STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM

☐ Amended Application

Case No.

558874287
SSN (Numbers Only)

Venue choice is based upon (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☑ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

VNO
Select 3 - Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Injured Worker (Completion of this section is required)

JAMES
First Name

MI

WALLACE
Last Name

3672 ROSENA RANCH RD
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

SAN BERNARDINO
City

CA
State

92407
Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

STATE OF CALIFORNIA
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☑ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

RIV

Select 3 - Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Injured Worker (Completion of this section is required)

ALVIN — MI

First Name

WATSON

Last Name

PO BOX 400375

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

HESPERIA — CA — 92340

City — State — Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City — State — Zip Code

WCAB1

IT IS CLAIMED THAT :

1. The injured worker born* 01/08/1965 (Date of birth : MM/DD/YYYY)

, while employed as a(n) CASE MANAGER

(Occupation at the time of injury)

suffered a: (Choose only one)

◯ specific injury on _____ (DATE OF INJURY: MM/DD/YYYY)

◉ cumulative trauma injury which began on

01/22/2018 and ended on 03/09/2018

(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

The injury occured at* 2471 N BEACHWOOD DR

(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

LOS ANGELES , CA 90068

(City)* (State)* (Zip Code)*

(State which parts of the body were injured)

Body Part 1 : 200 NECK Body Part 2 : 450 SHOULDERS - SCAPULA AND

Body Part 3 : 420 BACK - INCLUDING BACK Body Part 4 : 500 LOWER EXTREMITIES - NOT S

Other Body Parts : 841 NERVOUS SYSTEM - STRESS

2.The injury occurred as follows:

(Explain What The Worker Was Doing At The Time Of Injury And How The Injury Occured)

Field size limited to 325 characters

STRESS AND STRAIN DUE TO REPETITIVE MOVEMENT, UNCOMFORTABLE CHAIR,
INAPPROPRIATE LIGHTING, INJURED SHOULDERS, NECK, LOWER BACK AND LOWER
EXTREMITIES; STRESS/DEPRESSION/ANXIETY DUE TO HOSTILE WORK ENVIRONMENT
AND DISCRIMINATION BASED ON SEX ORIENTATION

3. Actual earnings at the time of injury

Rate of Pay $ _____ ◯ Monthly ◯ Weekly ◯ Hourly

State value of tips, meals, lodging or other advantages regularly received $ _____ ◯ Monthly ◯ Weekly ◯ Hourly

Number of hours worked per week. _____

4. The injury caused disability as follows

Last day off work due to injury : _____

(MM/DD/YYYY)

First Period of Disability: Start date _____ (MM/DD/YYYY) End date _____ (MM/DD/YYYY)

Second Period of Disability: Start date _____ (MM/DD/YYYY) End date _____ (MM/DD/YYYY)

State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☑ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle): Barajas, Rigoberto

Date of Injury (MM/DD/YYYY): 12/28/2017	Date of Birth (MM/DD/YYYY): 05/07/1953
Claim Number: 011975 105245 WC 01	Employer: Peri Formwork Systems

Requesting Physician Information

Name: SHAMEL HASHISH, M.D.

Practice Name: CMC - Rancho Cucamonga		Contact Name:	
Address: 9405 Fairway View Place		City: Rancho Cucamonga	State: CA
Zip Code: 91730	Phone: 909-481-7345	Fax Number: Main: 909-484-8661 PT: 909-481-5508	
Specialty: Physiatrist		NPI Number: 1205003027	
E-mail Address:			

Claims Administrator Information

Company Name: Gallagher Bassett		Contact Name: Tami Osheroff	
Address: PO Box 2831		City: Clinton	State: IA
Zip Code: 52733	Phone: 8004330181	Fax Number: 0000000000	
E-mail Address:			

Requested Treatment: (See Instructions for guidance; attach additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information (Frequency, Duration Quantity, etc.)
CONTUSION WALL OF THORAX	S20.219A	Ibuprofen 600 mg #45		Rx given in clinic
STRAIN NECK	S16.1XXA	Flexeril 10 mg # 30		Rx given in clinic

Requesting Physician Signature: [signature] Date: 02/21/2018

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

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☒ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request

Employee Information

Name (Last, First, Middle): Carbajal Lopez	Maria	De Jesus	
Date of Injury (MM/DD/YYYY): 06/21/2019		Date of Birth (MM/DD/YYYY): 10/01/1956	
Claim Number: 189034421-001		Employer: Wonderful Citrus	

Requesting Physician Information

Name: Greene, Michael NP			
Practice Name: Premier Occupational - Indio		Contact Name:	
Address: 81719 Dr. Carreon Blvd		City: Indio	State: CA
Zip Code: 92201-583	Phone: (760) 619-3053	Fax Number: (760) 619-3054	
Specialty: 363LA2200X		NPI Number: 1356430532	
E-mail Address: rfa@premieroccupational.com			

Claims Administrator Information

Company Name: Broadspire		Contact Name:	
Address: PO Box 14645		City: Lexington	State: KY
Zip Code: 40512	Phone: (866) 780-4075	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered, list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information (Frequency, Duration Quantity, etc.)
Sprain of unspecified site of right knee, subs encntr	S83.91XD			
Unsp fx right patella, subs for clos fx w routn heal	S82.001D			
Oth tear of medial meniscus, current injury, r knee, subs	S83.241D	Orthopedist consultation for the right knee	99204	In- House Orthopedist
Synovial cyst of popl teal space [Baker], right knee	M71.21			

