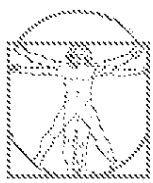

DOCTORS HOSPITAL AT RENAISSANCE

HEALTH SYSTEM

P.O. Box 3293
5501 S. McColl Rd.
Edinburg, Texas 78539
Ph: (956)-362-8677 | 956-DOCTORS

Fax Transmission

TO: TMC PRE AUTH	**FROM:** Radiology Insurance Verifiers
To FAX #: 15625060355	**From FAX #:**
COMPANY:	**VOICE #:**
PAGES: 13	**DATE:** 5/16/2024 1:11:14 **PM**

You are being faxed a total of 13 pages, excluding this cover sheet. If you do not receive the entire number of pages, or if there are any problems with the quality or legibility, please contact the above person at the department/ phone number listed above.

Comments: PRE CERTIFICATION FOR MRI C-SPINE WO 72148, PLEASE SEE ATTACHMENT. AND SEND TO FAX:956 362-7554

Confidential Notice

Family Physicians Clinic | Valley Night Clinic

FROM: Linda at Dr. Leonel Moreno's Office; 956-622-7628
TO: DHR Pre-Auth Dept 9563627554 (956) 362-7554
SUBJECT: attn: JANETTE
DATE: Thu, 05/16/24, 11:39 AM CDT

INSTRUCTIONS:

362-7554

DHR HEALTH
DIAGNOSTIC IMAGING ORDERS

Please ensure all bold boxed areas are completed

Patient's Name: Rebecca Reyes DOB: 8/31/67 Tel: 956.451.7764

Appointment Date: _____ Time: _____

FOR APPOINTMENTS CALL CENTRALIZED SCHEDULING TEL: (956) 362-7503 FAX: (956) 362-7509

- ARRIVE 30 MINUTES BEFORE APPOINTMENT AND ARRIVE AT REGISTRATION DESK WITH: (1) THIS FORM • (2) OUTSIDE STUDIES WITH REPORTS • (3) INSURANCE INFORMATION.
- FOR BEST SERVICE CALL US AND REGISTER A DAY BEFORE YOUR EXAM
- READ ONLY THE CHECKED OFF INSTRUCTIONS ON THE BACK OF THIS FORM FOR EACH SCHEDULED STUDIES.
- PLEASE LEAVE ALL VALUABLES AT HOME AS THE HOSPITAL/IMAGING CENTER DOES NOT ASSUME RESPONSIBILITY FOR LOST VALUABLES OR PERSONAL PROPERTY.

☐ RADIOLOGY DEPARTMENT 5501 S. McColl Road • Edinburg, TX 78539 • Tel: (956) 362-7500 • Fax: (956) 362-7505

☐ IMAGING CENTER AT DOVE 1100 E. Dove, Ste 101 • McAllen, TX, 78504 • Tel: (956) 362-8640 • Fax: (956) 362-8649

☐ IMAGING CENTER AT MAIN CAMPUS 5521 Doctors Drive • Edinburg, TX 78539 • Tel: (956) 362-7570 • Fax: (956) 362-7568

☐ IMAGING CENTER AT MED POINT 1200 E. Savannah, Ste. 1 • McAllen, TX 78503 • Tel: (956) 362-3500 • Fax: (956) 362-3699

☐ IMAGING CENTER AT MID VALLEY 1121 James Street • Weslaco, TX 78596 • Tel: (956) 362-3660 • Fax: (956) 362-3641

☐ IMAGING CENTER AT LONE STAR 2121 E. Griffin Parkway, Ste 15 • Mission, TX 78572 • Tel: (956) 362-3900 • Fax: (956) 362-3915

☐ CT Δ ☐ CTA Δ _____ ☐ R ☐ L ☐ Bilateral ☐ W/O IV Contrast ONLY ☐ W/ IV Contrast ONLY*
☐ 3D Reconstruction ☐ If W/O AND W/IV Contrast*, please contact a radiologist at 362-7541

☒ MRI ☐ MRA C spine ☒ W/O IV Contrast ☐ W/ IV Contrast ☐ R ☐ L ☐ Bilateral
☐ W/O AND W/IV Contrast

☐ ULTRASOUND _____ ☐ ABD Complete ☐ ABD Limited - Specify Area: _____
☐ Renal ☐ Pelvis ☐ OB ☐ Trans Vag

