

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

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		Amended Application	
Case No.			
558874287			
SSN (Numbers Only)			
Venue choice is based upon (Co	mpletion of this section is requ	uired)	
County of residence of employ	ee (Labor Code section 5501.5(a	a)(1) or (d).)	
County where injury occurred (Labor Code section 5501.5(a)(2)	or (d).)	
County of principal place of but	siness of employee's attorney (La	abor Code section 5501.5(a)(3) or	(d).)
VNO			
Select 3 - Letter Office Code For Pla	ace/Venue of Hearing (From the	Document Cover Sheet)	
Injured Worker (Completion of th		,	
JAMES			
First Name			
WALLACE			
Last Name			
3672 ROSENA RANCH RD			
Street Address/PO Box (Please lea	ve blank spaces between numbe	ers, names or words)	
Street Address2/PO Box (Please le	ave blank spaces between numb	ers, names or words)	
International Address (Please leave	blank spaces between numbers	names or words)	
SAN BERNARDINO	Service Services Hallings		
City		CA State	92407
Applicant (If other than Injured Wo	orker)	State	Zip Code
Insurance Carrier	Employer	Lien Claimant	
Name (Please leave blank spaces b	etween numbers, names or word	ds)	
·			
Street Address/PO Box (Please leav	e blank spaces between number	rs, names or words)	
Street Address2/PO Box (Please lea	ave blank spaces between numbo	ers, names or words)	
City		State	Zip Code
)WC/WCAB Form 1A (11/2008) - (Page	1)		WCAB1



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

	Amended Application	
Case No.		
SSN (Numbers Only)		
Venue choice is based upon (Completion of this section is	required)	
County of residence of employee (Labor Code section 550	1.5(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 attorne	ey (Labor Code section 5501.5(a)(3) or (d).)	
RIV	··	
Select 3 - Letter Office Code For Place/Venue of Hearing (From	ո the Document Cover Sheet)	
Injured Worker (Completion of this section is required)		
ALVIN		
First Name	MI	
WATSON		
Last Name		
PO BOX 400375		
Street Address/PO Box (Please leave blank spaces between I	numbers, names or words)	
		_
Street Address2/PO Box (Please leave blank spaces between	numbers, names or words)	
International Address (Please leave blank spaces between nu	umbers, names or words)	-
International Address (Please leave blank spaces 25	CA	92340
HESPERIA	State	Zip Code
City Worker)		
Applicant (If other than Injured Worker) Insurance Carrier Employer	Lien Claimant	
Insurance Carrier		
	or words)	
Name (Please leave blank spaces between numbers, names	s of words)	
Llock angeon between	n numbers, names or words)	
Street Address/PO Box (Please leave blank spaces between		
Street Address2/PO Box (Please leave blank spaces between	en numbers, names or words)	
Street Address2/PO Box (Please leave blank spaces between		
	State	Zip Code
City (Page 1)		WCAB1
DWC/WCAB Form 1A (11/2008) - (Page 1)		

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	
suffered a: (Choose only one) (Occupation	at the time of injury)
specific injury on	(DATE OF INJURY: MM/DD/YYYY)
cumulative trauma injury which began on	
01/22/2018 and end	ded on 03/09/2018
(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYYY)
The injury occured at* 2471 N BEACHWOOD DR	
,	e leave blank spaces between numbers, names or words)
LOS ANGELES	' CA 90068
(City)* (State which parts of the boo	(State)* (Zip Code)* dy were injured)
	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 - ST	RESS
2.The injury occurred as follows: (Explain What The Worker Was Doing At The Tim Field size limited to 325 characters STRESS AND STRAIN DUE TO REPETITIVE M INAPPROPRIATE LIGHTING, INJURED SHOUL EXTREMITIES; STRESS/DEPRESSION/ANXIE AND DISCRIMINATION BASED ON SEX ORIEN	OVEMENT, UNCOMFORTABLE CHAIR, DERS, NECK, LOWER BACK AND LOWER TY DUE TO HOSTILE WORK ENVIRONMENT
3. Actual earnings at the time of injury Rate of Pay \$ \int Month	
State value of tips, meals, lodging or other advantage received \$	Weekly
Number of hours worked per week.	Hourly
4. The injury caused disability as follows	
Last day off work due to injury :	
First Period of Disability: (MM/DD/YYY	Y) End date
Start date	(MM/DD/YYYY) (MM/DD/YYYY)
Second Period of Disability: Start date	(MM/DD/YYYY) End date (MM/DD/YYYY)
	(ויוויו/טט/וויו) (ויוויו/טט/וויווי)

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					je in Material Facts			
		ployee faces an imminent and serious t	hreat to	his or her health				
		nirmation of a prior oral request.	10167	CALSHALF CAMBRIS				
Employee Information		Pi-chorto	nergick.	eren grandette kalle		CONTRACTOR OF THE PROPERTY OF		
Name (Last, First, Middle	<u> </u>				un == fac faces			
Date of Injury (MM/DD/Y			Date of Birth (MM/DD/YYYY): 05/07/1953					
Claim Number: 011975	5 105245 W	2 01	Employer: Peri Formwork Systems					
Requesting Physician i						on a construction of the c		
Name: SHAMEL HASHI								
Practice Name: CMC -				Name:		State: Ch		
Address: 9405 Fairv	vay View Pi			ancho Cucamon		State: CA 909-481-5508		
Zip Code: 91730		Phone: 909-481-7345		mber: Main: 90!		203-40T-5500		
Specialty: Physiatri				mber: 12050030				
E-mail Address:	and the second second second	and the second s	WAS STR	**************************************				
Claims Administrator I			Contro	Name: Tami Os	heroff			
Company Name: Galla Address: PO Box 283				linton		State: IA		
Zip Code: 52733	<u> </u>			mber: 00000000	00			
E-mail Address:								
Requested Treatment	See instructio	ns for guldance; attach additional pa	ges If ne	icessary)				
List each specific reques	sted medical se	ervices, goods, or items in the below spa	ice or inc	licate the specific p	page number(s) of the a	attached medical		
report on which the requ	iested treatmer	t can be found. Up to five (5) procedure	s may be	e entered; list addit	ional requests on a sep	parate sheet if the		
space below is insufficie		Desirational Desirated		CPT/HCPCS	Other Infor	mation		
Diagnosis (Required)	ICD Code (Required)	Service/Good Requested (Required)		Code (If known)	(Frequency, Duratio	n Quantity, etc.)		
CONTUSION WALL OF	S20.219A	Ebuprofor Goo my #			Rx gi	ler in		
THORAX		(600 mg # =	45			mic		
		<u> </u>			0 = -1	Jer ih		
STRAIN NECK	S16.1XXA	Flexeril 10 r	P		1 x 2	, , ,		
ĺ		# 30			011	V10 .		
	1							
-								
		<u>·</u>		<u></u>				
					-			
Requesting Physician S	Signature:		•			Date: 02/21/2018		
Claims/Administrator/	UtilizationiRev	riew.Organization (URO) Response	新春 素	Gerte de la companya				
Approved	Denied or M	odified (See separate decision letter)	D	elay (See separate	notification of delay)			
Requested treatme	nt has been pre			isputed (See sepa	rate letter)			
Authorization Number (if assigned):		Date:					
Authorized Agent Name	e:		Signat					
Phone:		Fax Number:	E-mai	Address:				
Comments:								
1								

From: Wayne Starks

Fax: 17605133054

Fax: (859) 550-2170

Page: 2 of 3

07/23/2019 11:54 AM

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.

