME (DIFFUSE)	-	5/30/14	5/30/14	$24.00	$12.00	$0.00	$0.00	$12.00	20140619	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514163086186							Total:	$24.00	$12.00	$0.00	$0.00	$12.00			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
192756105 - NEA BAPTIST MORIAL OSPITAL	S	0514164230929	0	ZZZ -	A	-	-	5/30/14	5/31/14	$24,932.33	$850.00	$0.00	$0.00	$850.00	20140619	-	998 - CLAIM PAID AT MAXIMUM ALLOWABLE DAYS.
		0514164230929							Total:	$24,932.33	$850.00	$0.00	$0.00	$850.00			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
123512407 - WAL MART PHARMACY 10-0128	D	0514184357005	1	D ZZZ -	A	-	00603459315 - METHYLPREDNISOLONE 4 MG DOSEPK	7/3/14	7/3/14	$30.99	$29.52	$2.00	$0.00	$29.52	20140710	377 -$2.00 DIFFERENTIAL DISPENSING FEE INCLUDED IN PAID AMOUNT.	377 - $2.00 DIFFERENTIAL DISPENSING FEE INCLUDED IN PAID AMOUNT.
		0514184357005							Total:	$30.99	$29.52	$2.00	$0.00	$29.52			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
173002 - NEA BAPTIST CLINIC	J	0514188082902	1	99214 1 ZZZ - Established patient office or other outpatient, visit typically 25 minutes	A	3569 - UNSPECIFIED IDIOPATHIC PERIPHERAL NEUROP	-	4/1/14	4/1/14	$125.00	$70.05	$0.00	$0.00	$70.05	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514188082902							Total:	$125.00	$70.05	$0.00	$0.00	$70.05			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514188083552	1	99213 1 ZZZ - Established patient office or other outpatient visit, typically 15 minutes	A	3569 - UNSPECIFIED IDIOPATHIC PERIPHERAL NEUROP	-	3/6/14	3/6/14	$87.00	$36.30	$0.00	$0.00	$36.30	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514188083552							Total:	$87.00	$36.30	$0.00	$0.00	$36.30			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST NIC	J	0514188083616	1	73030 P ZZZ - X-RAY EXAM OF SHOULDER	A	71941 - PAIN IN JOINT INVOLVING SHOULDER REGION	-	3/4/14	3/4/14	$18.00	$15.00	$0.00	$0.00	$15.00	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514188083616							Total:	$18.00	$15.00	$0.00	$0.00	$15.00			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514188083625	1	72158 P ZZZ - MRI OF THE SPINAL CANAL	A	72210 - DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI	-	3/25/14	3/25/14	$320.00	$182.00	$0.00	$0.00	$182.00	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
184473002 - NEA BAPTIST CLINIC	J		2	72141 P ZZZ - MAGNETIC RESONANCE IMAGING	A	7224 - DEGENERATION OF CERVICAL INTERVERTEBRAL	- -	4/12/14	4/12/14	$160.00	$160.00	$0.00	$0.00	$160.00	20140717	061 -PAID IN FULL BY MEDICAID.	-
		0514188083625							Total:	$480.00	$342.00	$0.00	$0.00	$342.00			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514188083678	1	72125 P ZZZ - TOMOGRAPHY CERVICAL SPINE	A	7224 - DEGENERATION OF CERVICAL INTERVERTEBRAL	-	3/3/14	3/3/14	$115.00	$106.00	$0.00	$0.00	$106.00	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
184473002 - NEA BAPTIST CLINIC	J		2	72128 P ZZZ - TOMOGRAPHY THORACIC SPINE	A	72251 - DEGENERATION OF THORACIC OR THORACOLUMBA	-	3/3/14	3/3/14	$115.00	$106.00	$0.00	$0.00	$106.00	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
184473002 - NEA BAPTIST CLINIC	J		3	72131 P ZZZ - TOMOGRAPHY LUMBAR SPINE	A	72252 - DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	-	3/3/14	3/3/14	$115.00	$106.00	$0.00	$0.00	$106.00	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514188083678							Total:	$345.00	$318.00	$0.00	$0.00	$318.00			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514192057008	1	99213 1 ZZZ - Established patient office or other outpatient visit, typically 15 minutes	A	7234 - BRACHIAL NEURITIS OR RADICULITIS NOS	-	7/3/14	7/3/14	$89.00	$36.30	$0.00	$0.00	$36.30	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514192057008							Total:	$89.00	$36.30	$0.00	$0.00	$36.30			
									TOTAL:	$34,075.22	$5,896.13	$8.00	$0.00	$5,641.78			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514155082147	1	69990 2 ZZZ - MICROSURGERY ADD-ON	C	7234 - BRACHIAL NEURITIS OR RADICULITIS NOS	-	5/30/14	5/30/14	$380.00	$248.35	$0.00	$0.00	$0.00	20140619	225 - INVALID NCCI BILLING COMBINATIONS - PROCEDURE MUTUALLY EXCLUSIVE OR INCIDENTAL TO PD/ PENDING PROCEDURE. CMS DOES NOT ALLOW APPEALS.	-