☐ X-RAYS Δ _____ ☐ CXR 2 V. ☐ ABD 1 V./KUB ☐ ABD 2 V. ☐ R ☐ L ☐ Bilateral

☐ FLUOROSCOPY Δ* _____ (Dove Location ONLY) ☐ Barium Swallow ☐ Upper GI ☐ IVP*
☐ Small Bowel Follow Through ☐ Single Contrast BE ☐ Double Contrast BE

☐ OTHER _____

☐ SPECIAL INSTRUCTIONS ☆ Workers Comp ☆

* EXAMS WITH THIS SYMBOL * WILL HAVE LABS DRAWN (WITHIN 24 - 48 HOURS OF EXAM) TO CHECK BUN & CR LEVELS.
Δ LABS WILL BE DRAWN FOR HCG LEVELS WHENEVER REQUIRED FOR EXAM, TO RULE OUT PREGNANCY.

radiculopathy cervical region
CLINICAL DIAGNOSIS
(DO NOT USE "Rule Out" or "Possible")

Dr. Lionel Moreno
ORDERING PHYSICIAN'S NAME (print)

_____
REFERRING PHYSICIAN'S NAME
(NOT THE ORDERING PHYSICIAN)

L) M
ORDERING PHYSICIAN'S SIGNATURE / DATE

Radiology Staff Only
Orders Received By: _____
Date: _____ Time: _____

Reyes, Rebecca 56y F
DOB: 08/31/67

Patient Chart Report

Family Physicians Clinic LLP

⚠ The clinical information in this record has been released in accordance with confidentiality requirements

Patient Information

Demographics

		Additional Information	
Patient Number	66711		
Chart Number	43128		
Age/Sex	56y F		
Marital Status	Married		
Emp. Status	Employed		
Assigned Prov	Moreno, Leonel G. MD		
Primary Care Prov			
Care Coordinator			
Referring Prov			
Rel. to Guarantor	Employee		
Date of Birth	08/31/1967		
Race	Race Not Reported - Refusal		
Language	English		
Mother's Maiden			
Social Security #	467-53-3070		
Became Patient	11/13/23		
Last Visit	02/26/24		
Home Phone	(956) 451-7764		
Work Phone	(956) 618-7338	Email	Bigreyes89@yhoo.com
Mobile Phone	(956) 451-7764		
Address	2218 N. Ruby St. Edinburg, TX 78541-7579		
Patient Consent	Yes	Recall Method	Paper
Rx History Consent	Rx Hx Consent Given for Any Prescriber		
Date Set	11/13/23		
Consent Notes	Set During Patient Registration.		

Guarantor Information

Guarantor	McAllen ISD	Date of Birth	
Home Phone	(956) 618-6000	Social Security #	
Work Phone		Account Date	11/13/23
Address	2000 N 23rd	Employer	
City, State & Zip	McAllen TX 78501	Emp. Status	

Insurance Information

	Insurance Plan Name	Insurance ID	Group #	Subscriber Name	Relation	Start and End Dates
1	TriStar Risk Management	241120972		McAllen ISD	Employee	

Family Physicians Clinic LLP
606 S Broadway Street
McAllen, TX 78501-4906
(956) 682-4515

Daniel J. Guerra, M.D.
Leonel G. Moreno, M.D.
Juan M. Flores, Jr., D.O.
Jesus R. Garza, II, M.D.

Members of
The American Academy
Of Family Physicians

Patient: Rebecca Reyes
Date of Birth: 08/31/1967
SSN (last 4 #): 3070

Visit Date: 04/26/2024
Attending Provider: Leonel G. Moreno MD
Referring Provider:

Patient Visit Note

Active Problems & Conditions
- M54.12 - Cervical Radiculopathy Right
- M54.13 - Neuritis Brachial Right
- M75.41 - Shoulder Impingement Right
- M75.81 - Tendonitis Rotator Cuff Right

Chief Complaint
• The Chief Complaint is: f/u for work related injury to bilateral hands and shoulders / low back / patient went to see ortho and ortho recommened trigger injection to right shoulder / patient states therapy on her right hand due to tingling and numbness sensation when she stopped the fall on the day of incident. .