Requesting Physician Signature: [signature] Date: Jul 15, 2019

Claims Administrator/Utilization Review Organization (URO) Response

☒ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date: 7-25-19
Authorized Agent: Name:		Signature: Michelle Jackson
Phone:	Fax Number:	E-mail Address:

Comments:
Approved to consult with in house orthopedist

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

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☒ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle): **Contreras, Blanca** [000022542954] Home: 714-797-8947 Cell: 909-997-8947

Date of Injury (MM/DD/YYYY): **10/04/2018**	Date of Birth (MM/DD/YYYY): **05/09/1957**
Claim Number: **PENDING**	Employer: **UC RIVERSIDE**

Requesting Physician Information

Name: **JAYVEEH DE VENECIA NAVARRO MD**

Practice Name: **Kaiser Permanente On-the-Job Moreno Valley**		Contact Name: **Roxana Heredia**	
Address: **12815 HEACOCK ST**		City: **MORENO VALLEY**	State: **CA**
Zip Code: **92553-3116**	Phone: **844-789-0172**	Fax Number: **855-902-6796**	
Specialty: **Occupational Medicine**		NPI Number: **1881915924**	
E-mail Address:			

Claims Administrator Information

Company Name: **SEDGWICK CLAIM MGMNT SVCS INC**		Contact Name: **Pending**	
Address: **PO BOX 14433**		City: **LEXINGTON**	State: **KY**
Zip Code: **40512-4187**	Phone: **916-788-9901**	Fax Number: **916-771-2990**	
E-mail Address:			

Requested Treatment (see instructions for guidance; attach additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
1. Left Wrist Contusion, Init 2. Neck Muscle Strain, Init 3. Rib Contusion, Init 4. Left Knee Contusion, Init	**1. S60.212A 2. S16.1XXA 3. S20.219A 4. S80.02XA**	**Physical Therapy (INIT)**		**2X3=6 MEDRISK**

Requesting Physician Signature: (Electronically signed by:) **JAYVEEH DE VENECIA NAVARRO MD** Date: **October 09, 2018**

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

Employee Address: Blanca C Contreras
16977 Green Ash St
Fontana CA 92337-6886

Home Phone: 714-797-8947
Cell Phone: 909-997-8947
Work Phone:

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☐ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle): Hurtado,Daniel			
Date of Injury (MM/DD/YYYY): 08/22/2018		Date of Birth (MM/DD/YYYY): 09/05/1972	
Claim Number: 145086		Employer: G. Hurtado Construction	

Requesting Physician Information

Name: Ronna Parsa D.O			
Practice Name: Glendale Fidelity Medical Group		Contact Name:	
Address: 815 E. Colorado ST # 110A		City: Glendale	State: CA
Zip Code: 91205	Phone: (818) 242-1910	Fax Number: (818) 242-1990	
Specialty:		NPI Number:	
E-mail Address:			

Claims Administrator Information

Company Name: Applied Risk Services		Contact Name: Andrew Stodola	
Address: P.O. Box 3804		City: Omaha	State: NE
Zip Code: 68103	Phone:	Fax Number: (877) 234-4425	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
B shoulder rotator cuff	M75.101			
tenidinits/bursitis				
lumbar spine strain	S39.012A			

Requesting Physician Signature: Date:

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

State of California
Division of Workers' Compensation
Request for Authorization for Medical Treatment (DWC for RFA)

This form must accompany the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or narrative report substantiating the requested treatment.

☑ New Request ☐ Resubmission – Change in Material Facts

☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health

☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Employee Name (Last, First, Middle): Marquez-Tapia, Delia Leticia
Date of Injury (MM/DD/YYYY): 08/30/2018; CT: 12/20/2011 - 08/30/2018
Date of Birth (MM/DD/YYYY): 03/13/1964
Claim Number: 2018022174
Employer: BARON HR

Requesting Physician Information

Provider Name: Michael Salomon, DC
Practice Name: Mike Salomon DC INC
Contact Name:
Address: 155 W. Hospitality Lane Suite 245
City: San Bernardino State: CA
Zip Code: 92408 Phone: (323) 435-4523
Fax Number: (323) 433-4122
Provider Specialty: Chiropractic
License Number: DC23361
E-mail Address:

Claims Administrator Information

Claims Administrator Name: ICW
Contact Name: Magellan, Robert
Address: P.O. Box 2965
City: Clinton State: IA
Zip Code: 52733 Phone: (858) 350-2862
Fax Number: (858) 350-2755
E-mail Address:

Requested Treatment (see instructions for guidance; attach additional pages if necessary)

Either state the requested treatment in the below space or indicate the specific page number(s) of the accompanying medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; attach additional requests on a separate sheet.

Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration, Quantity, Facility, etc.)
Right shoulder rotator cuff strain; Left shoulder rotator cuff strain	S46.011A; S46.012A	Start PT for the B/L shoulders	97014, 97024, 97026, 97110, 97124, 97035, 97140	1x/wk for 8 wks
Same as above	Same as above	Start Acup for the B/L shoulders	97802, 97026, 97813, 97814	1x/wk for 8 wks, scheduled on 01/17/2019

Treating Physician Signature: Mike Salomon DC
Date of Request: 01/11/2019

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or modified (See Separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if Assigned):
Date:
Authorized Agent Name:
Signature
Phone: Fax Number:
E-mail Address:
Comments:

DWC Form RFA (version 012014)

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☐ New Request ☑ Resubmission – Change in Material Facts

☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health

☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle): PADILLA, JOHN

Date of Injury (MM/DD/YYYY): 07/01/2013 | Date of Birth (MM/DD/YYYY): 10/03/1971

Claim Number: WC600A69309 | Employer: TNT

Requesting Physician Information

Name: DR. KYLE LANDAUER, M.D.