Expedited Review Check Check box if request is a v Employee Information Name (Last, First, Middle): C	rincii Willi	rmation of a prior rica				
	o respective residence and					
	value and the same					
Date of Injury (MM/DD/YYYY	aroajai Lope	Z Maria	***************************************	De Jesus	·····	
Claim Number: 189034421-0	n. 00/21/20	19		of Birth (MM/DD/		1/1956
Requesting Physician Infor				layer Wonderful		
Name: Greene, Michael NP	nation					
Practice Name: Premier Occup			·		***************************************	
Address: 81719 Dr. Carreon Bl		(O	***************************************	act Name:		
Zio Code 92201-583	***************************************			Indio		State CA
Specialty 363LA2200X			accessory and the second second second second	Number: (760) 61	and the second second	
			NPII	Number 1356430	532	
	occupationa	l.com				
Claims Administrator Inform Company Name. Broadspire	atton		\$10 K.			
Address: PO Box 14645		***************************************	Cont	act Name.	***************************************	
			City.	Lexington	······································	State KY
	Phone: (8)	56) 780-4075	Fax N	lumber:	***************************************	
-mail Address: Requested Treatment (see in ist each specific requested on						
/Ph	ICD-Code (Required)	Sarvice/Good Re (Required	s insumble questec	CPT/HCPCS Code (If known)	Other (Freque	Information ncy, Duration ntity, etc.)
ree subs encoty	S83.91XD					
risp fx right patella, subs for clos fx routh heal	\$82.0010					
irrent injury, riknee, subs	583.2410	Orthopedist consultations of the consultation	on for the	99204	in- House Orth	opedist
movial cyst of popliteal space aker(, right knee	M71.21					
equesting Physician Signature				Date	1 Jul 15, 2019	
Approved Denied or Mo Requested treatment has be	on Review odified (See en previou	Organization (URO) Separate decision le	Respons	Maria de son de		
uthorization Number (if assigne	ed):		Dat		ose acparale	·cuci)
uthonzed Agent Name	······································			<u> </u>	1	
hone.	Fax Numb	*f*		الليدن Mمالا Bail Address:	Julion -	
omments approved to consult wi	***************************************	***************************************		an Muuress.	***************************************	

Page 1

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.

IMW. D									
New Request Expedited Review: C	hoo.	k boy if omployed for			LJ R€	submissi	on – Cha	nge in Ma	aterial Facts
Check box if request	is a	written confirmation	of a prior or	rient and ral reques	senous i t	nreat to n	is or ner	neaith	
Employee Information									
Name (Last, First, Midd		Contreras, Blanca	[000022542	9541 Ho	me: 714-	797-8947	Cell 90	79-997-89	947
Date of Injury (MM/DD/			\$			M/DD/YY			
Claim Number: PENDIN			***************************************			IVERSID			
Requesting Physician	Info	ormation		, , , , , , , , , , , , , , , , , , ,					
Name: JAYVEEH DE V	ENE	CIA NAVARRO ME)	in the state of th			XX		
Practice Name: Kaiser Permanente On-the-Job Moreno Valley				Contac	t Name: I	Roxana I	ler ed ia		
Address: 12815 HEACC	оск	ST		City: M	ORENO	VALLEY			State: CA
Zip Code: 92553-3116						5-902-67	96		
Specialty: Occupationa	al Me	edicine		NPI Nu	mber: 18	8191592	4		
E-mail Address:	······································			···	***************************************	***************************************			
Claims Administrator	Info	rmation							
Company Name: SEDG	WIC	K CLAIM MGMNT	SVCSINC	Contac	t Name: I	Pending			
Address. PO BOX 144	133			1	XINGTO	***************************************	***************************************	······································	State: KY
Zip Code: 40512-4187	Ph	one: 916-788-9901		Fax Nu	mber: 91	6-771-29	90		
E-mail Address:						***************************************	***************************************		
Requested Treatment	(see	instructions for g	idance; att	ach addi	tional pa	iges if ne	cessary	1	
List each specific reques of the attached medical	sted repo	medical services, go ort on which the requ	oods, or iten	ns in the t nent can	pelow spa	ace or ind	icate the	specific t	page number(s) may be entered:
list additional requests of	n a	separate sheet if the	space belo	w is insuf	ficient.				,,
Diagnosis (Required)		ICD-Code (Required		Good Red Required)		1	e (If known) (Frequency, D		er Information: uency, Duration uantity, etc.)
Left Wrist Contusion, Init Neck Muscle Strain, Init Rib Contusion, Init Left Knee Contusion, Init		1. S60.212A 2. S16.1XXA 3. S20.219A 4. S80.02XA	Physical 1	Therapy (IN	IT))		2X3=6 MEDRISK	
Requesting Physician S NAVARRO MD	igna	ture: (Electronically sign	ed by:) JAYV	EEH DE	VENECI	A	Date: O	ctober 0	9, 2018
Claims Administrator/I	Utili:	zation Review Orga	nization (U	RO) Res	ponse				
☐ Approved ☐ Denie Requested treatment ha	ed or is be	Modified (See sepa	rate decision d	n letter) ility for tre	Dela atment i	y (See se s disputed	parate no d (See se	otification parate le	of delay) tter)
Authorization Number (i	fass	signed):			Date:			· A ············	
Authorized Agent Name	:				Signatu	re:			
Phone:		Fax Nur	mber:		E-mail	Address:			
Comments:								······································	

1	1697	ca C Contreras 7 Green Ash St ana CA 92337-6886				Cell I	e Phone: Phone: : Phone:		797-8947 997-8947

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.

		ployee faces an imminent a nfirmation of a prior oral req			- Change in Material Facts her health
Employee Information	n .		<u> </u>		
Name (Last, First, Midd					
Date of Injury (MM/DD/	YYYY): 08/22/20	18	Date	of Birth (MM/DD/YY	YY): 09/05/1972
Claim Number: 145086			Emp	loyer: G. Hurtado Cons	struction
Requesting Physician	Information		40.		
Name: Ronna Parsa D.O	•				
Practice Name: Glendale Fidelity Medical Group		Conf	tact Name:	-	
Address: 815 E. Colorad	Address: 815 E. Colorado ST # 110A		City:	Glendale	State: CA
Zip Code: 91205	Phone: (818) 242-1910	Fax	Number: (818) 242-19	990
Specialty:			NPI	Number:	
E-mail Address:					
Claims Administrator	Information				
Company Name: Appli	ed Risk Services		Con	tact Name: Andrew St	odola
Address: P.O. Box 3804			City:	Omaha	State: NE
Zip Code: 68103	Phone:		Fax	Number: (877) 234-44	25
E-mail Address:	+				
Requested Treatment	t (see instructio	ons for guidance; attached	d add	itional pages if nec	essary)
of the attached medica	I report on which	ervices, goods, or items in to the requested treatment of heet if the space below is in	an be	found. Up to five (5)	the specific page number(s)) procedures may be entered;
Diagnosis (Required)	ICD-Code (Required)	Service/Good Reques (Required)	ted _.	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		200		Date	:
		riew Organization (URO) F			
Requested treatme	ent has been pre	(See separate decision lette viously denied Liability	for tr	eatment is disputed (te notification of delay) (See separate letter)
Authorization Number	<u> </u>)ate:	
Authorized Agent Nam			s	Signature:	
Phone:	Fax N	umber:	E	-mail Address:	
Comments:			••		

