CONFIDENTIAL
(When Filled In)

THE FURNISHING OF THIS FORM IS FOR THE CONVENIENCE OF THE SUBSCRIBER AND IS NOT AN ACKNOWLEDGEMENT OF LIABILITY OR WAIVER OF ANY RIGHT.

GOVERNMENT EMPLOYEES HEALTH ASSOCIATION CLAIM

SECTION I — SUBSCRIBER'S CLAIM AND CERTIFICATION

1. FULL NAME OF EMPLOYEE *(Subscriber)*	2. NAME *(If claim for dependent)*	3. RELATIONSHIP	4. AGE
Mario K. Giordano (P)	-	-	61

5. DATE INJURED OR BEGINNING OF SICKNESS: 7 June 1965 — TIME: A.M. / P.M.

6. INDICATE NATURE OF INJURY OR SICKNESS
Anemia, arthritis, low blood pressure

7. REASON FOR DIAGNOSTIC TESTS *(X-rays, laboratory tests, etc.)*
To find the source of the troubles.

8. IF AN INJURY, STATE WHEN, WHERE AND HOW IT OCCURRED *(State whether sickness or injury occurred on job)*
-

9. ARE YOU OR ANY MEMBER OF YOUR FAMILY COVERED UNDER ANY PLAN OR PLANS OTHER THAN GEHA FOR WHICH PAYROLL DEDUCTIONS ARE MADE, OR FOR WHICH AN EMPLOYER MAKES A CONTRIBUTION IN WHOLE OR IN PART, OR UNDER FEDERAL, STATE, OR OTHER GOVERNMENTAL PROGRAM WHICH PROVIDES BENEFITS FOR THIS ILLNESS OR ACCIDENT? ☐ YES ☒ NO

10. IF YES, GIVE NAME AND ADDRESS OF INSURANCE COMPANY OR OTHER ORGANIZATION PROVIDING SUCH COVERAGE AND AMOUNT THE OTHER INSURANCE COMPANY HAS PAID OR WILL PAY ON THIS CLAIM.

11. DATE	12. I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE
24 December 1965	Mario K. Giordano (SIGNATURE OF EMPLOYEE)

13. ADDRESS *(Street and No.)* — *(City or town)* — *(State)*

PLEASE ATTACH ITEMIZED BILLS

SECTION II — INSTRUCTIONS FOR DISPOSITION OF CHECK

1.	XX	CHECK WILL BE [illegible] PERSONALLY OR BY AN AUTHORIZED PERSON	CALL EXT. 4205			
2.		CHECK IS TO BE SENT VIA INTRA-OFFICE MAIL	ROOM NO.	BUILDING	EXT.	

SECTION III — REMARKS

FORM 5-63 1618 USE PREVIOUS EDITIONS.

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GROUP 1
Excluded from automatic downgrading and declassification

(4)

MEDICAL EXPENSE RECORD FOR SUBMISSION OF CLAIM

(Major Medical Only)

NAME OF PERSON FOR WHOM EXPENSES WERE INCURRED	RELATIONSHIP	DATE OF BIRTH
Mario K. GIORDANO (P)		13 Sept 1904
NAME OF INSURED: Same		

IMPORTANT - AN ITEMIZED BILL OR RECEIPT MUST BE ATTACHED TO THIS FORM FOR EACH ITEM OF EXPENSE FOR WHICH CLAIM IS MADE. All bills or receipts should include (1) name of patient, (2) the nature of illness or injury, (3) type of service, (4) description of surgery performed, (5) date(s) service was rendered, (6) amount charged, and (7), if drugs, the prescription number and pharmacy.

NATURE OF ILLNESS	TYPE SERVICE & BY WHOM GIVEN	Date Charges Incurred From	Date Charges Incurred To	TOTAL CHARGE
	See GIORDANO's itemized account attached			

A SEPARATE FORM MUST BE SUBMITTED FOR EACH PERSON COVERED — GRAND TOTAL

FORM 4-61 1823 (4-26)

Year: 1965 Name: Mario K.Giordano

Paid to:	Paid for: Illness	Paid for: Type of Service.	Date incurred From	Date incurred To.	Cost	Amt.Paid by Basic Plan	Balance Eligible for Major Medical
Argyle Pharmacy	Anemia & arthritis	Drug #313176,Tylenol	6/7		$ 6.--	-	6.00
Casualty Hospital	"	Room for three days	6/29	7/1	69.--	60.--	9.--
" "	"	Pharmacy **	"	"	10.15	10.15	-
" "	"	Sterile trays **	"	"	10.--	10.--	-
" "	"	X-rays **	"	"	65.--	65.--	-
" "	"	Laboratory tests etc. **	"	"	32.--	32.--	-
" "	"	EKG **	"	"	15.--	15.--	-
Taxi	"	To and from hospital	"	"	3.--	3.--	-
Dr.Hantsoo	"	Treatment in Hospital	"	"	42.--	42.--	-
Dr.Hantsoo	"	CBC in Casualty Hospital*	7/26;8/17;10/19.		18.--	18.--	-
Taxis	"	" " " To/From.	"	" "	9.--	9.--	-
Dr.Hantsoo	"	28 Office visits & injections	6/7	12/23	153.--	-	153.--
Taxies	"	3 times to Dr.H's Office	6/7	6/17 (3x3)	9.--	-	9.--
Taxis & buses	"	25 times " " "	7/6	12/23 (1.5x25)	37.50	-	37.50
			Totals:		$ 478.65;	264.15;	214.50

*: Out-patient care.

**: Hospital extras,all together $ 132.15.

24 December 1965.

Mario K. Giordano