History of Present Illness
This is a 56 year old Female with the following history: Come for follow up on hands an shoulder claim still has numbness to right hand. Patient was seen by a orthopedic doctorr and was told had impingement syndrome of right shoulder plus numbness of right hand probably secondary to cervical spine pathology. Patient had trigger point injection to right shoulder that did not help. Currently continue to complain of right wrist paina nd numbness

Positive Symptoms
Pertinent negative symptoms:
No systemic symptoms, no head symptoms, no neck symptoms, no eye symptoms, no otolaryngeal symptoms, no breast symptoms, no cardiovascular symptoms, no pulmonary symptoms, no gastrointestinal symptoms, no genitourinary symptoms, no endocrine symptoms, no hematologic symptoms, no musculoskeletal symptoms and no skin symptoms
Other History

• Allergy list reviewed. • Medication list reviewed.

Current Medication

Patient Name: Rebecca Reyes **Date: 04/26/2024**

- Alendronate Sodium 70 MG Oral Tablet 30 days, 0 refills
- Folic Acid 1 MG Oral Tablet 90 days, 0 refills
- Ibuprofen 800 MG Oral Tablet 1 tab every 8 hours with meals, 30 days, 0 refills
- Lisinopril 20 MG Oral Tablet 90 days, 0 refills
- Methotrexate Sodium 2.5 MG Oral Tablet 84 days, 0 refills
- Vitamin D (Ergocalciferol) 1.25 MG (50000 UT) Oral Capsule 84 days, 0 refills

Chief Complaint
The Chief Complaint is: F/u for work related injury to bilateral hands and shoulders / low back / patient went to see ortho and ortho recommened trigger injection to right shoulder / patient states therapy on her right hand due to tingling and numbness sensation when she stopped the fall on the day of incident.

Past Medical/Surgical History
Diagnoses:
Essential hypertension
Psoriatic arthritis, vitamin d deficiency, ostoporosis.

Social History
Caffeine use: No caffeine use.
Tobacco use: Not a current smoker.
Alcohol: Not using alcohol.
Drug Use: Not using drugs.
Work a secrtary for McAllen ISD.

Family History
Systemic hypertension

Physical Findings
- Vitals taken 04/26/2024 10:17 am

BP-Sitting L	103/68 mmHg
BP Cuff Size	Regular
Pulse Rate-Sitting	56 bpm
Temp-Oral	98.5 F
Height	62 in
Weight	175 lbs 6.4 oz
Body Mass Index	32.1 kg/m2
Body Surface Area	1.8 m2

Neck:
Suppleness: ° Neck demonstrated no decrease in suppleness.
Thyroid: ° Showed no abnormalities.
Cervical Mass: ° No cervical mass was seen.
Eyes:
General/bilateral:
Extraocular Movements: ° Normal.
Ears:
General/bilateral:
External Auditory Canal: ° External auditory meatus normal.
Tympanic Membrane: ° Normal.
Nose:
General/bilateral:
Discharge: ° No nasal discharge.
Sinus Tenderness: ° No sinus tenderness.
Pharynx:
Oropharynx: ° Normal.

Patient Name: Rebecca Reyes **Date: 04/26/2024**

Lymph Nodes:
° Supraclavicular lymph nodes were not enlarged. ° Axillary lymph nodes were not enlarged. ° Inguinal lymph nodes were not enlarged.
Chest:
° No thoracic asymmetry was noted.
Lungs:
° Normal breath sounds/voice sounds. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.
Cardiovascular:
Heart Rate And Rhythm: ° Normal.
Murmurs: ° No murmurs were heard.
Back:
° Normal.
Abdomen:
Auscultation: ° Bowel sounds were normal.
Palpation: ° Abdominal non-tender. ° No mass was palpated in the abdomen.
Liver: ° Not enlarged.
Spleen: ° Not enlarged.
Musculoskeletal System:
General/bilateral: • Overall findings persistent pain to right shoulder range of motion but currently able to move with normal range of motion. Alsohas pain to right wrist and numbness of right hand.
Shoulder:
Right Shoulder: • Pain was elicited during a crossed arm impingement test.
Skin:
° General appearance was normal. ° Texture was normal. ° Turgor was normal. ° Color and pigmentation were normal. ° Moisture was normal. ° Temperature was normal. ° No skin lesions.

Assessment
• [S43.421A - Sprain of right rotator cuff capsule, initial encounter] Acute right rotator cuff capsule sprain
• [M75.41 - Impingement syndrome of right shoulder] Impingement of right shoulder
• [M75.81 - Other shoulder lesions, right shoulder] Right rotator cuff tendonitis
• [M54.12 - Radiculopathy, cervical region] Right cervical radiculopathy

Plan
- **Radiculopathy, cervical region**
  Outside Procedures/MRI: MRI C-Spine w/out contrast
  Outside Procedures/Neurological Procedu: EMG-NCS
  Gabapentin 100 MG capsule TAKE ONE CAPSULE TWICE DAILY, 30 days, 0 refills

Due persistent neuropathic pain on right wrist will request MRI CERVICAL SPINE AND NCS to asses state of cervical spine disc and rule out carpal tunnel syndrome.