DWC Form RFA (Effective 2/2014)

State of California Division of Workers' Compensation Request for Authorization for Medical Treatment (C

✓ New Request ☐ Resubmission	- Change in Moto	rial Facts			
Expedited Review: Check box if					
			at to his or her heal	th	
Check box if request is a written c	ontirmation of a pr	ior oral request.	CONTROLS GARAGESTA NA PROPERTY.		
Employee Information					
imployee Name (Last, First, Middle):	Marquez-Tapia	Delia Leticia			
Date of Injury (MM/DD/YYYY): 0		/20/2011 - 08/30/2018		Data of Direct of O. C.	
laım Number: 2018022174				Date of Birth (MM Employer: BAR	/DD/YYYY): 03/13/1964 RON HR
equesting Physician Informatio	n			2.0	CONTIN
				A TO TORRESON OF	
rovider Name: Michael Salomon, DC ractice Name: Mike Salomon DC INC					
ddress: 155 W. Hospitality Lane Suite	245			Contact Name:	
p Code: 92408	Phone: (323)) 435-4523		City: San Bernardin	
ovider Specialty: Chiropractic				Fax Number: (323) 4 License Number: DO	433-4122
mail Address:				Literise Number: DO	225501
aims Administrator Informatio				L	
aims Administrator Name: ICW		n en		Contact Name: Mage	allen Data
dress: P.O. Box 2965				City: Clinton	State: IA
Code: 52733	Phone: (858)	350-2862			58) 350-2755
nail Address:					
quested Treatment (see instruc-	nelow engos or indi		pages if neges	Sary')	
quested Treatment (see instruction of the state the requested treatment in the live (5) procedures may be entered; attandards. Diagnosis	nelow engos or indi	icate the specific page nun sts on a separate sheet.	nber(s) of the accom	npanying medical repo	- N. 1994-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1
ner state the requested treatment in the ive (5) procedures may be entered; atta Diagnosis ht shoulder rotator cuff strain: Left	ich additional reques ICD-Code \$46.011A;	icate the specific page num sts on a separate sheet. Procedure Requested Start PT for the B/L	CPT/ 97014, 97024,	mpanying medical reportations of the MCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
ner state the requested treatment in the ive (5) procedures may be entered; atta Diagnosis tht shoulder rotator cuff strain; Left ulder rotator cuff strain	pelow space or indi ch additional reque	reate the specific page num sts on a separate sheet. Procedure Requested Start PT for the B/L shoulders	nber(s) of the accom	mpanying medical reportations of the MCPCS Code	Other Information: (Frequency, Duration
ner state the requested treatment in the ive (5) procedures may be entered; atta Diagnosis ht shoulder rotator cuff strain: Left	ich additional reques ICD-Code \$46.011A;	icate the specific page num sts on a separate sheet. Procedure Requested Start PT for the B/L	CPT/ 97014, 97024,	mpanying medical repo HCPCS Code 97026, 97110, 97140	Other Information: (Frequency, Duration Quantity, Facility, etc.) 1x/wk for 8 wks
ner state the requested treatment in the ive (5) procedures may be entered; atta Diagnosis tht shoulder rotator cuff strain; Left ulder rotator cuff strain	pelow space or indich additional requestional reques	reate the specific page numsts on a separate sheet. Procedure Requested Start PT for the B/L shoulders Start Acup for the B/L	CPT/ 97014, 97024, 97124, 97035,	mpanying medical repo HCPCS Code 97026, 97110, 97140	Other Information: (Frequency, Duration Quantity, Facility, etc.) 1x/wk for 8 wks
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ner state the requested treatment in the ive (5) procedures may be entered; atta Diagnosis tht shoulder rotator cuff strain; Left ulder rotator cuff strain ne as above	ICD-Code S46.011A; S46.012A Same as above	reate the specific page numsts on a separate sheet. Procedure Requested Start PT for the B/L shoulders Start Acup for the B/L shoulders	CPT/ 97014, 97024, 97124, 97035,	mpanying medical repo HCPCS Code 97026, 97110, 97140	Other Information: (Frequency, Duration Quantity, Facility, etc.) 1x/wk for 8 wks
ner state the requested treatment in the ive (5) procedures may be entered; atta Diagnosis the shoulder rotator cuff strain; Left ulder rotator cuff strain ne as above	ICD-Code S46.011A; S46.012A Same as above	reate the specific page numsts on a separate sheet. Procedure Requested Start PT for the B/L shoulders Start Acup for the B/L shoulders	CPT/ 97014, 97024, 97124, 97035, 97802, 97026,	mpanying medical repo HCPCS Code 97026, 97110, 97140 97813, 97814	Other Information: (Frequency, Duration Quantity, Facility, etc.) 1x/wk for 8 wks 1x/wk for 8 wks, scheduled on 01/17/2
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ner state the requested treatment in the live (5) procedures may be entered; atta Diagnosis that shoulder rotator cuff strain; Left ulder rotator cuff strain ne as above ing Physician Signature:	selow space or indich additional reques ICD-Code \$46.011A; \$46.012A Same as above	reate the specific page nunsts on a separate sheet. Procedure Requested Start PT for the B/L shoulders Start Acup for the B/L shoulders Acup for the B/L shoulders	CPT/ 97014, 97024, 97124, 97035, 97802, 97026,	mpanying medical report of the property of the	Other Information: (Frequency, Duration Quantity, Facility, etc.) 1x/wk for 8 wks 1x/wk for 8 wks, scheduled on 01/17/2
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Fax Server

Oct. 20. 2017 10:46AM

No. 3156 P. 5/16

State of California, Division of Workers' Compensation REQUEST FOR AUTHORIZATION DV/C Form RFA

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

New Request				7 Residentesia	n - Chance	in Material Facts
☐ Expedited Review	M. Check box if en	pioyee faces en immirent	end (or her heat	y ni mananakat LOCIA
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Employee Informit	on x as a second	が開発がある。			4	
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Date of Injury (MIM/O	D/YYY): 07/01/20	18	Da	te of Etrih (MM/DD/	YYYY): 10/03	/1971
Claim Number: W060				ployer: TNT		
Requesting Physics	an information is		ACULA V		2000	
Name: DR. KYLE LAN	DAVER, M.O.					
Practice Name: LONG	BEACH PRIME MI	ECRICAL GROUP	Cm	ntaci Name: NIA		· · · · · · · · · · · · · · · · · · ·
Address: 4014 LONG (Cin	LONG BEACH		Slate: CA
Zip Code: 90807	Phone: (502) 897-7100	Fax	Number: (552) 881-	9423	
Specially: ORTHOPE	IIC BURGEON		NP	Number: 16099238	95	
E-mail Address:	The same transport	32.0.010712				
Composition	r intompation 23			of the second		22000 B
Company Name: LIBI Address: P. O. BOX 98	KIY MUTUAL GR	OUP		fact Name: RAQUEL		
			City	WEST SACRAMENT	0	State: CA
Zip Code: 95798 E-mail Address:	Phone: (E	118) 621-1123	Fax	Number: (803) 480-1	980	
	2.000		****			
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		vices, goods, or items in th the requested tresiment ce				
list additional requests	on a separate sh	est if the space below is in:	u De wille	tauno. Up to imp (: lant	bloosgra	s may be entered:
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uthorized Agent Name	Cherion Taubado			mature: () /		
710/10: 915-621-1162	Fax Num	100F, 503-334-8141	_	neil Address:		
lomments:						
FCE is author	zod as requested. Ther	ts,CT				j
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DWC Form RFA (Effocine 2/2014)