Practice Name: LONG BEACH PRIME MEDICAL GROUP | Contact Name: NIA

Address: 4014 LONG BEACH BLVD, SUITE 210 | City: LONG BEACH | State: CA

Zip Code: 90807 | Phone: (562) 997-7100 | Fax Number: (562) 881-9423

Specialty: ORTHOPEDIC SURGEON | NPI Number: 1609923895

E-mail Address:

Claims Administrator Information

Company Name: LIBERTY MUTUAL GROUP | Contact Name: RAQUEL SHICORA

Address: P. O. BOX 999000 | City: WEST SACRAMENTO | State: CA

Zip Code: 95799 | Phone: (916) 621-1123 | Fax Number: (800) 450-1988

E-mail Address:

Requested Treatment (see instructions for guidance, attached additional pages if necessary):

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (if known)	Other Information: (Frequency, Duration Quantity, etc.)
Strain of muscle,	S39.012A	functional capacity		
fascia and tendon		evaluation		
of lower back,				
initial encounter				

Requesting Physician Signature: [signature] Date: 09/11/2017

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)

☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned): | Date: 11/07/2017

Authorized Agent Name: Cheiton Taubodo | Signature: [signature]

Phone: 916-631-1182 | Fax Number: 503-334-8141 | E-mail Address:

Comments:

PCE is authorized as requested. Thanks ,CT

FAXED SEP 22 2017

[ ] Prev Gp

ROSEVILLE- SUNRISE

12/04/20

729 SUNRISE AVE, STE #606
ROSEVILLE, CA 95661

ARROWHEAD EVALUATION SERVICES, INC.
1680 Plum Lane
Redlands, California 92374
(909) 335-2323

Patient No: 278381

DATE 11/09/20 TIME 5:00:00 P

APPLICANT: ROGELIO VAZQUEZ B/D 06/06/62 SS# *****2350 PHONE: 916-541-1058

MAILING ADDRESS: 5836 HIMALAYA WAY CITRUS HEOGHTS, CA 95621 ALT PHONE: N/A

TYPE OF INJURY: RIGHT ELBOW, RIGHT SHOULDER EMAIL: N/A

DOCTOR: DAVID BRODERICK, M.D. TYPE OF EXAM: PANEL QME Panel QME #: 2582502

SCHEDULING AGENCY: GALLAGHER BASSETT PHONE: 916-403-1607

CALLER: JACOB BABCOCK- JACOB_BABCOCK@GBTPA.COM FAX: 844-615-8884

APP. ATTY. FIRM: N/A

APP ATTY: APP. ATTY PHONE:

A.A. ADDRESS: A.A. FAX:

A.A. EMAIL ADDRESS:

DEF. ATTY. FIRM: N/A

DEF. ATTY: DEF. ATTY. PHONE:

DEF. ATTY. ADDRESS: DEF. FAX:

DEF. ATTY EMAIL ADDRESS:

INTERPRETER [☑] INTERPRETER NAME 11/06/20-DAVID-CERT

SCHED. AGENCY WILL SET INTERPRETER [☑] AGENCY ONE CALL PHONE: 866-672-5797

INS. CARRIER: GALLAGHER BASSETT

INS. ADDRESS: P.O. BOX 2840 CLINTON IA 52733-2840

CLAIM REP: JACOB BABCOCK PHONE: 916-403-1607 FAX:

CLAIM REP. EMAIL ADDRESS: JACOB_BABCOCK@GBTPA.COM

DATE OF INJURY: 01/21/20 **CT** - ADJ. NO. N/A CLAIM NO. 002042-025627-WC-01

EMPLOYER: PETERSEN PRECISION ENGINEERING

EMPLOYER ADDRESS: 611 BROADWAY ST REDWOOD CITY, CA 94063

PATIENT CONFIRM DATE 11/06/20 HIST/PX/SENT QME 110 MAILED

COVER LETTER 11/04/20INS MED RECS REC'D: [ ] [ ] [ ] [ ]

X-RAYS: REFERRAL TAKEN BY: fgomez 08/29/20]

LANAI DEMOGRAPHIC SHEET VERA, Staphanie 280732 PK QME 11/25/2020		**REFERRAL DATE** 10/9/2020	ARROWHEAD EVALUATION SERVICES, INC. 1680 Plum Lane Redlands, CA 92374 (909) 335-2323
APPOINTMENT DATE 12/5/2020		**APPOINTMENT TIME** 10:45 am	**DOCTOR** Paul Kim, MD
SERVICE REQUESTED QME: PQME	**PANEL NO.** 7356100	**APPOINTMENT SET BY** Karie D. Eckhoff: Bencivenga & Associates	**APPOINTMENT LOCATION** 2760 East Florence Avenue Huntington Park, CA 90255

Patient Information

PATIENT NAME	Staphanie Vera	**DOB**	8/23/2001	**GENDER**	Female
PATIENT ADDRESS	1426 South Woods Avenue Los Angeles, CA 90022	**SSN**	620-28-2332		
		PHONE			