Health Reminders
- Assess Alcohol Use satisfied 04/26/2024.
- Assess BMI satisfied 04/26/2024.
- Assess Tobacco Use satisfied 04/26/2024.
- Blood Pressure Measurement satisfied 04/26/2024.

Leonel G. Moreno MD

Patient Name: Rebecca Reyes **Date: 04/26/2024**

Electronically signed by: Leonel Moreno Date: 04/26/2024 16:33

FILL OUT ENTIRE PAGE

PT. NAME: Rebecca Reyes

DOB: 8/31/67

SSN: 467-53-3070

ACCT. #

INSURANCE VERIFICATION

(ATTACH COPY OF CARD IF APPLICABLE)

WORKMAN'S COMP

DATE / TIME OF ACCIDENT: 1/11/24 8:45 AM

HOW INJURY OCCURRED: Stepped edge of sidewalk - fell on knees & hands

PART OF BODY INJURED: Knees, hands, arms, lower back

EMPLOYER: McAllen ISD OCCUPATION: Secretary

ADDRESS: 1601 N. 27th St. TELEPHONE: 956-618-7338

CITY: McAllen STATE: TX ZIP: 78501

NAME OF SUPERVISOR: Rocio Nava LENGTH OF EMPLOYMENT: 20 yrs.

IF YOUR COMPANY PROVIDES INSURANCE PLEASE STATE THE CARRIER:

W/C CLAIM #: Texas HP 657-5385

CIRCLE ONE: TRADITIONAL PPO HMO (W/C) LIABILITY

GUARANTOR'S NAME: S.S.N.

I.D. # GRP# TAF

INSURANCE COMPANY: Tristar

ADDRESS: PO Box 2805 PHONE: 210-404-0400 / 210-404-0429

CITY: Clinton STATE: TN ZIP: 52733

EFFECTIVE DATE: COVERAGE: SLF SLF/SPS SLF/CHI FAM

COPAY: CO-INSURANCE: DEDUCTIBLE:

HAS DEDUCTIBLE BEEN MET? YES NO HOW MUCH?

NEXT DAY LAB, INJ., X-RAYS:

PREVENTIVE CARE: Mirena

MINOR SURGERY:

ACCIDENT CLAUSE:

COMMENTS:

IS PRECERTIFICATION REQUIRED FOR OUTSIDE REFERRAL OR FACILITY?

VERIFIED WITH: VERIFIED BY: DATE: 1/12/24

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, Unless the Division specifically requests a direct filing.

CLAIM #

CARRIER'S CLAIM # 825/060

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.): Reyes, Rebecca
2. Sex: F ☑ M ☐
3. Social Security Number: 467 -53 -3070
4. Home Phone: (956) 4517764
5. Date of Birth (m-d-y): 08 -31 -1987
6. Does the Employee Speak English? YES ☑ NO ☐ If No, Specify Language:
7. Race: White ☑ Black ☐ Asian ☐
8. Ethnicity: Hispanic ☑ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box: 2218 N Ruby St.
City: Edinburg State: TX Zip Code: 78541 County: Hidalgo
10. Marital Status: Married ☑ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children: 0
12. Spouse's Name: Esequiel Reyes
13. Doctor's Name: Dr. Luis Delgado
14. Doctor's Mailing Address (Street or P.O.Box):
City: McAllen State: TX Zip Code: 78501

15. Date of Injury (m-d-y): 1 -11- 2024
16. Time of Injury: 8 :45 am ☑ pm ☐
17. Date Last Time Began (m-d-y): - -
18. Nature of Injury*: Fell
19. Part of Body Injured or Exposed*: both knees
20. How and Why Injury/Illness Occurred*: Employee was walking down the sidewalk by Staff Development building and the parking lot towards the Staff Development office and fell on both knees as she turned right to continue on the sidewalk. (both knees are red and there is a bruise in the left knee.)
21. Was employee doing his regular job? YES ☑ NO ☐
22. Worksite Location of Injury (office, dock, etc.)*
23. Address Where Injury or Exposure Occurred Name of business if accident occurred on a business site: 1601 N 27th St.
Street or P.O. Box County
City: MCALLEN State: TX Zip Code: 78501
24. Cause of Injury (fall, tool, machine, etc.)*: fall
25. List Witnesses: none
26. Return to work date/or expected (m-d-y): - -
27. Did employee die? YES ☐ NO ☑
28. Supervisor's Name: Rocio Nava
29. Date Reported (m-d-y): 1 -11 -2024