Page 1

. FAXED SEP 22 2017

ROSEVILLE- SUNRISE

729 SUNRISE AVE, STE #606 ROSEVILLE, CA 95661

ARROWHEAD EVALUATION SERVICES, INC.

1680 Plum Lane Redlands, California 92374 (909) 335-2323

Patient No: 278381		DA	ATE1	1/09/20	TIME 5:00:0	0 P
APPLICANT:ROGELIO VAZQUEZ	B/D 06/06/62	_SS#_	*****2350	PHONE:_	916-541-	1058
MAILING ADDRESS: 5836 HIMALAYA WAY CITRUS HE	OGHTS, CA 956	521	ALT	PHONE:		N/A
TYPE OF INJURY: RIGHT ELBOW, RIGHT SHOULDER	EN	MAIL:	N/A		~~~	
DOCTOR: <u>DAVID BRODERICK</u> , M.D. TYPE OF	EXAM: <u>PANEL (</u>	QME		Panel QN	ME # <u>2582502</u>	2
SCHEDULING AGENCY: GALLAGHER BASSETT	-			_PHONE:_	916-403-16	507
CALLER: JACOB BABCOCK-JACOB BABCOCK@GBTPA	COM		· · · · · · · · · · · · · · · · · · ·	FAX:	844-615-888	34
APP. ATTY. FIRM: N/A						
APP ATTY:			APP. AT	ΓΥ PHONE	B:	
A.A. ADDRESS:	~~~~			A.A. FAX:		
A.A. EMAIL ADDRESS:					A distantible de de como de de	
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INTERPRETER [✓] INTERPRETER NAME 11/0	06/20-DAVID-CE	ERT				
SCHED. AGENCY WILL SET INTERPRETER [] AGENC	YONE CALL		· · · · · · · · · · · · · · · · · · ·	_ PHONE:	866-672-	5797
INS. CARRIER: GALLAGHER BASSETT						
INS. ADDRESS: P.O. BOX 2840 CLINTON IA 52733-2840						
CLAIM REP:_JACOB BABCOCK	PHONE:91	6-403	-1607	FAX:_		
CLAIM REP. EMAIL ADDRESS: JACOB BABCOCK@GBTPA	4.COM	***************************************	Maderia			
DATE OF INJURY0 <u>1/21/20 CT - ADJ</u>	. NO. <u>N/A</u>	CL	AIM NO(002042-025	6627-WC-01	
EMPLOYER: PETERSEN PRECISION ENGINEERING	4-12				EVENTAL AND	
EMPLOYER ADDRESS <u>611 BROADWAY ST REDWOOD C</u>	ITY, CA 94063				· · · · · · · · · · · · · · · · · · ·	
PATIENT CONFIRM DATE <u>11/06/20</u> HIST/PX/SENT_	QN	1E 110	MAILED_			
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	APPOINTMENT DATE 12/5/2020 RVICE REQUESTED QME: PQME TIENT NAME Staphanie Vera 1426 South Woo Los Angeles, CA Travelers Mailing/Billing Ad P.O. BOX 66005 Bencivenga & A P.O. Box 64093			ERRAL 0/9/202		ARROWHEAD 1680 Plum Lane Redlands, CA 92374 (909) 335-2323				ands, CA 4	
	_			NTMEN 0:45 a	IT TIME m	DOCTOR Paul Kim, MD					
			APPOINTMENT SET BY Karie D. Eckhoff: Bencivenga & Associates			APPOINTMENT LOCATION 2760 East Florence Avenue Huntington Park, CA 90255			/enue		
					rmation	'		<u> </u>	·		
PATIENT N	NAME	Staphanie Vera			DOB	8/23/	2001		GENDER	Female	
PATIENT A	ADDRESS	1426 South Woods Los Angeles, CA 9			SSN PHONE	620-2	28-2332				
		Ins	surance al	nd Cla	im Inforn	nation					
INSURANC COMPANY		Travelers Mailing/Billing Add P.O. BOX 660055		75265				Phon Fax:	Harrison e: (909) 6 (877) 801		
DEFENSE ATTORNE	Y	Bencivenga & Ass P.O. Box 64093 St		55164				Angela P Lin Phone: (909) 612-3870 Fax: (877) 222-8186 Email: aplin@travelers.com			
APPLICAN ATTORNE		Law Offices of Ed 10507 Valley Bould				nia 91 [.]	731	Edwa Phon Fax:	ard F. Figard F. Figard F. Figare: (626) 444-(626) 444-(626) an@figare	redo 44-9515 -9694	
EMPLOYE	R	PLS Check Cashe 1 S Wacker Dr #36			606						
CLAIN	Л#	DOI	oo omaaga	, 12 00	EAMS#		REASON	FOR CONSULT/BODY PARTS			
1. FPR12	200	CT: 12-28-2019 to 02	2-01-2020		13076823		Shoulder, Elbow, Wrist, FIngers, Thighs Knees, Calfs, Feet, Lower Back				
3.											
<u>4.</u> 5.											
<u> </u>			Interpre	eter In	formation	7					
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	PATIE	NT CONFIRMED		Date	es	COVE	R LETTE	R REC	EIVED		
ROR RECE	EIVED										
			Refe	erral Ta	ken By						
Maria Ose	eguera				D	ate	10/26/	2020 5	5:52:34 AN	Л	

Patient Name: MARIA VICTORIA

Date of Visit:26-Mar-2019

Document Type:sER Reports Site Name:7160 Lake Forest

MRN:110-083-391 Owner: Buchanan, Sonya DOB:27-Jun-1954

83/26/19: 18:16:85 MemorialCare Health ->

949 581 6457 MemorialCare Health Page 882



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 ED EDOH

Bed: Code Status Not on file

Patient Demographics

Address

8 HILLGATE PLACE ALISO VIEJO CA 92656 Phone

949-422-7038 (Home) 949-422-7038 (Mobile)

Emergency Contact(s)

Name Victoria, Elizabeth Victoria, Emiliano

Relation Daughter Spouse

Hómě Work 1111 949-616-2225 949-309-1727

Mobile 949-616-2225

949-309-1727

Epic Admission Information

Arrival Date/Time: 03/25/2019 1315

Emergency Bis Ambulance

Point of Origin: Primary Service:

Admit Date/Time:

Emergency Room Emergency

03/25/2019 1315

Hsieh, George D,

Date/Time:

Admit Category: Secondary

Service:

Means of Arrival: Transfer Source:

Admission Type:

Service Area:

MEMORIALCAR

E SERVICE

Unit:

IP Adm.