Insurance and Claim Information

INSURANCE COMPANY	**Travelers** Mailing/Billing Address: P.O. BOX 660055 Dallas, TX 75265	**Kurt Harrison** Phone: (909) 612-3865 Fax: (877) 801-9677
DEFENSE ATTORNEY	**Bencivenga & Associates** P.O. Box 64093 St. Paul, MN 55164	**Angela P Lin** Phone: (909) 612-3870 Fax: (877) 222-8186 Email: aplin@travelers.com
APPLICANT ATTORNEY	**Law Offices of Edward F. Figaredo** 10507 Valley Boulevard #510, El Monte, California 91731	**Edward F. Figaredo** Edward F. Figaredo Phone: (626) 444-9515 Fax: (626) 444-9694 Email: aa@figaredo-law.com
EMPLOYER	**PLS Check Cashers of California** 1 S Wacker Dr #3600 Chicago, IL 60606	

	CLAIM #	**DOI**	**EAMS #**	**REASON FOR CONSULT/BODY PARTS**
1.	FPR1200	CT: 12-28-2019 to 02-01-2020	13076823	Shoulder, Elbow, Wrist, FIngers, Thighs, Knees, Calfs, Feet, Lower Back
2.				
3.				
4.				
5.				

Interpreter Information

INTERPRETER NEEDED? No			**SCHEDULED BY:**		
NAME		**AGENCY**		**PHONE**	

Dates

PATIENT CONFIRMED	**COVER LETTER RECEIVED**
ROR RECEIVED	

Referral Taken By

Maria Oseguera	**Date**	10/26/2020 5:52:34 AM

MemorialCare

MemorialCare Saddleback Medical Center
24451 Health Center
Laguna Hills CA 92653-3689
PERTINENT REPORT

Patient: Victoria, Maria S
MRN: 001035824, DOB: 6/27/1954, Sex: F
Acct #: 21501522

Patient Info

Patient Name	Account Number	Gender	DOB (Age)
Victoria, Maria S (001035824)	21501522	Female	6/27/1954 (64 year old)

Unit	Room	Bed	Code Status
ED	EDOH	H	Not on file

Patient Demographics

Address	Phone
8 HILLGATE PLACE ALISO VIEJO CA 92656	949-422-7038 (Home) 949-422-7038 (Mobile)

Emergency Contact(s)

Name	Relation	Home	Work	Mobile
Victoria,Elizabeth	Daughter	949-616-2225		949-616-2225
Victoria,Emiliano	Spouse	949-309-1727		949-309-1727

Epic Admission Information

Arrival Date/Time:	03/25/2019 1315	Admit Date/Time:	03/25/2019 1315	IP Adm. Date/Time:	
Admission Type:	Emergency	Point of Origin:	Emergency Room	Admit Category:	
Means of Arrival:	Bls Ambulance	Primary Service:	Emergency	Secondary Service:	
Transfer Source:		Service Area:	MEMORIALCARE SERVICE AREA	Unit:	Saddleback E.D.
Admit Provider:		Attending Provider:	Hsieh, George D, MD	Referring Provider:	

Reason for Admission

	Codes	Comments
Closed head injury, initial encounter - Primary	S09.90XA	
Contusion of left knee, initial encounter	S80.02XA	
Strain of neck muscle, initial encounter	S16.1XXA	

Discharge Information - Hospital Account/Patient Record

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
03/25/2019 1558	Home	Home	None	Saddleback E.D.

Reviewed On: **3/25/2019** By: **Bedrosian, Jennifer M., RN**

Allergies as of 3/25/2019

No Known Allergies

Problem List

Active Problems:
No active hospital problems documented on the problem list

REPORT REVIEWED
DATE REVIEWED: 3/28/19
REVIEWED BY: Buchanan MD
NORMAL/ABNORMAL: Reviewed
PLAN:

Medical History

No past medical history on file.

Surgical History

No past surgical history on file.

[ ] Prev Gp

FONTANA 2015

12/02/20

9161 Sierra Ave, Suite #114
Fontana, CA 92335

ARROWHEAD EVALUATION SERVICES, INC.
1680 Plum Lane
Redlands, California 92374
(909) 335-2323

Patient No: 273981 DATE 08/28/20 TIME 3:00:00 P

APPLICANT: MARLON VIRUETE-AMADOR B/D 08/13/90 SS# *****4003 PHONE: 323-695-2794

MAILING ADDRESS: 16755 SABINA LN., FONTANA, CA 92336 ALT PHONE: N/A

TYPE OF INJURY: ARM, WRIST EMAIL: MARLON13VIREUTE@GMAIL.CO

DOCTOR: PAUL J. MARSH, D.C. TYPE OF EXAM: PANEL QME Panel QME #7307443

SCHEDULING AGENCY: KHAKSHOUR FREEMAN A LAW CORPORATION PHONE: 323-372-1212

CALLER: STEPHANIE MERLOS FAX: 323-352-0212

APP. ATTY. FIRM: KHAKSHOUR FREEMAN A LAW CORPORATION

APP ATTY: BENJAMIN KHAKSHOUR,ESQ. APP. ATTY PHONE: 323-372-1212

A.A. ADDRESS: 5455 WILSHIRE BLVD., STE 2111 LOS ANGELES CA 90036 A.A. FAX: 323-352-0212

A.A. EMAIL ADDRESS: SMERLOS@KFALC.COM

DEF. ATTY. FIRM: JACOBS & ASSOCIATES

DEF. ATTY: CARL JACOBS DEF. ATTY. PHONE: 213-235-1287

DEF. ATTY. ADDRESS: 7162 BEVERLY BLVD STE. 581 LOS ANGELES CA 90036 DEF. FAX: 213-986-3517

DEF. ATTY EMAIL ADDRESS:

