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	05-26-2022
Patient Control No		Charge Amount	150
		Rendering Provider	Kevin Calhoun

Payment Compliance Dates

e-Bill Transmission

HEALTH INSURANCE CLAIM FORM

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

AMTRUST NORTH AMERICA

SUBMITTED ELECTRONICALLY VIA DATA DIMENSIONS

PICA

PICA

CARRIER

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)
000-00-0000

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
CHRIS MILANA

3. PATIENT'S BIRTH DATE MM DD YY
X
SEX M [ ] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
CHRIS MILANA

5. PATIENT'S ADDRESS (No., Street)
8020 DE PALMA, ST. #208

6. PATIENT RELATIONSHIP TO INSURED
Self [ ] Spouse [ ] Child [ ] Other [X]

7. INSURED'S ADDRESS (No., Street)
8020 DE PALMA, ST. #208

CITY
LAKEWOOD

STATE

8. RESERVED FOR NUCC USE

CITY
LAKEWOOD

STATE

ZIP CODE
90713

TELEPHONE (Include Area Code)
( )

ZIP CODE
90713

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)
[ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY
X
SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT?
[ ] YES [X] NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)
32145689-1

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 [ ] 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.
SIGNATURE ON FILE
SIGNED _____ DATE 11/11/2022

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 _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

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

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)

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 01

Z98891 A0100 A0103 A0104 SEE ATTACHED

A. A0104 B. C. D.

E. A009 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 11				99205	19					NPI	50 1
2 11				99204	21					NPI	100 1
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
330184132 X

26. PATIENT'S ACCOUNT NO.
477DB9122800-1

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
[ ] YES [ ] NO

28. TOTAL CHARGE
150

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.)
KEVIN CALHOUN
SIGNATURE ON FILE 12/06/2022
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
TELEMEDICINE ONLY
2440 W SHAW AVE #106
FRESNO CALIFORNIA
93711-3300

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

HEALTH INSURANCE CLAIM FORM

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

PICA

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

CMS1500 Page 1 of 1 PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLACKLUNG (ID#) OTHER (ID#)	1.a INSURED'S I.D. NUMBER (For Program in item 1): 556-46-4521
2. PATIENT'S NAME(Last Name, First Name, Middle Initial): ANKIT GUPTA	3. PATIENT'S BIRTH DATE MM 03 DD 30 YY 95 SEX M F
	4. INSURED'S NAME(Last Name, First Name, Middle Initial): ANKIT GUPTA
5. PATIENT'S ADDRESS (NO.,Street): RAJENDRA NAGAR	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
	7. INSURED'S ADDRESS (NO.,Street): RAJENDRA NAGAR
CITY: Anatone STATE: WA	8. RESERVED FOR NUCC USE: Value
	CITY: Anatone STATE: WA
ZIPCODE: 99401 TELEPHONE(Include Area Code): (996) 865-4856	
	ZIPCODE: 99401 TELEPHONE(Include Area Code): (996) 865-4856
9. OTHER INSURED'S NAME(Last Name, First Name, Middle Initial): Value	10. IS PATIENT'S CONDITION RELATED TO: Value
	11. INSURED'S POLICY GROUP OR FECA NUMBER: Value
a. OTHER INSURED'S POLICY OR GROUP NUMBER: Value	a. EMPLOYMENT?(Current or Previous) YES NO
	a. INSURED'S DATE OF BIRTH MM 03 DD 30 YY 95 SEX M F
b. RESERVED FOR NUCC USE: Value	b. AUTO ACCIDENT? YES NO PLACE (State)
	b. OTHER CLAIM ID (Designated by NUCC): 994218WC981 Value
c. RESERVED FOR NUCC USE: Value	c. OTHER ACCIDENT? YES NO
	c. INSURANCE PLAN NAME OR PROGRAM NAME: Value
d. INSURANCE PLAN NAME OR PROGRAM NAME: Value	10d. CLAIM CODES (Designated by NUCC): Value
	d. IS THERE ANOTHER HEALTH BENIFIT PLAN? Yes No **If yes,** complete items 9,9a, and 9d.
READ BACK OF FORM BEFORE COMPLETEING & 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 benifits either to myself or to government benifits 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 benifits to the undersigned physician or supplier for service described below. SIGNED
14.DATE OF CURRENT ILLNESS, INJURY,or PREGNANCY (LMP) MM Value DD Value YY Value QUAL. Value	15. OTHER DATE QUAL. Value MM Value DD Value YY Value
	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 00 00 00 TO 00 00 00
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17.a value 17.b NPI value
	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 00 00 00 TO 00 00 00
19.ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Value	20. OUTSIDE LAB? Yes No $CHARGES Value Value
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. Value Value A. Value B. Value C. Value D. Value E. Value F. Value G. Value H. Value I. Value J. Value K. Value L. Value	22. RESUBMISSION CODE Value ORIGINAL REF. NO. Value 23. PRIOR AUTHORIZATION NUMBER Value