Saddleback E.D.

Admit Provider:

Attending

Provider:

MD

AREA

Referring

Reason for Admission

Closed head injury, initial encounter - Primary Contusion of left knee, initial encounter

Strain of neck muscle, initial encounter

Provider.

Discharge Information - Hospital Account/Patient Record

Discharge Date/Time: Discharge Disposition: Discharge Destination: Discharge Provider: Unit 03/25/2019 1558

Home

Home

None

S09,90XA S80.02XA

S16.1XXA

Saddleback E.D.

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

Codes Comments

Allergies as of 3/25/2019

No Known Allergies

Problem List

Active Problems:

No active hospital problems documented on the problem list

DATE REVIEWED: REVIEWED BY:

NORMAL/ABNORMAL

Medical History

No past medical history on file.

PLAN:

Surgical History

No past surgical history on file.

Victoria, Maria S (MRN#001035824) Printed at 3/26/19 1815

Page 2

FONTANA 2015

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: <u>PAUL J. MARSH, D.C.</u> TYPE OF EXAM: <u>PANEL QME</u> Panel QM	ME # <u>7307443</u>
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	E: 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 JACOBSDEF. ATTY. PHONE	E: <u>213-235-1287</u>
DEF. ATTY. ADDRESS: 7162 BEVERLY BLVD STE. 581 LOS ANGELES CA 90036 DEF. FAX	ζ: <u>213-986-3517</u>
DEF. ATTY EMAIL ADDRESS:	
INTERPRETER [] INTERPRETER NAME	
SCHED. AGENCY WILL SET INTERPRETER [] AGENCYN/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:_	444
CLAIM REP. EMAIL ADDRESS:	
DATE OF INJURY04/14/17	
EMPLOYER: RESTORATION MANAGEMENT COMPANY	
EMPLOYER ADDRESS4142 POINT EDEN WAY HAYWARD, CA 94545	
PATIENT CONFIRM DATE <u>08/27/20</u> HIST/PX/SENTQME 110 MAILED02/07/20)
COVER LETTER _{03/11/20 INS} MED RECS REC'D: [1"] [03/25/20] [][]
X-RAYS: REFERRAL TAKEN BY:fnariao	02/05/20 1

WAL	QME: PQME Jeltz Walker 13732 Hill Grove Eastvale, CA 92 URANCE MPANY Gallagher Bass Mailing/Billing A P.O. BOX 2840 Wai & Connor, 150 S. Los Robl PLICANT TORNEY PLOYER CLAIM # DOI 13732 Hill Grove Eastvale, CA 92 Gallagher Bass Mailing/Billing A P.O. BOX 2840 Levy Restauran DOI 1002531 104815			ERRAL 0/27/20		ARROWHEAD EVALUATION SERVICES, INC. 1680 Plum Lane Redlands, CA 92374 (909) 335-2323					
				INTMEN 12:30 p	IT TIME m	R		CTOR Weber, MD			
SER			Viviana	APPOINTMENT SET BY Viviana Polanco: Wai & Connor, LLP			APPOINTMENT LOCATION 770 Magnolia Avenue #2K Corona, CA 92879				
					rmation			,			
PAT	IENT NAME	Jeltz Walker			DOB	5/30/1977		GENDER	Male		
PAT	IENT ADDRESS	13732 Hill Grove S Eastvale, CA 9288			SSN PHONE	570-53-6461					
		Ins	surance al	nd Cla	im Inforn	nation					
ı		Gallagher Bassett Mailing/Billing Add P.O. BOX 2840 Cli	ress:	733				Curtis Lee Phone: (916) 403-1592			
		Wai & Connor, LL 150 S. Los Robles		600 Pa	isadena, C	A 91101	Phon Fax: Emai		2-7700		
ı		Gordon, Edelsteir 3580 Wilshire Blvd 90010									
ЕМР	LOYER	Levy Restaurant									
		DOI			EAMS#	REASON	FOR CONSULT/BODY PARTS				
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Jayı						11/0/2	.5200.	<u></u>			

KAISER PERMANENTE

ROI PATIENT DEMOGRAPHIC Walker, Jeltz

MRN: 000005578725, DOB: 5/30/1977, Sex: F

Patient Demographics DOB Patient Name Sex Walker, Jeltz (000005578725) 5/30/1977 Female Date Of Birth Gender Identity Race Ethnicity Preferred Spoken Preferred Written 05/30/1977 Female Black/African American/United Language Language American States English English **Patient Demographics** Address Phone 310-493-1783 (Home) 13732 Hill Grove St 000-000-0000 (Work) EASTVALE CA 92880 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

Kaiser Permanente Page 1

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ZU	NAI DEMOGRAPH INIGA, Jos e 6044 /04/2021			REFERRAL DATE 12/15/2020				ARRO' EVALUATION	WHEA	Redlai 92374	Plum Lane nds, CA 335-2323	
	APPOINTM	IFNT	DATE	APPOIN	ITMEN	IT TIME	 		DO	CTOR	300-2020	
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36	RVICE REQUEST QME: PQME	ED	2603821	ANEL NO. 2603821 APPOINT Leo Manza Patient uniga Vest Stonebridge Court o, CA 91762 Insurance and ers /Billing Address: DX 660055 Dallas, TX 75					590 Riverside Drive Chino, CA 91710			
				Patien	t Info	rmation						
РА	TIENT NAME	Jos	se Zuniga			DOB	5/1	0/1971		GENDER	Male	
		11!	52 West Stonebri	idae Court		SSN	xxx-xx-2988				1	
PA	TIENT ADDRESS	age court		PHONE	.	3) 572-14:	25					
		1		urance an	d Cla							
		Ι_							Laura	Orozco		
INS	SURANCE		ivelers							e: (909) 61	2-3819	
CO	MPANY)				5265				Email:			
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AP	PLICANT											
AT	TORNEY											
EM	PLOYER	Ed	elmann USA Inc	: BERT C	Ο.							
	CLAIM#	DO				EAMS#		REASON	FOR C	ONSULT/B	ODY PARTS	
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				Refer	ral Ta	ken By						
Na	llely Gomez					D	ate	12/15/	/2020 9	:40:22 AM		