30. Date of Hire (m-d-y): 03/03/2015
31. Was employee hired or recruited in Texas? YES ☑ NO ☐
32. Length of Service in Current Position: Months 10 Years 8
33. Length of Service in Occupation: Months 8 Years 10
34. Employee Payroll Classification Code: 8810
35. Occupation of Injured Worker: Sec-Director Bilingual Dept
36. Rate of Pay at this Job: $ 21.45 Hourly $ 858.00 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ ____ for ____ Hours or ____ Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

Karina Garza-Coord. for Risk Management

40. Name and Title of Person Completing Form: Rocio Nava
41. Name of Business: MCALLEN ISD
42. Business Mailing Address and Telephone Number Street or P.O. Box: 1601 N. 27th St Portable 13 Telephone: (956) 618-7338
City: MCALLEN State: TX Zip Code: 78501
43. Business Location (if different from mailing address) Number and Street: 2000 N 23rd St
City: McAllen State: TX Zip Code: 78501
44. Federal Tax Identification Number: 74-6001658
45. Primary North American Industry Classification System Code: (6 digit) 611110
46. Specific NAICS Code (6 digit) 611110
47. Texas Comptroller Taxpayer No.: 74-6001658
48. Workers' Compensation Insurance Company: Self Insured
49. Policy Number:
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) 1/11/24
X Rocio O Nava Karina Garza (Risk Mgmt. Coord.) Date 1/11/24

DWC FORM-1 (Rev. 10/05) Page 3

DIVISION OF WORKERS' COMPENSATION

McALLEN INDEPENDENT SCHOOL DISTRICT

EMPLOYEE BENEFITS DEPARTMENT

EMPLOYEE'S ELIGIBILITY FOR WORK RELATED ILLNESS OR INJURY

This is to certify the below named person, an employee of McAllen I.S.D., has sustained a possible work-related injury or illness and is entitled to select the Doctor, Chiropractor, and for Pharmacy of his/her choice for treatment or medication.

Name of Employee: Rebecca Reyes Phone #: (956) 451-7764

Employee SSN: XXX-XX- 3070 Location: Bilingual Dept.

Date of Injury: 01/11/24 Time of Injury: 08:45 ☑ AM ☐ PM

Injury Description: Walking on sidewalk toward SD to pick up parents and students. When exiting the gate turned right stepping on the edge of sidewalk and fell on both knees and hands.

Name of Hospital, Clinic or Doctor: _____

Supervisor: _____ Witness: _____

To Be Completed by Physician

Treatment Date: _____ Is Illness ☐ Injury ☐ Work Related: YES ☐ NO ☐

Diagnosis: _____

Prognosis: _____

Treatment Administered: _____

Date of Next Treatment & Frequency: _____

Medication Prescribed: _____

Return to: ☐ Regular Work ☐ Home ☐ Hospital

Work Restrictions: _____ Effective Until: _____

Authorized Signature: _____ Date: _____

**Please forward this form to the Employee Benefits Department via email: benefits@mcallenisd.net **

CLAIMS ADMINISTRATOR, TRISTAR Risk Management, P.O. BOX 2305, Clinton, IA 52733-2305
PH#: 210-404-0400 EXT: 2911 * FAX#: 210-404-0429

McALLEN INDEPENDENT SCHOOL DISTRICT

EMPLOYEE BENEFITS DEPARTMENT

SUPERVISORS ACCIDENT INVESTIGATIVE REPORT

Name of Injured: Rebecca Reyes Employee ID#: 700594

Campus: Bilingual/ESL/FL Department Location: Side walk by Staff Development Bldg. and parking lot

Job Title: Secretary

Time of Incident: 8:45 am Date of Incident: 1/11/24 Date reported if different: 1/11/2024

How long has employee worked with your department: 2.5 years

Describe the details of the accident (How/What/Where/Why): Mrs. Reyes was walking towards the Staff Development office. She was on the sidewalk, and she exited the gate by the portables and turned right towards the Staff Development office (on the sidewalk by the Staff Development Bldg. and the parking lot) and fell on both of her knees.

