COUNTY ~~OF SA~~N LUIS OBISPO

CLAIM

Vendor Name ARTHUR BEAL

☐ Employer I.D. No. or ☐ Social Security No. (CHECK ONE) 552-07-7350

Vendor address 881 HILLCREST (STREET/P.O. BOX) CAMBRIA, CA 93428 (CITY, STATE, ZIP)

Requesting department SAN LUIS OBISPO GENERAL HOSPITAL

Instructions:

Claim shall not be considered or allowed unless it is itemized to show:

A. Vendor's Employer I.D. or S.S. Number.
B. Names, dates, and particular serviced rendered.
C. Claims must be signed by the Vendor, approved by the head of the department before filing with the County Auditor-Controller.
D. Vendor must make separate claims for each department.
E. Mail General County Claims to County Auditor-Controller Room 300 Courthouse, San Luis Obispo, Calif. 93408.

I HEREBY CERTIFY that this claim and the items, amounts and statements as therein set out are true and correct; that no part thereof has been heretofore paid; that the amount claimed is justly due and is presented within one year after the last items thereof have accrued.

VENDOR SIGN HERE SEE ATTACHED DATE 1/23/90

DATE 19	DESCRIPTION		DOLLARS	CTS
7/3/89	OUTPATIENT VISIT ARTHUR BEAL	92.00		
8/10/89	MEDICARE PAID	29.60		
8/14/89	MEDICARE PAID	48.64		
8/17/89	PATIENT PAID	92.00		
8/17/89	MEDI-CAL PAID	6.36		
1/23/90	MEDI-CONTRACTUAL	7.40		
	REFUND DUE PATIENT		TOTAL	92 00

VENDOR –DO NOT WRITE BELOW THIS LINE

EXPENDITURE AUTHORIZED AND APPROVED

DEPARTMENT HEAD _____ BY _____

AUDITOR-CONTROLLER

BY Patti Anderson

FUND OR ORG	ACCOUNT	ACTIVITY	OPTION	CHARGE CODE	DOCUMENT NO	AMOUNT	ENCUMBRANCE NUMBER	DESCRIPTION
6001	9734		100	P 1019		92.00		Enc.