184473002 - NEA BAPTIST CLINIC	J		2	22845 2 ZZZ - ANTERIOR INSTRUM 3 VERTE SEGS	A	7234 - BRACHIAL NEURITIS OR RADICULITIS NOS	-	5/30/14	5/30/14	$2,000.00	$862.61	$0.00	$0.00	$862.61	20140619	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514155082147							Total:	$2,380.00	$1,110.96	$0.00	$0.00	$862.61			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514156113916	1	71020 P ZZZ - X-RAY EXAM OF CHEST	A	5180 - PULMONARY COLLAPSE	-	5/28/14	5/28/14	$21.00	$18.00	$0.00	$0.00	$18.00	20140612	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514156113916							Total:	$21.00	$18.00	$0.00	$0.00	$18.00			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
181611002 - NEA BAPTIST CLINIC	J	0514157059662	1	00600 7 ZZZ - ANESTHESIA FOR PROCEDURES ON CERVICAL SPINE AND CORD; NOT OT ERWISE	A	7234 - BRACHIAL NEURITIS OR RADICULITIS NOS	-	5/30/14	5/30/14	$1,680.00	$503.16	$0.00	$0.00	$503.16	20140612	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514157059662							Total:	$1,680.00	$503.16	$0.00	$0.00	$503.16			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514163086186	1	72020 P ZZZ - XRAY EXAM OF SPINE	A	7233 - CERVICOBRACHIAL SYNDROME (DIFFUSE)	-	5/30/14	5/30/14	$24.00	$12.00	$0.00	$0.00	$12.00	20140619	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514163086186							Total:	$24.00	$12.00	$0.00	$0.00	$12.00			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
192756105 - "A BAPTIST MORIAL HOSPITAL	S	0514164230929	0	ZZZ -	A	-	-	5/30/14	5/31/14	$24,932.33	$850.00	$0.00	$0.00	$850.00	20140619	-	998 - CLAIM PAID AT MAXIMUM ALLOWABLE DAYS.
		0514164230929							Total:	$24,932.33	$850.00	$0.00	$0.00	$850.00			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
123512407 - WAL MART PHARMACY 10-0128	D	0514184357005	1	D ZZZ -	A	-	00603459315 - METHYLPREDNISOLONE 4 MG DOSEPK	7/3/14	7/3/14	$30.99	$29.52	$2.00	$0.00	$29.52	20140710	377 -$2.00 DIFFERENTIAL DISPENSING FEE INCLUDED IN PAID AMOUNT.	377 - $2.00 DIFFERENTIAL DISPENSING FEE INCLUDED IN PAID AMOUNT.
		0514184357005							Total:	$30.99	$29.52	$2.00	$0.00	$29.52			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
473002 - NEA BAPTIST CLINIC	J	0514188082902	1	99214 1 ZZZ - Established patient office or other outpatient, visit typically 25 minutes	A	3569 - UNSPECIFIED IDIOPATHIC PERIPHEROP NEUROP	-	4/1/14	4/1/14	$125.00	$70.05	$0.00	$0.00	$70.05	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514188082902							Total:	$125.00	$70.05	$0.00	$0.00	$70.05			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514188083552	1	99213 1 ZZZ - Established patient office or other outpatient visit, typically 15 minutes	A	3569 - UNSPECIFIED IDIOPATHIC PERIPHERAL NEUROP	-	3/6/14	3/6/14	$87.00	$36.30	$0.00	$0.00	$36.30	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514188083552							Total:	$87.00	$36.30	$0.00	$0.00	$36.30			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST NIC	J	0514188083616	1	73030 P ZZZ - X-RAY EXAM OF SHOULDER	A	71941 - PAIN IN JOINT INVOLVING SHOULDER REGION	-	3/4/14	3/4/14	$18.00	$15.00	$0.00	$0.00	$15.00	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514188083616							Total:	$18.00	$15.00	$0.00	$0.00	$15.00			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514188083625	1	72158 P ZZZ - MRI OF THE SPINAL CANAL	A	72210 - DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI	-	3/25/14	3/25/14	$320.00	$182.00	$0.00	$0.00	$182.00	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
184473002 - NEA BAPTIST CLINIC	J		2	72141 P ZZZ - MAGNETIC RESONANCE IMAGING	A	7224 - DEGENERATION OF CERVICAL INTERVERTEBRAL	-	4/12/14	4/12/14	$160.00	$160.00	$0.00	$0.00	$160.00	20140717	061 -PAID IN FULL BY MEDICAID.	-
		0514188083625							Total:	$480.00	$342.00	$0.00	$0.00	$342.00			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514188083678	1	72125 P ZZZ - TOMOGRAPHY CERVICAL SPINE	A	7224 - DEGENERATION OF CERVICAL INTERVERTEBRAL	-	3/3/14	3/3/14	$115.00	$106.00	$0.00	$0.00	$106.00	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
184473002 - NEA BAPTIST CLINIC	J		2	72128 P ZZZ - TOMOGRAPHY THORACIC SPINE	A	72251 - DEGENERATION OF THORACIC OR THORACOLUMBA	-	3/3/14	3/3/14	$115.00	$106.00	$0.00	$0.00	$106.00	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
184473002 - NEA BAPTIST CLINIC	J		3	72131 P ZZZ - TOMOGRAPHY LUMBAR SPINE	A	72252 - DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	-	3/3/14	3/3/14	$115.00	$106.00	$0.00	$0.00	$106.00	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514188083678							Total:	$345.00	$318.00	$0.00	$0.00	$318.00			