INTERPRETER [ ] INTERPRETER NAME

SCHED. AGENCY WILL SET INTERPRETER [ ] AGENCY N/A PHONE:

INS. CARRIER: BERKSHIRE HATHAWAY

INS. ADDRESS: P.O. BOX 881716 SAN FRANCISCO CA 94188

CLAIM REP: VICTOR GONZALEZ PHONE: 916-695-1929 FAX:

CLAIM REP. EMAIL ADDRESS:

DATE OF INJURY 04/14/17 CT 01/01/15 - 03/22/19 ADJ. NO. 12100814 CLAIM NO. 55066066

EMPLOYER: RESTORATION MANAGEMENT COMPANY

EMPLOYER ADDRESS: 4142 POINT EDEN WAY HAYWARD, CA 94545

PATIENT CONFIRM DATE 08/27/20 HIST/PX/SENT QME 110 MAILED 02/07/20

COVER LETTER 03/11/20 INS MED RECS REC'D: [1"] [03/25/20] [ ] [ ]

X-RAYS: REFERRAL TAKEN BY: mariao 02/05/20]

LANAI DEMOGRAPHIC SHEET WALKER, Jeltz 281532 RBW QME 12/30/2020		REFERRAL DATE 10/27/2020	ARROWHEAD EVALUATION SERVICES, INC. 1680 Plum Lane Redlands, CA 92374 (909) 335-2323
APPOINTMENT DATE 1/7/2021		APPOINTMENT TIME 12:30 pm	DOCTOR Robert Weber, MD
SERVICE REQUESTED QME: PQME	PANEL NO. 2601649	APPOINTMENT SET BY Viviana Polanco: Wai & Connor, LLP	APPOINTMENT LOCATION 770 Magnolia Avenue #2K Corona, CA 92879

Patient Information

PATIENT NAME	Jeltz Walker	DOB	5/30/1977	GENDER	Male
PATIENT ADDRESS	13732 Hill Grove Street Eastvale, CA 92880	SSN	570-53-6461		
		PHONE			

Insurance and Claim Information

INSURANCE COMPANY	**Gallagher Bassett** Mailing/Billing Address: P.O. BOX 2840 Clinton, IA 52733	**Curtis Lee** Phone: (916) 403-1592
DEFENSE ATTORNEY	**Wai & Connor, LLP** 150 S. Los Robles Ave. Suite 600 Pasadena, CA 91101	**Raffi Jatorossian** Phone: (626) 792-7700 Fax: (626) 792-7970 Email: yasminjimenez@waiconnor.com
APPLICANT ATTORNEY	**Gordon, Edelstein, Krepak, Grant, Felton & Goldstein** 3580 Wilshire Blvd. Suite 1800, Los Angeles, California 90010	
EMPLOYER	**Levy Restaurant** ,	

	CLAIM #	DOI	EAMS #	REASON FOR CONSULT/BODY PARTS
1.	003531-104815-WC-01	CT: 09-01-1999 to 03-09-2019	12178421	Circulatory system and other body parts
2.				
3.				
4.				
5.				

Interpreter Information

INTERPRETER NEEDED? No		SCHEDULED BY:			
NAME		AGENCY		PHONE	

Dates

PATIENT CONFIRMED	COVER LETTER RECEIVED
ROR RECEIVED	

Referral Taken By

Sayde Santos	Date	11/6/2020 5:52:38 PM

Patient Demographics

Patient Name	Sex	DOB
Walker, Jeltz (000005578725)	Female	5/30/1977

--

Date Of Birth	Gender Identity	Race	Ethnicity	Preferred Spoken Language	Preferred Written Language
05/30/1977	Female	Black/African American	American/United States	English	English

Patient Demographics

Address	Phone
13732 Hill Grove St EASTVALE CA 92880	310-493-1783 (Home) 000-000-0000 (Work) 310-493-1783 (Mobile)

Emergency Contacts

Contact Person (Rel.)	Home Phone	Work Phone	Mobile Phone
Jackiey Walker (Mother)	--	--	909-678-9965

Social History

Tobacco History

Smoking Status
Never Assessed
Smokeless Tobacco Use
Unknown

LANAI DEMOGRAPHIC SHEET ZUNIGA, Jose 604409 RK QME 01/04/2021	REFERRAL DATE 12/15/2020	ARROWHEAD EVALUATION SERVICES, INC. 1680 Plum Lane Redlands, CA 92374 (909) 335-2323
APPOINTMENT DATE 2/22/2021	APPOINTMENT TIME 11:00 am	DOCTOR Robert Kolesnik, M.D. G44386
SERVICE REQUESTED QME: PQME / PANEL NO. 2603821	APPOINTMENT SET BY Leo Manzano: Travelers	APPOINTMENT LOCATION 4590 Riverside Drive Chino, CA 91710

Patient Information

PATIENT NAME	Jose Zuniga	DOB	5/10/1971	GENDER	Male
PATIENT ADDRESS	1152 West Stonebridge Court Ontario, CA 91762	SSN	xxx-xx-2988		
		PHONE	(323) 572-1425		

Insurance and Claim Information

INSURANCE COMPANY	**Travelers** Mailing/Billing Address: P.O. BOX 660055 Dallas, TX 75265	**Laura Orozco** Phone: (909) 612-3819 Email: lorozco@travelers.com
DEFENSE ATTORNEY		
APPLICANT ATTORNEY		
EMPLOYER	**Edelmann USA Inc. - BERT CO.** ,	

	CLAIM #	DOI	EAMS #	REASON FOR CONSULT/BODY PARTS
1.	FJC1079	08-17-2018		Neck, Left Shoulder
2.				
3.				
4.				
5.				