List any instructions given, for the activity that gave rise to the injury, written or verbal, prior to the incident: N/A

What could have been done to prevent this injury? N/A

What special protective equipment was provided or required? (Ex Goggles, Special Shoes, Gloves, Safety Belt, Back Belt, etc.) YES ☐ NO ☐ If yes, describe type: N/A

What have you done thus far? (Ex. Safety Counseling, Equipment Repaired, Defects Corrected)? Has employee attended any Safety Training recently or related to the activity? District safety training yearly.

Additional Comments: N/A; no witness

Supervisor Name: Rocio Nava

Department: Bilingual/ESL/FL Department

Supervisor Signature: Rocio Nava Date: 1/11/2024

**This form is due in the Employee Benefits Department within 24 hours from date of accident.*

CLAIMS ADMINISTRATOR, TRISTAR Risk Management, P.O. BOX 2805, Clinton, IA 52733-2805
PH#: 210-404-0400 EXT: 2911 • FAX#: 210-404-0429

McALLEN INDEPENDENT SCHOOL DISTRICT

EMPLOYEE BENEFITS DEPARTMENT

EMPLOYEE INCIDENT REPORT

Name of Employee: Rebecca Reyes Employee ID#: 700594

Employee Address: 2218 N. Ruby St. Edinburg TX 78541

Campus: Bilingual Department Location: Achieve Early College-Portable 13

Job Title: Secretary to Bilingual Director

Time of Incident: 9:45 am Date of Incident: _____ Date reported if different: 01/11/2024

Describe the details of the accident (How/What/Where/Why) BE VERY SPECIFIC: Walking on sidewalk toward SD to pick up parents and students. When exiting the gate turned right stepping on the edge of sidewalk and fell on both knees and hands.

Body Location(s) affected by Incident: Knees and Hands

What special protective equipment was provided or required? (Ex. Goggles, Special Shoes, Gloves, Safety Belt, Back Belt, etc.) YES ☐ NO ☐ If yes, describe type: N/A

Was such equipment being used or worn at the time of incident? YES ☐ NO ☐ If yes, describe: N/A

Was equipment the source or cause of the incident? (Ex. Guards missing, equipment faulty, etc.) YES ☐ NO ☑ If yes, describe: _____

Were there any witnesses to the incident: YES ☐ NO ☑ If yes, please list names and department: _____

I, the undersigned, herewith certify that the above is true and correct statement of fact, and that I made such statement of my own free will.

Employee Signature: Rebecca Reyes Date: 1/11/24

***This form is due in the Employee Benefits Department within 24 hours from date of accident.**

CLAIMS ADMINISTRATOR, TRISTAR Risk Management, P.O. BOX 2005, Clinton, IA 52733-2005
PH#: 210-404-0400 EXT: 2911 • FAX#: 210-404-0429

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

TRISTAR RISK MANAGEMENT
PO BOX 2805
CLINTON IA 52733

CARRIER

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID# DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	241120972	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
REYES, REBECCA	08 31 1967 M [ ] F [X]	MCALLEN ISD
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
2218 N RUBY ST	Self [ ] Spouse [ ] Child [ ] Other [X]	2000 N 23RD
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
EDINBURG TX		MCALLEN TX
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
78541-7579 (956)4517764		78501 (956)6186000
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
		TRISTAR RISK MANAGEMENT
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 11/13/2023

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. 444 MM DD YY 01 13 2024	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
01 11 2024 QUAL. 431		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. S8001XA B. S8002XA C. S335XXA D. S40011D		23. PRIOR AUTHORIZATION NUMBER
E. G5601 F. M7581 G. H. I. J. K. L.		

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02262024	02262024	11		99213		ABC	175 00	1		OB NPI	MDJ9224TX 1013077213
2 02262024	02262024	11		99080	73	ABC	20 00	1		OB NPI	MDJ9224TX 1013077213
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID
741601453	[X]	CE2002LZ	[X] YES [ ] NO	$ 195 00	$ 0 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (956) 6824515
LEONEL D MORENO MD	FAMILY PHYSICIANS CLINIC L	FAMILY PHYSICIANS CLINIC
SIGNED 02/28/2024	606 S BROADWAY ST	606 S BROADWAY STREET
	MCALLEN TX 78501-4906	MCALLEN TX 78501-4906
	a. 1013995273 b.	a. 1013995273 b.

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