Provider Name and ID		ICN	Dtl #	Procedure Code Desc	Dtl Status	Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Desc	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514192057008	1	99213 1 ZZZ - Established patient office or other outpatient visit, typically 15 minutes	A	7234 - BRACHIAL NEURITIS OR RADICULITIS NOS	-	7/3/14	7/3/14	$89.00	$36.30	$0.00	$0.00	$36.30	20140717	365 -FEE ADJUSTED TO MAXIMUM ALLOWABLE	-
		0514192057008							Total:	$89.00	$36.30	$0.00	$0.00	$36.30			

									TOTAL:	$34,075.22	$5,896.13	$8.00	$0.00	$5,641.78			

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Third Party Liability Unit

P.O. Box 1437, Slot S-296 Little Rock, AR 72203-1437
501-537-1070 · Fax: 501-682-1644

May 13, 2016

NOYL HOUSTON
HOUSTON LAW FIRM PA
923 UNION
PO BOX 3076
JONESBORO AR 72403

RE:	Donald Oswald
Case#:	155357
Insured:	Arkansas Highway and Transportation
DOL:	03/03/2014

Dear Sir/Madam:

In reference to our letter dated September 4, 2014, Medicaid has made ***additional payments of $3,390.59***. For your convenience, an itemized listing of the additional payments is attached.

This letter supersedes our previous correspondence dated May 11, 2016 relating to this incident.

NOTE: Providers of service have one (1) year from the date of service to bill Medicaid for reimbursement. Please notify this office in advance of settlement to ensure the Medicaid amount is the correct updated amount. If you fail to notify us prior to settlement you may be responsible for additional payments made between the last letter received and the settlement date.

As a condition of Medicaid eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Arkansas Department of Human Services to the extent of any amount which may be paid by Medicaid for the benefit of the applicant.

Please make the check payable to the **Arkansas Medicaid** and mail it to the following address:

Arkansas Department of Human Services
Division of Medical Services
ATTN: Third Party Liability Unit
P. O. Box 1437, Slot S296
Little Rock, Arkansas 72203-1437

TAX ID#

LNM

When an action or claim is brought by a medical assistance recipient or his legal representative against a third party who may be liable for injury, disease, disability, or death of a medical assistance recipient, any settlement, judgment, or award obtained is subject to the division's claims for reimbursement of the benefits provided to the recipient under the medical assistance program.

No judgment, award, or settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease, or disability, in which the department as interest, shall be satisfied without first giving the department notice and a reasonable opportunity to establish its interest.

The payments attaches to past and future Medicaid payments. If additional payments are made by Medicaid, this unit will periodically update the amount of the payments.

The Department of Human Services has an interest in this matter. Since we have a claim, please provide reasonable notice of all settlement negotiations and hearings so the department can take appropriate action to protect the interest of the Medicaid Program.

We appreciate your cooperation in this matter. Please do not hesitate to contact us at (501) 537-3432 should you have any questions.