Interpreter Information

INTERPRETER NEEDED?	SCHEDULED BY:		
No			
NAME	AGENCY	PHONE	

Dates

PATIENT CONFIRMED	COVER LETTER RECEIVED
ROR RECEIVED	

Referral Taken By

Nallely Gomez	Date	12/15/2020 9:40:22 AM

RECEIVED
JAN 04 2021

Sedgwick formerly SRS*
PO Box 14214

Lexington, KY 40512-4214

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 552-80-2217

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)
Pena, Anthony	01 15 1949 M X F	Turtle & Hughes
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
8082 Madera	Self / Spouse / Child / Other X	1550 S Milliken Ave Ste F
CITY: HESPERIA	STATE: CA	8. RESERVED FOR NUCC USE	CITY: Ontario	STATE: CA
ZIP CODE: 92345	TELEPHONE (Include Area Code): (760) 5534088		ZIP CODE: 91761-2324	TELEPHONE (Include Area Code): (909) 2188644

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
		301811384380001
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 NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC): Y4 301811384380001
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. 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:

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. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
10 08 2018 QUAL. 431	QUAL. 10 08 2018	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Dwight Brown		20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. S5011XA B. S60221A C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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 10 17 18 10 17 18 11			WC002	A		12.46	1		ZZ NPI	2083X0100X 1528280906
TX Phy Progress Rpt-PR-2 or narrative equivalent										
2 10 17 18 10 17 18 11			73090 RT	A		37.09	1		ZZ NPI	2083X0100X 1528280906
X-Ray, forearm, 2 views										
3 10 17 18 10 17 18 11			99214	AB		149.33	1		ZZ NPI	2083X0100X 1528280906
Level 4 + Return Visit										
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	30. Rsvd for NUCC Use
770469725 X	I23 0942181718	YES NO	$ 198.88	$ 0.00	198.88

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.)

Michael C Chiang, MD 11/01/2018
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

CMC - LAX Ontario
Concentra Medical Centers
1101 S Milliken Ave Ste C

Ontario, CA 91761
a. 1245374693 b.

33. BILLING PROVIDER INFO & PH # (888) 352-6794

Occupational Health Centers
of California, A Medical Corp
PO Box 3700
Rancho Cucamonga, CA 91729-3700

a. 1992844898 b. A63516

PHYSICIAN OR SUPPLIER INFORMATION — PATIENT AND INSURED INFORMATION — CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

SEDGWICK/KROGER/HH/MEDRISK / TP097
P.O. BOX 14452
LEXINGTON, KY 40512

Page: 1 of 1
Tracking #: 2499670

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA ☐ ☐ ☐ PICA ☐ ☐ ☐

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☒ (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
	609209902
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PEREZ, JOSE	3. PATIENT'S BIRTH DATE MM DD YY 01 15 1968 SEX M ☒ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial) FOOD 4 LESS #359/JEFFERSON PAR	
5. PATIENT'S ADDRESS (No., Street) 4601 LEXINGTON AVE #110	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☒
7. INSURED'S ADDRESS (No., Street) 1748 S. JEFFERSON BLVD., DEREK CARR	
CITY LOS ANGELES	STATE CA
8. RESERVED FOR NUCC USE	
CITY LOS ANGELES	STATE CA
ZIP CODE 90029	TELEPHONE (Include Area Code) ( )
ZIP CODE 90018	TELEPHONE (Include Area Code) ( )
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 30189610593-0001
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO
	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)
	b. OTHER CLAIM ID (Designated by NUCC) Y4 30189610593-0001
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO
	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 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

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 02 06 2018 QUAL. 439	15. OTHER DATE QUAL. 454 MM DD YY 02 27 2018	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
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) PWKOZWPC7P0EHSAQ_01		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M75.51 B. M19.90 C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

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 06 28 18	11		99204	25	AB	¤225 95	1	N N	0B NPI	G51661 1194833202
2 06 28 18	11		97535	59	AB	¤35 19	1	N N	0B NPI	G51661 1194833202
3 N400003029320 UN4 | KENALOG-40 10MG 06 28 18	11		J3301		AB	¤7 00	4	N N	0B NPI	G51661 1194833202
4 06 28 18	11		20610		AB	¤83 21	1	N N	0B NPI	G51661 1194833202
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	30. Rsvd. for NUCC Use
954643269 ☒	157475850	☒ YES ☐ NO	$ ¤351 35	$ 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 # (800) 992-4442
FELDMAN M.D., RICHARD J.	USHW OF CALIFORNIA-LA-GRAND LA GRAND MEDICAL CLINIC, 1400 S GRAND AVE, STE 611 LOS ANGELES, CA 90015-9998	U.S. HEALTHWORKS MEDICAL GROUP PC P.O. BOX 50042 LOS ANGELES, CA 90074-9998
SIGNED DATE	a. 1316927338 b.	a. 1316927338 b. 193200000X

