



From	Priyanka	To	AmTrust North America
Telephone		Clearinghouse	Jopari
Fax	-----	Payer ID	16535
Email	Admin@gmail.com		

Original Bill

Medical Treatment

Patient Name	Chris Milana	Billing Provider	WorkMed California, APC
Claim Number	32145689-1	DOS	10-09-2023
Patient Control No		Charge Amount	114.06
		Rendering Provider	Shelly Calhoun

Payment Compliance Dates

e-Bill Transmission

HEALTH INSURANCE CLAIM FORM

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

Tristar Risk Management
Submitted Electronically via Jopari
(Payer ID: 41556)

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form

PICA
CMS1500 Page 1 of 1 PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLACKLUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Milana, Chris								3. PATIENT'S BIRTH DATE MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>							
5. PATIENT'S ADDRESS (NO., Street) 8020 De Palma, St. #208								6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>							
CITY Lakewood						STATE		8. RESERVED FOR NUCC USE							
ZIP CODE				TELEPHONE (Include Area Code)											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)							
a. OTHER INSURED'S POLICY OR GROUP NUMBER												11. INSURED'S POLICY GROUP OR FECA NUMBER Value			
b. RESERVED FOR NUCC USE												a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			
c. RESERVED FOR NUCC USE												b. OTHER CLAIM ID (Designated by NUCC) 32145689-1 Value			
d. INSURANCE PLAN NAME OR PROGRAM NAME												c. INSURANCE PLAN NAME OR PROGRAM NAME Value			
												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete items 9, 9a, and 9d.			

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 government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 10/10/2023		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for service described below. SIGNED	
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14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. Value Value Value				15. OTHER DATE QUAL. MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17.a		17.b	
				NPI			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. Value B. Value C. Value D. Value E. Value F. Value G. Value H. Value I. Value J. Value K. Value L. Value							

20. OUTSIDE LAB? \$CHARGES <input type="checkbox"/> Yes <input type="checkbox"/> No								22. RESUBMISSION CODE ORIGINAL REF. NO.							
23. PRIOR AUTHORIZATION NUMBER															

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE		C. AMG		D. PROCEDURES, SERVICES, OR SUPPLIES					E. DIAGNOSIS POINTER	
From To										(Explain Unusual Circumstances)						
MM	DD	YY	MM	DD	YY					CPT/HCPCS	MODIFIER					
1																
2						11		value		00	00	00	00	00		
3	00	00	00	00	00	00		value	value	00	00	00	00	00		
4	00	00	00	00	00	00		value	value	00	00	00	00	00		
5	00	00	00	00	00	00		value	value	00	00	00	00	00		
6	00	00	00	00	00	00		value	value	00	00	00	00	00		
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	00	00	00	00	00	00		value	value	00	00	00	00	00		

25. FEDERAL TAX ID NUMBER 330184132				SSN <input type="checkbox"/>		EIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 477db9122800-1				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			
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1.a INSURED'S LD. NUMBER (For Program in item 1) 000-00-0000				Image not found or type unknown form					
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Meraki RCM Solutions, LLC									
7. INSURED'S ADDRESS (NO., Street) 1055 W. 7th St, 33rd Floor									
CITY Los Angeles				STATE California					
ZIP CODE 90017				TELEPHONE (Include Area Code)					
11. INSURED'S POLICY GROUP OR FECA NUMBER Value									
a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER CLAIM ID (Designated by NUCC) 32145689-1 Value									
c. INSURANCE PLAN NAME OR PROGRAM NAME Value									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete items 9, 9a, and 9d.									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for service described below. SIGNED									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MMDDYY TO MMDDYY									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MMDDYY TO MMDDYY									
20. OUTSIDE LAB? \$CHARGES <input type="checkbox"/> Yes <input type="checkbox"/> No									
22. RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER									
F. \$ CHARGES		G. DAYS OR UNITS		H. EFSDT Family Plan		I. ID QUAL.		J. RENDERING PROVIDER ID.#	
						ZZ			
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00 00		00		00		NPI		1215628623	
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGRESS OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Shelly Calhoun SIGNATURE ON FILE SIGNED 10/10/2023 DATE				32. SERVICE FACILITY LOCATION INFORMATION Telemedicine Only 2440 W Shaw Ave #106 2440 W Shaw Ave #106 Fresno California a. 1487029278 b.			
33. BILLING PROVIDER INFO & PH # () WorkMed California, APC PO BOX 3327 Seal Beach California 90740 a. 1487029278 b.							

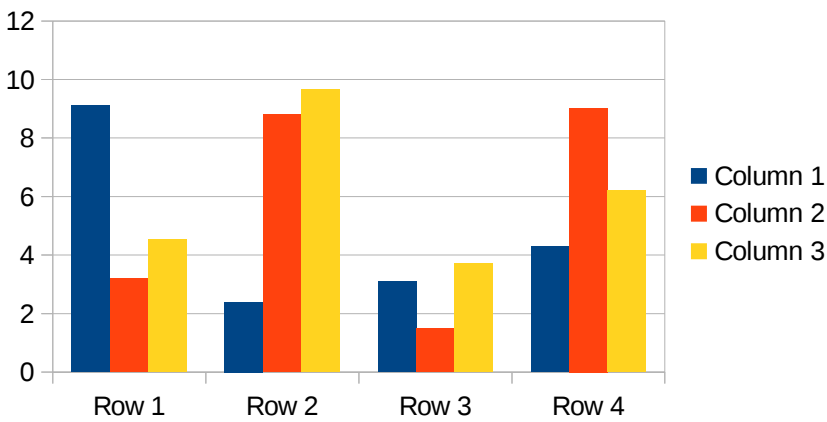
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