#### HEALTH INSURANCE CLAIM FORM

	Sedgwick former PO Box 14214	ly srs*	
	Lexington, KY 4	0512-4214	
EALTH INSURANCE CLAIM FORM PROVED SYNITIONAL INFORMALAIM COMMITTEE (M.CO.) 02(12)			
T] pa			AREA T
MEDICATE REDICATE OFF		14. INSURENTE I.O. NUMER	(Por Program in Item 1)
(Mainticester) (Mainticester) (TUP/DCOR) (Mainti- PATIENT'S NAME (Last Name, First Name, Middle (1928)	# 101) (101) (104) X (104)	552-80-2217	
Pena, Anthony	3. PATIED/TS SHITH CATE SEX SEX OI 15 1949 W X F	4. PARLESCOPE NAME (Land Harras, First Names, Middle In	(340)
PATIENT'S ACOPESS (No., Smeat)	01 15 1949 w A F A	Turtle & Hughes	***************************************
8082 Madera	Sur Spouse Chief Cher X	1550 S Milliken Ave	Ste F
Y	TE S RESERVED FOR MUSC USE	ary	STATE
HESPERIA CA		Ontario	CA
CODE TELEPHONE (Include Area Code)		1	VE (Include Area Code)
92345 (760) 5534088		<u> </u>	09) 2188644
THER RELIFEDS NAME (Last Name, First Name, Middle 11546	10. SI PATIENC'S CONCITION RELATED TO:	11. INSUREDS POLICY GROUP OR FECA NUMBER	
THER SALBEDS POLCY OR GEOLP MARKER	a. EMPLOYMENTY (Current or Previous)	301811384380001	***************************************
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ESERVED POR NUCCUSE		B. OTHER CLAIM ID (Designated by NUCC)	м
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EBEPD/2D POPINLOCIAE	© 5TH-ERACCIONATY	C. INSUPANCE PLAN NAME OR PROGRAM NAME	
	Tres No		
NELFONICE PLANIUME ON PHOGRAU NAVE	TOIL COURSE COME (Consignated by NUCC)	G. STHERE ANOTHER HEALTH BENEFIT PLANS	
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FIGAD BAD ROPE SERVING WHO WAS A SHAPE OF POPULATION OF POPULATION OF AUTHORIZED PERSONS SIGNATURE. I AUTHORIZED PERSONS SIGNATURE. I AUTHORIZED PERSONS SIGNATURE.	y medical or other information hecessary to process this claim.	13. INBUREITE OR AUTHORIZED PERSONS SKRWITU bereits to the around gred physician or aupplier i	E I authorize payment of medical or services described below.
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SEDGWICK/KROGER/HH/MEDRISK / TP097 P.O. BOX 14452

LEXINGTON, KY 40512

#### HEALTH INSURANCE CLAIM FORM

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

Page: 1 of 1 Tracking #: 2499670

PICA					PICA
1. MEDICARE MEDICAID		— HEALTH PLAN — BIKLUNG		1a. INSURED'S I. D. NUMBER	(For Program in Item 1)
(Medicare#) (Medicaid#)			X (10#)	609209902	A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
2. PATIENT'S NAME (Last Name, PEREZ, JOSE	HIST Name, SAIGDIE INITAL)	3. PATIENT'S BIRTH DATE   SI   MM   DD   YY     SI   O1   15   1968 MX	×	4. INSURED'S NAME (Last Name, First ) FOOD 4 LESS #359/5	·
5. PATIENT'S ADDRESS (No., St	rest)	6. PATIENT RELATIONSHIP TO INSUR		7. INSURED'S ADDRESS (No., Street)	, <u> </u>
4601 LEXINGTON	AVE #110	Self Spouse Child	other 🔀 📗	1748 S. JEFFERSON BI	LVD., DEREK CARR
CITY	STATE	8. RESERVED FOR NUCC USE		CITY	STATE
LOS ANGELES	CA			LOS ANGELES	CA
ZIPCODE	TELEPHONE (Indude Area Code)		[		PHONE (Indude Area Code)
90029				90018 (	)
9. OTHER INSURED'S NAME (LA	st Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATE	о тα:	11. INSURED'S POLICY GROUP OR FE 30189610593-0001	CA NUMBER
a. OTHER INSURED'S POLICY C	DR GROUP NUMBER	a, EMPLOYMENT? (Current or Previous	,	a. INSURED'S DATE OF BIRTH MM   DD   YY	SEX
		X YES NO	´	MM DD I YY	M
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT?	ACE (State)	b. OTHER CLAIM ID (Designated by NU	
		YES X NO	' ' '	Y4   30189610593-000	)1
C. RESERVED FOR NUCCUSE		c. OTHER ACCIDENT?		C. INSURANCE PLAN NAME OR PROG	RAM NAME
		YES X NO			
d, INSURANCE PLAN NAME OR	PROGRAM NAME	18d. CLAIM CODES (Designated by NU	CC)	d. 18 THERE ANOTHER HEALTH BENE	
READ	BACK OF FORM BEFORE COMPLETING	A SIGNING THIS FORM		YES X NO #yes, o	complete items 9, 9s, and 9d.
12. PATIENT'S OR AUTHORIZED	PERSON'S SIGNATURE I authorize the	release of any medical or other information to myself or to the party who accepts assign	necessary	payment of medical benefits to the un services described below.	
below.	reat by American Baroninion remember a nor	willyout a sta party will accopia abolg		services described below.	
SIGNED_Signature	on File	DATE		Signature or	ı File
14. DATE OF CURRENT ILLNES		OTHER DATE	Υ	16. DATES PATIENT UNABLE TO WOR	K IN CURRENT OCCUPATION
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17. NAME OF REFERRING PROV !	<u>-</u> '-			18. HOSPITALIZATION DATES RELATE	
 19. ADDITIONAL CLAIM INFORM	17!  AATION (Designated by NI SCC)	NPI		FROM	TO
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I	J. L к. l	<u> </u>			
24. A. DATE(S) OF SERVICE From T		DURES, SERVICES, OR SUPPLIES in Unusual Circumstances)	E. DIAGNOSIS	F. G. H. DAYS ERSOT OR FEMTLY SCHARGES UNITS FISH	I. J. ID. RENDERING
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31. SIGNATURE OF PHYSICIAN	PERENTIAL D	CILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#	(800 )992-4442
INCLUDING DEGREES OR C	n the reverse USAW OF	CALIFORNIA-LA-GRAN		U.S. HEALTHWORKS MI	EDICAL GROUP PC
apply to this bill and are made FELDMAN M.D., R		CAL CLINIC, 1400 S GRAND AVE, S	l	P.O. BOX 50042	074_0000
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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

∏ PIÇA				1110	SODIES OFFICE	U11 717		
1. MEDICARE MEDICAID YRICARE	CHAMPVA	GBO!	IP.	FECA OTH	ER 1a. INSURED'S (.D. NUM	eco .		
(Medicare#) (Medicald#) (ID#/DoD#)	(Member ID#	HEAL	YP YH PLAN	FECA OTH BLX LUNG (IO#) (IO#)			(For Program In	Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Inklat)	<u> </u>	<u> </u>	L_	112.17 112.17				
PEREZ MARIA	`	MM	BIRTH DATE	SEX	4. INSURED'S NAME (La		,	
5. PATIENT'S ADDRESS (No., Street)			61968	M F X	<u> HISTORIC</u>	MISSIO	<u>V INN HOI</u>	<u>"EL &amp; </u>
4019 RUBIDOUX BLVD	1,				7. INSURED'S ADDRESS			
GITY ROBIDOUX BLVD				olher Olher	<u>  36</u> 49 MISS	ION INI	V AVE	
	• 1 1	3. RESERVE	Þ FOR NUCC	JSE	CITY		\$:	TATE
ZIP CODE TELEPHONE (Include Ave.	CA				RIVERSIL	E		CA
TECCITIONS (MODGE A)					ZIP CODE	TELEPH	ONE (Include Area Co	de)
<u>92509</u> (951 <del>)</del> 783-7.	360				92501	( (	95)1784030	)n   🖺
9. OTHER INSURED'S NAME (Last Name, First Name, Middle	e Inklai) - Y	O. IS PATIE	VT'8 CONDITIO	ON RELATED TO:		ROUP OR FECA	NUMBER	<u>~</u>
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a. OTHER INSURED'S POLICY OR GROUP NUMBER		i. EMPLOYM	ENT? (Current	or Previous)		BIRTH	SEV.	<u></u>
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14 DATE OF CURRENT HANDS WHICH	<del></del>		⊑ <u>12182</u>	<u>018 —                                    </u>				
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17 NAME OF REFERENCE PROVIDES OF STATE OF STATE		<u> </u>	<u> </u>		PHOM ; ;	٦	ro j	1 1
I		1			18. HOSPITALIZATION DA	TES RELATED T	O CURRENT SERVIC	EŞ
DN KHALID AHMED MD		PI	<u> 134193</u>	923_	FROM			''
19. AUDITIONAL CLAIM INFORMATION (Designated by NUC)	<b>C</b> )				20. OUTSIDE LAB?	8	CHARGES	
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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

TRAVELERS INSURANCE

PO BOX 660055 DALLAS, TX 75266

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. MEDICARE MEDICAID	TRICARE	CHAMP		ROUP ALTH PLAN	FECA BLKLU	OTHER ING	1a. INSURED'S I D.	NUMBER	₹	(For Program	in Item 1)
(Medicare #) (Medicaid #)	(ID#/DoD#)	(Membe		(ID#)	(ID#)	X (ID#)	E9R0253				
. PATIENT'S NAME (Last Name,	First Name, Middle Initia	1)	3. PATIENT	'S BIRTH DAT	E	SEX	4. INSURED'S NAM	E (Last N	ame, First Nar	ne, Middle Initial)	
PIZANO, JUANA				7 1963	м	FX	PIZANO, J	UANA			
. PATIENT'S ADDRESS (No., Str	eet)		6. PATIENT	RELATIONSH	IIP TO INSUI	RED	7. INSURED'S ADD	RESS (No	o., Street)	****	····
1608 MARKET LYNI	1 CT		Self X	Spouse	Child	Other	1608 MARK	ET L	YNN CT		
CITY		STATE	8. RESERVE	ED FOR NUCC	USE		CITY				STATE
BAKERSFIELD		CA					BAKERSFIE	LD			CA
ZIP CODE	TELEPHONE (Include A	rea Code)					ZIP CODE		TELEPHO	ONE (Include Are	ea Code)
93307	()						93307		()		
. OTHER INSURED'S NAME (Las	t, First, Middle Initial)		10. IS PATIE	ENT'S CONDIT	ION RELAT	ED TO:	11. INSURED'S PO	LICY GRO	OUP OR FECA	NUMBER	
. OTHER INSURED'S POLICY O	R GROUP NUMBER		a. EMPLOY	MENT? (Curre	nt or Previou	s)	a. INSURED'S DAT		TH	SEX	
				X YES	NO		03 27 1		ŧ	м	FX
RESERVED FOR NUCC USE			b. AUTO AC	CIDENT?			b. OTHER CLAIM I	) (Design	ated by NUCC	)	
				YES	X NO	PLACE(State)	!				
. RESERVED FOR NUCC USE		· · · · · · · · · · · · · · · · · · ·	c. OTHER A	L	٠.٠٠	L	c. INSURANCE PLA	N NAME	OR PROGRA	M NAME	
				YES	X NO						
. INSURANCE PLAN NAME OR F	PROGRAM NAME		10d. CLAIM	CODES (Desi	لسسسا	JCC)	d. IS THERE ANOT	HER HEA	LTH BENEFIT	PLAN?	1
					-		YES X	NO If	yes, complete	items 9, 9a and 9	∋d.
	M BEFORE COMPLET						13. INSURED'S OR	AUTHOR			.1
PATIENT'S OR AUTHORIZED necessary to process this claim.							authorize payment				
accepts assignment below.							' '				
SIGNATURE			DATE	04/20	)/2020		- 01014ED -		rure on		
I. DATE OF CURRENT ILLNESS MP)	, INJURY, or PREGNAN	15. C	Other Date	ММ	DD YY		16.DATES PATIEN	T UNABLI DD YY	E TO WORK I	CURRENT OC MM DD	
	QUAL 431	QUA	L.	1			FROM		TC		!
7. NAME OF REFERRING PROV	IDER OR OTHER SOU	RCE 17a.					18. HOSPITALIZAT		ES RELATED		
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9. ADDITIONAL CLAIM INFORMA		IUCC)	1 1 = 0				20. OUTSIDE LAB?		\$ CH	ARGES	I
/26/17;11/1/18;	11/12/18						YES X	NO	1		
1. DIAGNOSIS OR NATURE OF		Relate A-L to se	rvice line belo	ow (24E)) ICD	Ind. O		22. RESUBMISSIO			_	
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4. A. DATE(S) OF SERVICE	B.	h	CEDURES S	ERVICES, OR	L	] E.	F.	G. T	н. ј.	T	
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INCLUDING DEGREES OR CRE	DENTIALS	SERVICE FAC	JILLEY LOCA	HON NEURM	TION		33. BILLING PROVI	DEK INF	O & PH# ()	•	
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SG006 Sedgwick 14421