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Received: 2018-07-27
Mapping: BillImage_837P_5010_CMS1500_0212

HEALTH INSURANCE CLAIM FORM

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

PACIFIC COMP CLAIM THOUSANDS
P O BOX 5042
THOUSAND OAKS CA 91359

CARRIER

PICA ☐ PICA ☐

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☒ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 614-58-4660

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PEREZ MARIA

3. PATIENT'S BIRTH DATE MM DD YY: 01 16 1968 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): HISTORIC MISSION INN HOTEL &

5. PATIENT'S ADDRESS (No., Street): 4019 RUBIDOUX BLVD

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 3649 MISSION INN AVE

CITY: RIVERSIDE STATE: CA

8. RESERVED FOR NUCC USE

CITY: RIVERSIDE STATE: CA

ZIP CODE: 92509 TELEPHONE (Include Area Code): (951)783-7360

ZIP CODE: 92501 TELEPHONE (Include Area Code): (951)7840300

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: 00058689

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): 00058689

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 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 12182018

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: 10 08 2017 QUAL. 4

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN KHALID AHMED MD

17a.

17b. NPI 1134193923

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S33.5XXD B. S43.004D C. S63.91XD D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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 PERMANENT AND STATIO 070219	070219	11	01	99205	17 93	A-D	285 20	1		NPI	1134193923
2 FACE TO FACE INTERVI 070219	070219	11	01	99354	17 93	A-D	171 52	1		NPI	1134193923
3 CHRONIC CARE MANAGEM 070219	070219	11	01	99490		A-D	76 50	1		NPI	1134193923
4 MEDICAL REPORT 070219	070219	11	01	WC004		A-D	217 77	14		NPI	1134193923
5 REPORT TRANSCRIPTION 070219	070219	11	01	99199	59	A-D	116 10	1		NPI	1134193923
6 PROLONG EM WO CONT 6 070219	070219	11	01	99358		A-D	149 40	4		NPI	1134193923

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒: 20-4097050

26. PATIENT'S ACCOUNT NO.: 0001210

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 1016 49

29. AMOUNT PAID $

30. Rsvd for NUCC Use 1016 49

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.)

KHALID AHMED MD

SIGNED 9/12/2019

32. SERVICE FACILITY LOCATION INFORMATION

KHALID B AHMED MD
675 N PARK AVE
POMONA CA 91768
a. 1134193923 b.

33. BILLING PROVIDER INFO & PH # (909) 868-1160

KHALID AHMED MD
P O BOX 799
POMONA CA 91769
a. 1134193923 b. A33354

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

TRAVELERS INSURANCE

PO BOX 660055
DALLAS, TX 75266

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLKLUNG OTHER ( ) (Medicare #) ( ) (Medicaid #) ( ) (ID#/DoD#) ( ) (Member ID#) ( ) (ID#) ( ) (ID#) [X] (ID#)		1a. INSURED'S I D. NUMBER (For Program in Item 1) E9R0253
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PIZANO, JUANA	3. PATIENT'S BIRTH DATE SEX MM DD YY 03 27 1963 M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) PIZANO, JUANA
5. PATIENT'S ADDRESS (No., Street) 1608 MARKET LYNN CT	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) 1608 MARKET LYNN CT
CITY BAKERSFIELD STATE CA	8. RESERVED FOR NUCC USE	CITY BAKERSFIELD STATE CA
ZIP CODE 93307 TELEPHONE (Include Area Code) ( )		ZIP CODE 93307 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last, First, 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 SEX MM DD YY 03 27 1963 M [ ] F [X]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE(State) [ ] YES [X] NO	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
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.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 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 04/20/2020

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 11 12 18 QUAL 431	15. Other Date QUAL MM DD YY	16.DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN MARTIN LEVINE	17a. 17b. NPI 1669470860	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 4/26/17;11/1/18; 11/12/18		20. OUTSIDE LAB? $ CHARGES [ ] YES [X] NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0 A. G4489 B. M5412 C. M5020 D. M5416 E. M7612 F. M25561 G. M25562 H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER CL#E9R0253

	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												
2	03 18 20	03 18 20	11		ML104	95 25	ABCD	3000.00	48		NPI	1669470860
3	03 18 20	03 18 20	11		95831		ABCD	60.00	1		NPI	1669470860
4	03 18 20	03 18 20	11		95851	59	ABCD	40.00	1		NPI	1669470860
5											NPI	
6											NPI	
											NPI	

25. FEDERAL TAX I D. NUMBER SSN EIN 842378114 [ ] [X]	26. PATIENT'S ACCOUNT NO. 99110846	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE $3100.00	29. AMOUNT PAID $	30. Rsvd for NUCC use
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.) LEVINE, MD, MARTIN SIGNED 04/20/2020 DATE	32. SERVICE FACILITY LOCATION NFORMATION MARTIN LEVINE MD 44303 N LOWTREE AVENUE LANCASTER, CA 93534 a. b.		33. BILLING PROVIDER INFO & PH# ( ) MEDICAL LEGAL REPORTING PARTNERS 14600 SHERMAN WAY STE 100A VAN NUYS, CA 91405 a. b.		