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	value	value									
	01 01 18 01 01 18	01	value	00	00 00 00 00		00 00	00	00	NPI	1215628623
2	value	value									
	00 00 00 00 00 00	value	value	00	00 00 00 00		00 00	00	00	NPI	1215628623
3	value	value									
	00 00 00 00 00 00	value	value	00	00 00 00 00		00 00	00	00	NPI	1215628623
4	value	value									
	00 00 00 00 00 00	value	value	00	00 00 00 00		00 00	00	00	NPI	1215628623
5	value	value									
	00 00 00 00 00 00	value	value	00	00 00 00 00		00 00	00	00	NPI	1215628623
6	value	value									
	00 00 00 00 00 00	value	value	00	00 00 00 00		00 00	00	00	NPI	1215628623
	value	value									
	00 00 00 00 00 00	value	value	00	00 00 00 00		00 00	00	00	NPI	1215628623

25. FEDERAL TAX I.D NUMBER SSN EIN 38-4144036	26. PATIENT'S ACCOUNT NO. 477db9122800-1	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $ 0.00.00	29. AMOUNT PAID $ 0.00	30. Rsvd for NUCC Use - 0.00
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.) Angel Mancheno SIGNATURE ON FILE 10/10/2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION City of Industry City of Industry City of Industry City of Industry California a. 28-4144036 b.	33. BILLING PROVIDER INFO & PH # ( ) Halo Services Inc P.O. Box 1968 Montebello California 90640 a. 28-4144036 b.

HEALTH INSURANCE CLAIM FORM

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

AMTRUST NORTH AMERICA

SUBMITTED ELECTRONICALLY VIA DATA DIMENSIONS

CARRIER

CMS1500 PAGE 1 OF 1

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): 613-02-9476

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LETICIA GARCIA

3. PATIENT'S BIRTH DATE MM DD YY: 05 15 72 SEX M X F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): LETICIA GARCIA

5. PATIENT'S ADDRESS (No., Street): 12790 MERIT DR STE 200

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

7. INSURED'S ADDRESS (No., Street): 12790 MERIT DR STE 200

CITY: DALLAS | STATE: TX

8. RESERVED FOR NUCC USE

CITY: DALLAS | STATE: TX

ZIP CODE: 75251 | TELEPHONE (Include Area Code): (323) 873-0827

ZIP CODE: 75251 | TELEPHONE (Include Area Code): (323) 873-0827

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM DD YY: 05 15 72 SEX M ☐ F X

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? X ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC) X

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 _____ 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 QUAL.

15. OTHER DATE QUAL. MM DD YY 11/11/2022

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 01 17 17

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) INTERPRETING SERVICES - PERLA RAMIREZ

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. B. C. D. 01

E. Z710 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	DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2	01 17 17 01 17 17	11		T1013	A		280	8		ZZ NPI	1063480192
3										NPI	
4										NPI	
5										NPI	
6										NPI	

SEE ATTACHED

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

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.) 47-1397278 X

SIGNED PERLA RAMIREZ KM DATE 12/06/2022

32. SERVICE FACILITY LOCATION INFORMATION 477DB9122800-1

LOS ANGELES

5860 AVALON BLVD

a. LOS ANGELES b. CALIFORNIA

33. BILLING PROVIDER INFO & PH # 280 ( ) (310) 756-9887

SERENITY INTERPRETING SERVICES

a. 1534 S MESA ST b.

SAN PEDRO CALIFORNIA 90731

1215628623

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)