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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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): 000-00-0000

2. PATIENT'S NAME(Last Name, First Name, Middle Initial): Milana, Chris	3. PATIENT'S BIRTH DATE: MM 07 / DD 13 / YY 66 — 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: CA	8. RESERVED FOR NUCC USE	CITY: Los Angeles — STATE: California
ZIPCODE: — TELEPHONE(Include Area Code):		ZIPCODE: 90017 — 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: Value
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT?(Current or Previous): ☒ YES ☐ NO	a. INSURED'S DATE OF BIRTH: MM / DD / YY — SEX: M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO — PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC): 32145689-1 Value
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Value
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	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.	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
		20. OUTSIDE LAB? ☐ Yes ☐ No $CHARGES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		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		23. PRIOR AUTHORIZATION NUMBER

A. Value B. Value C. Value D. Value
E. Value F. Value G. Value H. Value
I. Value J. Value K. Value L. 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	05 26 22 05 26 22	11	value	00	00 00 00 00		00	00	00	ZZ NPI	1215628623
2	00 00 00 00 00 00	value	value	00	00 00 00 00		00	00	00	NPI	1215628623
3	00 00 00 00 00 00	value	value	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	NPI	1215628623
5	00 00 00 00 00 00	value	value	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	NPI	1215628623

25. FEDERAL TAX I.D NUMBER: 330184132 SSN ☐ EIN ☐	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 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 10/10/2023 (SIGNED / 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.