SG006
Sedgwick 14421

Page 1 of 1

HEALTH INSURANCE CLAIM FORM

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

PICA CLAIM # WC-7868

1. MEDICARE (Medicare#) / MEDICAID (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): 624746667
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Rosales, Max	3. PATIENT'S BIRTH DATE: 08 08 94 SEX: M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): Sonic AutoBuena Park Honda
5. PATIENT'S ADDRESS (No., Street): 10403 GRIDLEY ROAD	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street): 6411 Beach Blvd
CITY: SANTA FE SPRINGS STATE: CA	8. RESERVED FOR NUCC USE	CITY: Buena Park STATE: CA
ZIP CODE: 90670 TELEPHONE (Include Area Code): ( )		ZIP CODE: 906212896 TELEPHONE (Include Area Code): ( )
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: WC-7868
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): CA	b. OTHER CLAIM ID (Designated by NUCC): Y4 WC-7868
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
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.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 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 09/28/2020

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: 03 07 20 QUAL 439	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DQ Edward L Barawid	17a. OB 20A11795 17b. NPI 1497041792	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Sonic AutoBuena Park Honda		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. S39.012D B. S39.012A C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. WC-7868 23. PRIOR AUTHORIZATION NUMBER

	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	ADL 15 min 09 28 20 09 28 20	11		97535		A	50 24	1.00		PXC NPI	2083X0100X 1891775235
2	Level 4 Return Visit Permanent Stationary Ev 09 28 20 09 28 20	11		99214	17	AB	157 00	1.00		PXC NPI	2083X0100X 1891775235
3	Prolong EM Before/After Pt 1st Hr 09 28 20 09 28 20	11		99358		A	157 91	1.00		PXC NPI	2083X0100X 1891775235
4	Primary Tx Phy Perm Stat Rpt/Form PM4 1st pg 09 28 20 09 28 20	11		WC004		A	41 84	1.00		PXC NPI	2083X0100X 1891775235
5	Primary Tx Phy Perm Stat Rpt/Form PM4 ea addl 09 28 20 09 28 20	11		WC004		A	154 38	6.00		PXC NPI	2083X0100X 1891775235
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 943418907 [ ] [X]	26. PATIENT'S ACCOUNT NO.: 942833720	27. ACCEPT ASSIGNMENT? For govt. claims, see back: [X] YES [ ] NO	28. TOTAL CHARGE: $ 561 37	29. AMOUNT PAID: $ 0 00	30. Rsvd for NUCC Use
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.) A76120 Coppelson, Aaron SIGNED Signature on File DATE 10/05/2020	32. SERVICE FACILITY LOCATION INFORMATION CMC - LAX La Palma 40 Centerpointe Dr La Palma CA 90623 a. 1487089157 b.	33. BILLING PROVIDER INFO & PH # (888) 352-6794 Occspecialists Corp PO Box 3800 Rancho Cucamonga CA 917293800 a. 1053507558 b.			

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Invoice # 20549231 06/15/2017

York
PO Box 619079
Roseville, CA 95678

RECEIVED
JUN 19 2017 B
OSC West

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (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): 559-33-4834
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Ruano, Francisco	3. PATIENT'S BIRTH DATE MM DD YY: 08/09/1959 SEX M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street): 14179 Northstar Ave	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
CITY: PHELAN STATE: CA	8. RESERVED FOR NUCC USE
ZIP CODE: 92329 TELEPHONE (Include Area Code): ( )(714) 235-1280	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PON RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	e. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Ruano, Francisco	
7. INSURED'S ADDRESS (No., Street): 14179 Northstar Ave	
CITY: PHELAN STATE: CA	
ZIP CODE: 92329 TELEPHONE (Include Area Code): ( )(714) 235-1280	
11. INSURED'S POLICY GROUP OR FECA NUMBER: SCIH-043471	
a. INSURED'S DATE OF BIRTH MM DD YY: 08/09/1959 SEX M [ ] F [ ]	
b. OTHER CLAIM ID (Designated by NUCC): State of CA - IHSS	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 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

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: 02/03/2017 QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Marc Forrest	17a. 1801873070 17b. NPI 1922289099
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): AUTHORIZATION ATTACHED	
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 A. S33.5XXD B. S63.509D C. S93.402D D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

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 05/09/2017	11		97110	GP	ABC	$162 00	3		NPI	1174605406
2 05/09/2017	11		97140	GP	ABC	$50 00	1		NPI	1174605406
3 05/12/2017	11		97113	GP	ABC	$90 00	1		NPI	1174605406
4 05/15/2017	11		97110	GP	ABC	$162 00	3		NPI	1174605406
5 05/15/2017	11		97140	GP	ABC	$50 00	1		NPI	1174605406
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 27-0276119 [ ] [X]	26. PATIENT'S ACCOUNT NO.: Invoice # 20549231	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO	28. TOTAL CHARGE: $514 00	29. AMOUNT PAID: $	30. Rsvd.for NUCC Use: $514 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.): YVETTE SARDILLO SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: Align / Power Center Physical Therapy An 17270 Bear Valley Road, Ste 105 VICTORVILLE, CA 92395 a. 1508948837 b.		33. BILLING PROVIDER INFO & PH #: (904)998-0211 ( ) Align Networks, Inc. P.O. Box 105159 Atlanta, GA 30348-5159 a. 1508948837 b.		

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION