TRISTAR RISK MANAGEMENT
SUBMITTED ELECTRONICALLY VIA JOPARI
(PAYER ID: 41556)

HEALTH INSURANCE CLAIM FORM

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

PICA

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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): 000-00-0000

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

3. PATIENT'S BIRTH DATE MM DD YY — SEX M ☒ F ☐

4. INSURED'S NAME(Last Name, First Name, Middle Initial): MERAKI RCM SOLUTIONS, LLC

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

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

7. INSURED'S ADDRESS (NO.,Street): 1055 W. 7TH ST, 33RD FLOOR

CITY: LAKEWOOD — STATE:

ZIPCODE: — TELEPHONE(Include Area Code):

8. RESERVED FOR NUCC USE

CITY: LOS ANGELES — STATE: CALIFORNIA

ZIPCODE: 90017 — TELEPHONE(Include Area Code):

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

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

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

c. OTHER ACCIDENT? ☐ YES ☐ NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: Value

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

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Value

d. IS THERE ANOTHER HEALTH BENIFIT PLAN? ☒ Yes ☐ No **If yes,** complete items 9,9a, and 9d.

PATIENT AND INSURED INFORMATION

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.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17.a

17.b NPI

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

19.ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ Yes ☐ No $CHARGES

22. RESUBMISSION CODE ORIGINAL REF. NO.

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

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. AMG	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	value	00	00 00 00 00		00 00	00	00	ZZ	
															NPI	1215628623
2																
3	00	00	00	00	00	00	value	value	00	00 00 00 00		00 00	00	00	NPI	1215628623
4	00	00	00	00	00	00	value	value	00	00 00 00 00		00 00	00	00	NPI	1215628623
5	00	00	00	00	00	00	value	value	00	00 00 00 00		00 00	00	00	NPI	1215628623
6	00	00	00	00	00	00	value	value	00	00 00 00 00		00 00	00	00	NPI	1215628623
	00	00	00	00	00	00	value	value	00	00 00 00 00		00 00	00	00	NPI	1215628623
	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 ☐: 330184132

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.)

Robinson Langille

SIGNATURE ON FILE SIGNED — 10/10/2023 DATE

32. SERVICE FACILITY LOCATION INFORMATION

Fresno-New
2440 W Shaw Ave #106
2440 W Shaw Ave #106
Fresno California

a. NPI 1487029278 b.

33. BILLING PROVIDER INFO & PH #( )

WorkMed California, APC
PO BOX 3327
Seal Beach California 90740

a. NPI 1487029278 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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