Page 1 of 1

미약교 REALTH INSURANCE CLAIM FORM		3
1EALTH INSUHANCE CLAIM FORM PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		
TIPICA CLAIM# WC-7868		PICA
I. MEDICARE MEDICAID TRICARE CHAMP	A GROUP PLAN BEKLUNG THE	ER 1a. INSURED'S I.D. NUMBER (For Program in Nam 1)
(Medicarell) (Medicalds) (IDMDoDII) (Marrier	A GROUP PLAN BEX LING X (104)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE BEX	4. INSURED'S NAME (Lest Name, First Name, Middle Initial)
Rosales, Max	08 08 94 MX F	Sonic AutoBuena Park Honda
S. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
10403 GRIDLEY ROAD	Set Spouse Child Other X	I must make
СПУ		CITY STATE
SANTA FE SPRINGS CA	_	Buena Park CA ZIP CODE TELEPHONE (Include Area Code)
ZIP CODE TELEPHONE (Include Area Code)		2. 5552
90670 ( )	10, IS PATIENT'S CONDITION RELATED TO:	906212896 /
). OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	WC-7868
LOTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (Current or Previous)	A INSURED'S DATE OF BIRTH SEX
FALLER MODULES & LOCAL OU ALCOL MOMBEL	X YES NO	MM DD YY M F
A RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State	b. OTHER CLAIM ID (Designated by NUCC)
	YES X NO CA	¥4 WC-7868
. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	C INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	
I. INBURIANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d 18 THERE ANOTHER HEALTH BENEFIT PLAN?
		YES X NO # yes, complete items 9, 6s, and 9d.
READ BACK OF FORM SEFORE COMPLETS 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I muthorize th	IG & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits either	r to myself or to the party who accepts assignment	envices described below.
below.	00 100 1000	61 1 0x Wile
SIGNED Signature On File	DATE 09/28/2020	SKAMED Signature On File
	OTHER DATE MM   DD   YY	16, DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
03 07 20 UML 1439		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
i ha	0E 20A11785	FROM DO YY MM DO YY
DO: Edward L Barawid T B. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	75. NPI   1497041792	20. CUTSIDE LAB? \$ CHARGES
		TYES TNO
Sonic Autobuena Park Honda  1. DIAGNOSIS OR NATURE OF ILINESS OR INJURY Relate A-1 to as	nice line below (24E)	22 RESUBMISSION
		ORIGINAL REF. NO.
A THEORETTE AND THE PARTY OF TH	D. L.	23. PRIOR AUTHORIZATION NUMBER
E.L. J.L. K	Н	-
MA DATE(S) OF SERVICE B. C. D. PROC	EDURES, SERVICES, OR SUPPLIES E	P. G. H. I. J. RENDERING
From To PLACEOF (EX	Sein Unusual Circurestenoss) DIAGNO PCS   MODIFIER POINTE	CR (Faile)
ADL 15 min	1	PXC 2083X0100X
09 28 20 09 28 20 11 9753	5 A	50 24 1.00 NPI 1891775235
Level 4 Return Visit Persanent Stationary Ev		PXC 2083X0100X
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09 28 20 09 28 20 11 WC00	4	154 38 6.00 NP 1891775235
	1111	NPI
25 FEDERAL TAX I.D. NUMBER SON EIN 25 PATIENT'S	ACCOUNT NO. 27 ACCEPT ASSIGNMENT	
	To down cause the person	\$ 561.37 \$ 0.00
	720   X YES   NO FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( 888) 352-6794
INCLUDING DEGREES OR CREDENTIALS		Occapedialists Corp
(I couldy that the statements on the revenue CNC — L3 apply to this bill and are made a part thereot.)	X La Paina rpointe Dr	PO Box 3800
A76120 Coppelson, Aaron	Ca. 90623	Rancho Cucamonga CA 917293800
Signature on File 10/05/2020 3 4 4 070	89157 b	- 1053507558 b
SIGNÉD DATE "14870		1000001000

APPROVED-0MB-6938-1197 FORM 1500 (02-12)

NUCC Histruction Manual available at: www.nucc.org

HEALTH INSURANCE CLAIM FORM

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

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

TITTIPICA

YORK
PO Box 619079
Roseville, CA 95678 Invoice # 20549231 06/15/2017

## RECEIVED

JUN 1 9 2017 B

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	RICARE CHAN	MPVA GROUP HEALTH	PLAN FECA	OTHER 1a. INSURED'S	10 millions		PICA
	#/DoD#) (Mont	her ID#) HEALTH (ID#)	PLAN BLKLUNG	Floren I		(For Program is	ı llem 1
2. PATIENT'S NAME (Last Name, First Name	i, Middle Initial)	3. PATIENTS BIF		1	AME (Lent Name File	st Name, Middle Initial)	
Ruano, Francisco  5. PATIENT'S ADDRESS (No., Street)		08/09/1	959 MX I	FI Duana Fo		st name, Middle Initial)	
1		6. PATIENT RELA	ATIONSHIP TO INSURED	Ruano, Fr.	<u> ANCISCO</u> DDRESS (No., Street	1	
14179 Northstar Ave		Self Spou	use Child Othe	. [62]		,	
DUELAN	STAT	E 8. RESERVED FO	OR NUCC USE	14179 Nor	Insiar Ave		
ZIP CODE TELEPHON	CA	_		PHELAN		8	TATE
TELEPHON	NE (Include Area Code)			ZIP CODE	TEL	EPHONE (Include Area Coo	<u> </u>
92329 ( )	(714) 235-1280			02220		/ \	
9. OTHER INSURED'S NAME (Last Name, Fire	il Name, Middle Initial)	10. IS PON RELATI	ED TO:	92329 11. INSURED'S PO	DLICY GROUP OR F	(714) 235	-1280
a. OTHER INSURED'S POLICY OR GROUP NO				000110404	m 4	ECW NDWREH	
A STATE OF THE STA	JMBER	e. EMPLOYMENT?	(Current or Previous)	SCIH-0434 a. INSURED'S DAT MM I D	E OF SIRTH	Of the Control of the	
b. RESERVED FOR NUCC USE		XY	ES NO	MM	O I YY	SEX	_
- TON NOCE USE		b. AUTO ACCIDENT	7? PLACE (5	D8/09	/1959 D (Designated by NU	M F [	
- CECEDITES -		YE		4 1 1	•	ICC)	
E RESERVED FOR NUCC USE		c. OTHER ACCIDEN		State of CA	- IHSS	20111111	
d this is a second		YE	S X NO	- TOURNE PLA	TANE UK PROG!	VVM NAME	
d. Insurance flan name or program na	ME	10d. CLAIM CODES	(Designated by NUCC)	d. IS THERE ANOTH	AED MENT TO THE		
•					7		
READ BACK OF FOR 12. PATIENT'S OR AUTHORIZED PERSON'S SIG to process this claim. I also request payment of	M BEFORE COMPLETING	& SIGNING THIS FOI	RM.	13. INSTIDENT		implete Items 9, 9a, and 9d.	
to process this claim. I also request payment of below.	government benefits either !	erease or any medical o to myself or to the party	if other information necessar who accepts assignment	payment of medic	Al Decimins to the used	DN'S SIGNATURE I authori aralgned physician or suppl	ze let for
				services described	Delow.	y = === r as welpfill	J. 101
SIGNED Signature On File		DATE		picken Cina	nature On File	_	
4. DATE OF CURRENT ILLNESS, INJURY, or PE	REGNANCY (LMP) 15. C	THER DATE		18 DATES DATISAN	lalure On File	).	
U2/03/2017 QUAL	QUA	il i M	M   DD   YY	FROM	D I YY WORK	IN CURRENT OCCUPATION	Ÿ
7. NAME OF REFERRING PROVIDER OR OTHE	R SOURCE 178.	18018730	170.		i	10 1 1	
Marc Forrest	17b.	NPI 19222890		FROM DE	1 TYPECATED	TO CURRENT SERVICES	Y
B. ADDITIONAL CLAIM INFORMATION (Designation)	ed by NUCC)			20. OUTSIDE LAB?		TO CHARGES	
DIAGNOSIS OR NATION OF THE	IACHED			YES X		LUUNGES	
DIAGNOSIS OR NATURE OF ILLNESS OR INJ	URY Relate A-L to service	fine below (24E)	CD Ind. D	22. RESUBMISSION			
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F. L	G		н. L	23. PRIOR AUTHORIZA	ATION NUMBER		
A DATE(S) OF SERVICE B	K, L		1.1	-	THE PROPERTY OF THE PROPERTY O		
From To PLACE	OF C. D. PROCEDU	RES, SERVICES, OR S Inusual Circumstances		F. T	G. H. I.	T	
M DD YY MM DD YY SERVIC	CE EMG CPT/HCPCS	MODIFIE	DIAGNOSI ER POINTER	SI I	G. H. I. DAYS EPSDT (D.	J. RENDERING	- 1
SERVICE SERVIC	CE EMG   CPT/HCPCS	- N-0941		S CHARGER			
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