Sincerely,

LaDonna N. Mayo

LaDonna N. Mayo, Insurance/Healthcare Analyst II
Division of Medical Services
Administrative Services Section
Third Party Liability Unit

Arkansas Title XIX

Recipient Profile Request

Version: 1.1

For Dates of Service Between Mar 3, 2014 and May 13, 2016

Complete Recipient Name and ID: 8085042101 - OSWALD, DONALD

Date of Birth: 05/01/1952

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514303101650	1	99214 1 ZZZ - Established patient office or other outpatient, visit typically 25 minutes	A	7220 - DISPLACEMENT OF CERVICAL INTERVERTEBRAL	-	10/29/2014	10/29/2014	$131.00	$70.05	$0.00	$0.00	$70.05	11/06/2014	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0514303101650 - Total										$131.00	$70.05	$0.00	$0.00	$70.05			

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
101693105 - ST BERNARDS MEDICAL CENTER	M	0514357192881	1	95913 G ZZZ - NERVE CONDUCTION STUDIES; 13 OR MORE STUDIES	A	7220 - DISPLACEMENT OF CERVICAL INTERVERTEBRAL	-	12/18/2014	12/18/2014	$260.00	$105.19	$0.00	$0.00	$105.19	01/01/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0514357192881 - Total										$260.00	$105.19	$0.00	$0.00	$105.19			

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0514358081936	1	99214 1 ZZZ - Established patient office or other outpatient, visit typically 25 minutes	A	7220 - DISPLACEMENT OF CERVICAL INTERVERTEBRAL	-	12/22/2014	12/22/2014	$131.00	$70.05	$0.00	$0.00	$70.05	01/01/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0514358081936 - Total										$131.00	$70.05	$0.00	$0.00	$70.05			

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
101854002 - EMERGENCY PHY ASSOCIATES	J	0514363053864	1	95913 P ZZZ - NERVE CONDUCTION STUDIES; 13 OR MORE STUDIES	A	7220 - DISPLACEMENT OF CERVICAL INTERVERTEBRAL	-	12/18/2014	12/18/2014	$425.00	$224.98	$0.00	$0.00	$224.98	01/08/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0514363053864 - Total										$425.00	$224.98	$0.00	$0.00	$224.98			

Recipient Profile Request

Version: 1.1

For Dates of Service Between Mar 3, 2014 and May 13, 2016

Complete Recipient Name and ID: 8085042101 - OSWALD, DONALD

Date of Birth: 05/01/1952

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0515008100716	1	71020 P ZZZ - X-RAY EXAM OF CHEST	A	4019 - UNSPECIFIED ESSENTIAL HYPERTENSION	-	01/02/2015	01/02/2015	$21.00	$18.00	$0.00	$0.00	$18.00	01/15/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0515008100716 - Total										$21.00	$18.00	$0.00	$0.00	$18.00			
Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
181611002 - NEA BAPTIST CLINIC	J	0515009075693	1	01810 7 ZZZ - ANESTHESIA FOR ALL PROCEDURES ON NERVES, MUSCLES, TENDON, FA CIA, A	A	3540 - CARPAL TUNNEL SYNDROME	-	01/06/2015	01/06/2015	$640.00	$191.68	$0.00	$0.00	$191.68	01/15/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0515009075693 - Total										$640.00	$191.68	$0.00	$0.00	$191.68			
Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0515009096026	1	64721 2 ZZZ - REVISE MEDIAN NERVE AT WRIST	A	3540 - CARPAL TUNNEL SYNDROME	-	01/06/2015	01/06/2015	$1,085.00	$581.63	$0.00	$0.00	$581.63	01/15/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0515009096026 - Total										$1,085.00	$581.63	$0.00	$0.00	$581.63			
Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M	0515009193497	1	80048 G ZZZ - Blood test, basic group of blood chemicals	A	V7281 - PREOP CARDIOVASC EXAM	-	01/02/2015	01/02/2015	$308.00	$12.09	$0.00	$0.00	$12.09	01/15/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M		2	81001 G ZZZ - URINALYSIS AUTO W/SCOPE	A	V7281 - PREOP CARDIOVASC EXAM	-	01/02/2015	01/02/2015	$121.00	$4.52	$0.00	$0.00	$4.52	01/15/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M		3	85025 G ZZZ - BLOOD COUNT HEMOGRAM AND PLATELET COUNT	A	V7281 - PREOP CARDIOVASC EXAM	-	01/02/2015	01/02/2015	$134.00	$11.10	$0.00	$0.00	$11.10	01/15/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	

