**Yuri Falkinstein, M.D., FAAOS**

**FELLOW, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS**

05/22/2023

Applicant Attorney : PATEL ABHISHEK   
Defense Attorney: TEST  
Adjustor Name :   
  
Re: Applicant: PATEL ABI   
Employer: TEST   
DOI: 03/05/2000   
Claim: 45345   
  
Please be advised that PATEL ABI has been scheduled with Yuri Falkinstein, M.D. on 05/29/2023 at 09:45 AM. The appointment will be held at:

West Coast Spine Institute

**EAST LA  
45, ASHFORD STREET**

**LA, CALIFORNIA, 90002**

In order to assist you in a timely manner and comply with Labor Code section 4060 we are requesting the following:

 A Fully executed **Joint/Advocacy Letter** and **all medical records** **MUST** be received **no later than 30 days before the patient’s scheduled appointment**. **If this does not occur, the above appointment may be RESCHEDULED**.

 **If the medical records are not received within the timeline given, it may become necessary to issue a supplemental report and/or the patient will be rescheduled for a second appointment.**

 **ll overnight packages must be sent to 16530 Ventura Blvd., Suite 130, Encino, CA 91436.** All other correspondence must be sent to P.O. Box 261656 Encino, CA 91426.

 The Parking fee for WEST COAST SPINE EAST LA is **$ 10.00** .Please be sure the patient is given a map to our location.

 Missed Appointment charge is $503.75. If the appointment is cancelled within six (6) days of the scheduled appointment, we will charge $503.75 plus the time spent reviewing the medical records per the labor code.

Thank you,

APPOINTMENT DEPARTMENT

**SCHEDULING: (818) 582-2600**  
**P.O. Box 261656, Encino, CA 91426**

**FAX: (818) 855-2466**

**State of California**

**DIVISION OF WORKERS’ COMPENSATION - MEDICAL UNIT**

**AME or QME Declaration (Lab. Code § 4062.3(i))**

|  |  |
| --- | --- |
| **Case Name :** PATEL ABI | **V:** TEST |
|  |  |
|  |  |
| **Claim No: 45345** | **EAMS or WCAB Case No. (*if any*):** |

I, MARCILES DACRES , declare:

1. I am over the age of 18 and not a party to this action.

*2.* My business address is **: P.O. Box 261656 Encino, CA 91426**

3. On the date shown below, I served the attached original, or a true and correct copy of the original:

* **Attorney Appointment notice**
* **Patient Appointment Notice**

By placing it in a sealed envelope, addressed to the person or firm named below, and by:

A Depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.

B placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business’s practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.

C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

D placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*

E personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: Date Served: Addressee and Address Shown on Envelope:

*(For each addressee,*

*Enter A - E as appropriate)*

**\_\_A\_\_\_\_\_\_\_\_ 05/22/2023** **Please See Attached Service List\_**

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: **05/22/2023**

MARCILES DACRES

(*Signature of declarant) (Print name)*

QME Form 122

Rev. February 2009

**Service List**

|  |  |
| --- | --- |
| **Case Name :**  PATEL ABI | **V:** TEST |
|  |  |
| **Claim No: 45345** | **EAMS or WCAB Case No. (*if any*):** |

,

PATEL ABHISHEK

QWEQ

QWE, IDAHO 23423

TEST

45634

EWTERT, ALABAMA 23423

WORKERS COMPENSATION APPEALS BOARD

BAKERSFIELD

1800 30TH ST, #100

BAKERSFIELD , CALIFORNIA 93301

**Yuri Falkinstein, M.D., FAAOS**

**FELLOW, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS**

05/22/2023

**PATEL ABI**

135

,

Dear Mr. /Mrs.: **PATEL ABI**

Please be advised that an appointment has been scheduled for you to see Yuri Falkinstein, M.D. on 05/29/2023 at 09:45 AM. Your appointment will be held at:

WEST COAST SPINE INSTITUTE

EAST LA  
45, ASHFORD STREET  
LA, CALIFORNIA 90002

The parking fee for this location is $ 10.00.  
   
Please make sure you keep this appointment as it is the most important medical appointment for your case. Please allow ample time (minimum 3 hours) to be at our office.  
   
Please review and compare this appointment with any other appointment letter you may have received. In case of any discrepancies, please contact our office immediately for clarification.  
   
Kindly note that you must check in at the above address 15 minutes prior to your scheduled appointment time with proof of identification.  
   
**It is necessary that you contact our office at 818-582-2600, 10 days prior to your appointment, for a detailed history of your injury.** This will save you time at your scheduled appointment.   
   
If you have no knowledge of this appointment, please contact your attorney ASAP.

Thank you,

APPOINTMENT DEPARTMENT

**SCHEDULING: (818) 582-2600**  
**P.O. Box 261656, Encino, CA 91426**

**FAX: (818)855-2466**

# State of California

# Division of Workers' Compensation-Medical Unit

# QME Appointment Notification Form

**Please complete this form in its entirety** .*The Administrative Director requires that you serve this appointment notification form on the employee and the claims administrator, or, if none the employer, and their attorneys in a represented case, if known, within five (5) business days after having scheduled the injured worker to be seen for a QME comprehensive medical-legal evaluation. You may not cancel the appointment less than six (6) calendar days prior to the appointment date, except for good cause (See, 8 Cal. Code Regs. §34). If you reschedule an appointment, review regulation 34 and the ethical rules in regulation 41 (See, 8 Cal Code Regs. §§ 34, 41(a) (7) and (a)*

**Employee Information** (Completion of this section is required)

|  |  |
| --- | --- |
| PATEL ABI | *345-345-3453* |
| Employee Name | Ph Phone Number |

|  |  |  |  |
| --- | --- | --- | --- |
| *135* |  |  |  |
| Employee Street Address | Employee City | State | Zip Code |

|  |  |  |
| --- | --- | --- |
| *03/05/2000* | *123* | *45345* |
| Date of Injury | Panel Number | Claim or Case Number |

**Employer Information**

|  |  |  |  |
| --- | --- | --- | --- |
| TEST | | | |
| Employer Name | | | |
| 424 |  | ALABAMA | 22132 |
| Employer Street Address | Employer City | State | Zip code |

**Claims Administrator Information**

*(Completion of this section is required)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
| Claims Administrator Name (Insert the name of person handling the claim) | | | Phone Number |
|  | | |  |
| Claims Administrator Company (Insert the name of Company handling the claim) | | | Phone Number |
|  |  |  |  |
| Claim Administrator Street Address | Claim Administrator City | State | Zip code |

**Appointment Information**

*(Completion of this section is required)*

Date of Appointment call: 05/22/2023 Date of Appointment: **05/29/2023**

Time of Appointment: **09:45 AM**

|  |  |  |  |
| --- | --- | --- | --- |
| **45, ASHFORD STREET** | **LA** | **CALIFORNIA** | **90002** |
| Examination Address | Examination City | State | Zip code |

If an interpreter is required? Yes No .If an interpreter required, indicate language:

QME Name: **YURI FALKINSTEIN, MD** QME Street Address: **P.O. BOX 261656** QME City: **Encino** Zip code: **91426**

Date Signed: 05/22/2023 Signature of the QME:

*Note to Claims Administrator: The Administrative Director's regulation 10160 requires you to forward a completed, DWC-AD form 101(DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report) (see, 8 Cal. Code Regs. §§ 10160 and 10161) together with all medical reports and medical records prior to the scheduled examination with the QME. You must also provide the employee with a DWC-AD form 100 (DEU) (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) prior to the examination.*