Recipient Profile Request

Version: 1.1

For Dates of Service Between Mar 3, 2014 and May 13, 2016

Complete Recipient Name and ID: 8085042101 - OSWALD, DONALD

Date of Birth: 05/01/1952

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M	0515009193497	4	71020 G ZZZ - X-RAY EXAM OF CHEST	A	V7281 - PREOP CARDIOVASC EXAM	-	01/02/2015	01/02/2015	$482.00	$17.00	$0.00	$0.00	$17.00	01/15/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M		5	93005 G ZZZ - ELECTROCARDIOGRAM, TRACING	A	V7281 - PREOP CARDIOVASC EXAM	-	01/02/2015	01/02/2015	$213.00	$17.00	$0.00	$0.00	$17.00	01/15/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0515009193497 - Total										$1,258.00	$61.71	$0.00	$0.00	$61.71			

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M	0515013188655	1	64721 G ZZZ - REVISE MEDIAN NERVE AT WRIST	A	3540 - CARPAL TUNNEL SYNDROME	-	01/06/2015	01/06/2015	$2,952.00	$320.00	$0.00	$0.00	$320.00	01/22/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0515013188655 - Total										$2,952.00	$320.00	$0.00	$0.00	$320.00			

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0515154082519	1	99214 1 ZZZ - Established patient office or other outpatient, visit typically 25 minutes	A	3540 - CARPAL TUNNEL SYNDROME	-	06/01/2015	06/01/2015	$131.00	$70.05	$0.00	$0.00	$70.05	06/11/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0515154082519 - Total										$131.00	$70.05	$0.00	$0.00	$70.05			

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
181611002 - NEA BAPTIST CLINIC	J	0515162067865	1	01810 7 ZZZ - ANESTHESIA FOR ALL PROCEDURES ON NERVES, MUSCLES, TENDON, FA CIA, A	A	3540 - CARPAL TUNNEL SYNDROME	-	06/09/2015	06/09/2015	$560.00	$167.72	$0.00	$0.00	$167.72	06/18/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0515162067865 - Total										$560.00	$167.72	$0.00	$0.00	$167.72			

Recipient Profile Request

Version: 1.1

For Dates of Service Between Mar 3, 2014 and May 13, 2016

Complete Recipient Name and ID: 8085042101 - OSWALD, DONALD

Date of Birth: 05/01/1952

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0515163096014	1	64721 2 ZZZ - REVISE MEDIAN NERVE AT WRIST	A	3540 - CARPAL TUNNEL SYNDROME	-	06/09/2015	06/09/2015	$1,085.00	$581.63	$0.00	$0.00	$581.63	06/18/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0515163096014 - Total										$1,085.00	$581.63	$0.00	$0.00	$581.63			

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M	0515174190083	1	80048 G ZZZ - Blood test, basic group of blood chemicals	A	3540 - CARPAL TUNNEL SYNDROME	-	06/08/2015	06/08/2015	$308.00	$12.09	$0.00	$0.00	$12.09	07/02/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M		2	81001 G ZZZ - URINALYSIS AUTO W/SCOPE	A	3540 - CARPAL TUNNEL SYNDROME	-	06/08/2015	06/08/2015	$121.00	$4.52	$0.00	$0.00	$4.52	07/02/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M		3	85025 G ZZZ - BLOOD COUNT HEMOGRAM AND PLATELET COUNT	A	3540 - CARPAL TUNNEL SYNDROME	-	06/08/2015	06/08/2015	$99.00	$11.10	$0.00	$0.00	$11.10	07/02/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M		4	85610 G ZZZ - PROTHROMBIN TIME	A	3540 - CARPAL TUNNEL SYNDROME	-	06/08/2015	06/08/2015	$101.00	$5.61	$0.00	$0.00	$5.61	07/02/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M		5	85730 G ZZZ - THROMBOPLASTIN TIME,PARTIAL(PTT)	A	3540 - CARPAL TUNNEL SYNDROME	-	06/08/2015	06/08/2015	$126.00	$8.58	$0.00	$0.00	$8.58	07/02/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M		6	64721 G ZZZ - REVISE MEDIAN NERVE AT WRIST	A	3540 - CARPAL TUNNEL SYNDROME	-	06/09/2015	06/09/2015	$2,752.00	$320.00	$0.00	$0.00	$320.00	07/02/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0515174190083 - Total										$3,507.00	$361.90	$0.00	$0.00	$361.90			

Recipient Profile Request

Version: 1.1

For Dates of Service Between Mar 3, 2014 and May 13, 2016

Complete Recipient Name and ID: 8085042101 - OSWALD, DONALD

Date of Birth: 05/01/1952

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
184473002 - NEA BAPTIST CLINIC	J	0515215070152	1	72141 P ZZZ - MAGNETIC RESONANCE IMAGING	A	7231 - CERVICALGIA	-	07/27/2015	07/27/2015	$160.00	$160.00	$0.00	$0.00	$160.00	08/13/2015	061 - PAID IN FULL BY MEDICAID.	
0515215070152 - Total										$160.00	$160.00	$0.00	$0.00	$160.00			

Provider Name and ID		ICN		Procedure Code Desc		Diagnosis Code Desc	NDC Description	First Dte of Svc	Last Dte of Svc	Billed Amount	Allwd Amt	Copay Amount	Ins Amt	Paid Amount	Paid Date	Dtl Major EOB Description	Header EOB Description
192756105 - NEA BAPTIST MEMORIAL HOSPITAL	M	0515216188668	1	72141 G ZZZ - MAGNETIC RESONANCE IMAGING	A	7210 - CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY	-	07/27/2015	07/27/2015	$3,423.00	$406.00	$0.00	$0.00	$406.00	08/13/2015	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	
0515216188668 - Total										$3,423.00	$406.00	$0.00	$0.00	$406.00			
Overall - Total										$15,769.00	$3,390.59	$0.00	$0.00	$3,390.59			

RKANSAS STATE CLAIMS COMM. ION
MOTOR VEHICLE ACCIDENT REPORT FORM

SECTION I

CLAIMANT Donald Oswald and Karen Oswald ADDRESS 205 E. Oak

CITY & STATE Bono, AR ZIP CODE 72416

DATE OF ACCIDENT: March 3, 2014 TIME: 5:59 p.m.

MOTOR VEHICLE DAMAGED: TYPE small pickup MAKE Toyota YEAR 1994

DRIVEN BY: Donald Oswald ADDRESS See above.

Give a brief description of accident, showing how accident happened, exact loss and extent of damage to car.

An AHTD snow plow truck was traveling northbound on U.S. Highway 63 down "Bono Hill", Bono, AR, at excessive speed on ice, lost control and veered into my (Southbound) lane, hitting my truck in the left rear quarter panel causing it to spin violently, injuring my neck, back, shoulder, arms and wrists., as well as damage to my pickup.

****

SECTION II

*vehicle was totaled but I retained the salvage.

Has this vehicle been repaired? Yes ( ) No ( ) If repairs have been made, give the following information: Amount $ 1,985.00* Have you paid for the repairs? Yes ( ) No ( ) NOTE *St. Farm's letter Re: Payment of $1,985.00 (actual cash value of $3,075.00 less $500.00 deductible and salvage) is attached to complaint

If repairs have not been made, list three estimates below and attach copies of each of them.

	NAME	ADDRESS	AMOUNT
1.	N/A		$
2.			
3.			

****

SECTION III

Was vehicle covered by Insurance? Yes (X) No ( ) Liability Only ( )

Comprehensive: Yes (X) No ( ) What is your deductible? $ 100.00

Collision: Yes (X) No ( ) What is your deductible? $ 500.00

NAME OF INSURANCE CARRIER ADDRESS

State Farm Insurance, PO Box 2371, Bloomington, IL 61702-2371

****

SECTION IV

Type of State Vehicle involved snow plow truck License No.

Driver Jeffrey Armstrong Property of which State Agency AR Hwy & Transportation Dept

If accident was investigated by the State Police, give name of investigating officer: Cpl. Darren Crook If investigation was made by some other agency, give name and title of officer making the investigation:

****

SECTION V

The undersigned states on oath that he/she is familiar with the matters and things set forth in the above statement, and that he/she verily believes that they are true.

Donald Oswald
Donald Oswald, Claimant

Karen Oswald
Karen Oswald, Claimant

(Notary Seal)

Sworn to and subscribed before me at Jonesboro, AR
City, State

on this ___ day of May month, 2016. year

My Commission Expires ___

OFFICIAL SEAL - #12692133
Lisa M. Westmoreland
CRAIGHEAD COUNTY

Lisa M. Westmoreland
Notary Public

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ARKANSAS STATE CLAIMS COMMISSION
PROPERTY DAMAGE/PERSONAL INJURY INCIDENT REPORT FORM

SECTION I

CLAIMANT Donald Oswald and Karen Oswald ADDRESS 205 E. Oak

CITY & STATE Bono, AR ZIP CODE 72416

DATE OF INCIDENT: March 3, 2014 19____ TIME 5:59 p.m.

Give a brief description of incident, showing how incident happened, exact loss and extent of damage to property and/or injury to person:

An AHTD snow plow truck was traveling northbound on U.S. Highway 63 down "Bono Hill", Bono, AR, at excessive speed on ice, lost control and veered into my (Southbound) lane, hitting my truck in the left rear quarter panel causing it to spin violently, injuring my neck, back, shoulder, arms and wrists., as well as damage to my pickup.

(If personal injury claim only, move on to Section IV)

****

SECTION II *Vehicle was "totaled", but salvage was retained. See attacned letter.

Has this property been repaired? Yes ( ) No ( ) If repairs have been made, give the following information: Amount: $1,985.00 paid for total loss* Have you paid for the repairs? Yes ( ) No ( )

NOTE: Attach a copy of repair bill. *St. Farm's letter Re: Payment of $1,985.00 (actual cash value of $3,075.00 less $500.00 deductible and salvage) is attached to complaint

If repairs have not been made, list three estimates below and attach copies of each of them.

	NAME	ADDRESS	AMOUNT
1.	N/A		$
2.			$
3.			$

****

SECTION III

Was property covered by insurance? Yes (X) No ( )

If yes, what is the deductible? $ 500.00

NAME OF INSURANCE CARRIER: St. Farm Insurance

ADDRESS: PO Box 2371, Bloomington, IL 61702-2371

****

SECTION IV

Is injured covered by medical insurance? Yes (X) No ( )

If yes, what is the deductible? $ N/A

If yes, is medical insurance:

A. Job-based Yes ( ) No (X)
B. Uninsured Motorist Yes (X) No ( )
C. Private Pay Yes (X) No ( )
Also $5,000 in medpay.

NAME OF INSURANCE CARRIER: St. Farm Insurance Co.

ADDRESS: PO Box 661001, Dallas, TX 75266-1001

****

SECTION V

If incident was investigated by the police or by some other agency, give name and title of officer/person making the investigation: Arkansas State Police, Cpl. Darren Crook.

****

SECTION VI

The undersigned states on oath that he/she is familiar with the matters and things set forth in the above statement, and that he/she verily believes that they are true.

Donald Oswald
Donald Oswald, Claimant

Karen Oswald
Karen Oswald, Claimant

(Notary Seal)

Sworn to and subscribed before me at Jonesboro, AR City & State

on this ____ day of May, 2016.

day month year

My Commission Expires:

OFFICIAL SEAL - #12692133
Lisa M. Westmoreland
NOTARY PUBLIC
CRAIGHEAD COUNTY
EXPIRES: 11-19-2025

Lisa M. Westmoreland
Signature of Notary Public

BEFORE THE STATE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

DONALD OSWALD
KAREN OSWALD **CLAIMANTS**

V. **CLAIM NO. 16-0752-CC**

ARKANSAS STATE HIGHWAY AND
TRANSPORTATION DEPARTMENT **RESPONDENT**

ANSWER

COMES THE RESPONDENT and for its Answer to the Complaint herein states:

1. The Respondent denies all allegations of the Complaint not admitted herein.

2. The Claimants' damages, if any, were not caused by the negligence of the Arkansas State Highway and Transportation Department or its employees.

WHEREFORE, the Respondent PRAYS for dismissal of the Complaint, for cost, and all proper relief.

ARKANSAS STATE HIGHWAY AND
TRANSPORTATION DEPARTMENT

By: Steve Abed

Steven W. Abed
Staff Attorney
AHTD, Legal Division
Arkansas Bar No. 96059
P. O. Box 2261
Little Rock, AR 72203-2261
(501) 569-2278

3h

CERTIFICATE OF SERVICE

I, Steven W. Abed, certify that I have served the foregoing Answer upon the Claimant by mailing a true copy of same this 2nd of June, 2016, to:

Noyl Houston
Houston Law Firm, P. A.
923 Union
Jonesboro, AR 72403

Steven W. Abed

BEFORE THE ARKANSAS STATE CLAIMS COMMISION

KAREN OSWALD AND DONALD OSWALD — **CLAIMANTS**

V. **CLAIM NO. 16-0752-CC**

ARKANSAS STATE HIGHWAY COMMISSION AND ARKANSAS STATE HIGHWAY AND TRANSPORTATION DEPARTMENT — **RESPONDENTS**

FULL AND COMPLETE SETTLEMENT AND RELEASE

For the sole consideration of Two Hundred Twenty Five Thousand Dollars and zero cents ($225,000.00) that the undersigned, Karen Oswald and Donald Oswald, as husband and wife, do hereby release, discharge and forever acquit Jeffery Armstrong, Arkansas State Highway and Transportation Department, Arkansas State Highway Commission (collectively AHTD), their agents, employees, successors, and assigns liable or who might be liable in any way or in any manner as result of an accident which occurred on or about March 3, 2014, in Craighead County, Arkansas. This release shall operate as a full and final discharge of all causes of action in tort or in contract, or of any kind, of the undersigned, presently existing and which may arise in the future, of whatever kind and whatever nature against Jeffery Armstrong, Arkansas State Highway and Transportation Department, Arkansas State Highway Commission.

It is further expressly agreed by the undersigned that the amount to be paid herein is in full and final satisfaction of any and all claims including, but not limited to, any claim for bad faith, personal injury, wrongful death, damage to property, loss of consortium, and for any and all damages, known or unknown, or demands against Jeffery Armstrong, Arkansas State Highway and Transportation Department, Arkansas State Highway Commission which may arise out of said accident.

The undersigned hereby accepts AHTD's unconditional promise not to dispute liability for said claim filed by the undersigned before the Arkansas State Claims Commission as full and complete consideration as described above. It is understood that tender of payment by warrant will be made payable to: the undersigned, Karen Oswald and Donald Oswald, as husband and wife and their attorney, Noyl Houston in the amount of Two Hundred Twenty Five Thousand Dollars and zero cents ($225,000.00), which has been agreed to by the undersigned. This settlement, in accordance with Arkansas State Law, is contingent upon approval from the Arkansas State Claims Commission, Joint Budget Committee or Legislative Council and the Arkansas General Assembly. The undersigned hereby accepts the aforementioned sum as full, sufficient, final consideration, and final payment with respect to the above-mentioned claim before the Arkansas State Claims Commission for all claims past, present, and future that are a result of the accident of March 3, 2014.

The undersigned, hereby declares the terms of this settlement have been completely read, are fully understood, and are voluntarily accepted for the purpose of making a full and final compromise, adjustment, and settlement of any and all claims, disputed or otherwise, for the express purpose of dismissing and precluding forever any and all claims, including further or additional claims arising out of the aforesaid matter.

EXECUTED THIS 15th DAY OF July, 2016.

Karen Oswald
Karen Oswald, Claimant

Donald Oswald
Donald Oswald, Claimant

Social Security Number

Social Security Number

SUBSCRIBED AND SWORN to before me this 15th day of July, 2016.

Lisa M. Westmoreland
NOTARY PUBLIC

My Commission Expires:

Witnessed and approved by:

Noyl Houston
Attorney for Claimants

Prepared by:

Steve Abed

Steven W. Abed
Staff Attorney
Arkansas State Highway
And Transportation Department

STATE CLAIMS COMMISSION DOCKET
OPINION

Amount of Claim $ 375,500.00 **Claim No.** 16-0752-CC

	Attorneys
Donald & Karen Oswald **Claimant**	Noyl Houston, Attorney **Claimant**
vs.	
AR Highway & Transportation Dept. **Respondent**	David Dawson, Attorney **Respondent**

State of Arkansas

Date Filed May 17, 2016

Type of Claim Property Damage, Personal Injury, ~~Pain & Suffering~~

FINDING OF FACTS

This claim was filed for property damage, personal injury and pain & suffering in the amount of $375,500.00 against Arkansas Highway & Transportation Department.

Present at the hearing on August 11, 2016 was the Claimant, represented by Noyl Houston and the Respondent, represented by David Dawson, Staff Attorney.

A "Negotiated Settlement Agreement" signed by the claim parties were submitted to the Claims Commission by the Respondent, along with the Respondent's recommendation of payment in the amount of $225,000.00 in full payment of this claim, in a letter or Answer received on August 11, 2016.

The Claims Commission hereby unanimously **allows this "Negotiated Settlement Agreement" by the parties in the amount of $225,000.00 and will include the claim in a claims bill to the 91st Arkansas General Assembly, Fiscal Session 2016, for subsequent approval and payment.**

IT IS SO ORDERED.

(See Back of Opinion Form)

CONCLUSION

Upon consideration of all the facts, as stated above, the Claims Commission hereby unanimously allows this claim in the amount of $225,000.00 **and will include the claim in a claims bill to be submitted to the 91st General Assembly, Fiscal Session 2016, for subsequent approval and payment.**

Date of Hearing August 11, 2016

Date of Disposition August 11, 2016

Chairman

Commissioner

Commissioner

**Appeal of any final Claims Commission decision is only to the Arkansas General Assembly as provided by Act #33