

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

AMTRUST NORTH AMERICA SUBMITTED ELECTRONICALLY VIA DATA DIMENSIONS

PPROVED BY NATIONAL UI	NIFORM CLAIM COMMIT	TEE (NUCC) 02/12	!				Ci	MS1500 PAG	E 1 OF 2	PICA	
I. MEDICARE MEDIC	AID TRICARE	CHAMP ¹	VA GRO	OUP FEC	A OTHER	1a. INSURED'S I.D. N	UMBER		(For Pr	ogram in Item 1))
(Medicare#) (Medica	id#) [(ID#/DoD#)	(Member	ID#) (ID#)) (ID#)	LUNG (ID#)	000-00-0000					
2. PATIENT'S NAME (Last Na CHRIS MILANA	me, First Name, Middle Ir	itial)	3. PATIENT	S BIRTH DATE	SEX F	4. INSURED'S NAME (CHRIS MILANA	(Last Name,	First Name,	Middle Ini	itial)	
5. PATIENT'S ADDRESS (No. 8020 DE PALMA, ST. #208	, Street)		6. PATIENT	RELATIONSHIP TO		7. INSURED'S ADDRE 8020 DE PALMA, S'		eet)			
ĺ.		STATE	Self	Spouse Child	Other	·	11,11200			STATE	
LAKEWOOD		SIAIL	o. NESERVI	ED FOR NOOD OSE		LAKEWOOD				SIAIL	
ZIP CODE 90713	TELEPHONE (Includ	le Area Code)				ZIP CODE 90713		TELEPHONI	E (Include	Area Code)	
9. OTHER INSURED'S NAME	(Last Name, First Name,	Middle Initial)	10. IS PATIE	ENT'S CONDITION R	ELATED TO:	11. INSURED'S POLIC	CY GROUP C	R FECA NU) JMBER		
		,									
a. OTHER INSURED'S POLIC	Y OR GROUP NUMBER		a. EMPLOYI	MENT? (Current or Pr		a. INSURED'S DATE (OF BIRTH	М		SEX F	
o. RESERVED FOR NUCC U	SE		b. AUTO AC		NO PLACE (State)	b. OTHER CLAIM ID (I	i Designated b			· L	
				YES		32145689-1					
c. RESERVED FOR NUCC US	SE		c. OTHER A		NO	c. INSURANCE PLAN	NAME OR P	ROGRAM N	IAME		
I. INSURANCE PLAN NAME	OR PROGRAM NAME		10d. CLAIM	CODES (Designated		d. IS THERE ANOTHE	R HEALTH E	BENEFIT PL	AN?		
READ BACK OF FORM BEFORE COMPLETING 8			10.0.0000000000000000000000000000000000	TUI0 F07-1				7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 -			
2. PATIENT'S OR AUTHORI: to process this claim. I also	ZED PERSON'S SIGNAT	URE I authorize the	release of any	medical or other inform		 INSURED'S OR AU payment of medica services described 	I benefits to t				for
below. SIGNATURE				11/11/2022							
SIGNED	ESS IN IURY of PREGN	IANCY (I MP) 15	DA	ATE		SIGNED	INARI E TO	WORK IN C	LIBBENT	OCCUPATION	
14. DATE OF CURRENT ILLN MM DD YY	QUAL.	QI	JAL.	MM DD	YY	16. DATES PATIENT UMM DE	O YY	то		DD YY	
17. NAME OF REFERRING P	ROVIDER OR OTHER SO					18. HOSPITALIZATION MM DE FROM	DATES RE	LATED TO		T SERVICES DD ! YY	
i 19. ADDITIONAL CLAIM INFO	RMATION (Designated b		b. NPI			20. OUTSIDE LAB?			HARGES		
	05 11 11 1500 00 11 11 10			(0.45)		0 YES	NO				
21. DIAGNOSIS OR NATURE 0104	A0100	A0103	vice line below	A0104 ICD Insee	ATTACHED	22. RESUBMISSION CODE	1	RIGINAL R	EF. NO.		
009 E.	F. L	C. G.		— D. L. — H. L		23. PRIOR AUTHORIZ	ZATION NUM	BER			
I	J. L	K.	EDITOES SED	L. L	S E.	F.	G.	H. I.		J.	
From MM DD YY MM	To PLACE OF DD YY SERVICE		lain Unusual Ci		DIAGNOSIS POINTER		DAYS E	PSDT ID.	F	RENDERING PROVIDER ID. #	ŧ
11	1		992	205 19					50	1	
11			992	204 21				NPI	100	1	
								NPI			
		1	- 1	1 1 1				NPI			
								IMPT			
								NPI			
								NPI			
1 ! !	!			1 ! !							
330184132RAL TAX I.D. NUMB	ER SSN EXN	2477DB9122800s	ACCOUNT NO). 27. ACCEPT	ASSIGNMENT?	28. TOTAL CHAP59E	29. A	MOUNT PA	ID 3	80. Rsvd for NUC	CC Use
				YES	NO	\$	\$				
31. SIGNATURE OF PHYSICI INCLUDING DEGREES O (I certify that the statement	R CREDENTIALS		ACILITY LOCA ICINE ONLY AW AVE #106	TION INFORMATION		33. BILLING PROVIDE	R INFO & PI	Н# ()		
KEVIN CALHOUN are m SIGNATURE ON FILE		FRESNO		FORNIA							
SIGNATURE UN FILE	12/00/2022	93711-3300	l.	h		9	b				
SIGNED	DATE	a.	C	U.		a.	D.				

HEALTH INSURA APPROVED BY NATIONAL UN		(, -,)				
1. MEDICARE MEDICAID	TRICARE CHAMPVA	GROUP HEALTH PLAN FECA BLACKLUNG OTHER				
(Medicare#) (Medicaid#)	(ID#/DoD#) (Membe	er ID#) (ID#) (ID#)				
2. PATIENT'S NAME(Last Name, Firs ANKIT GUPTA	t Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM DD YY 03 30 95 M F				
5. PATIENT'S ADDRESS (NO.,Street RAJENDRA NAGAR)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other				
^{CITY} Anatone	STATE WA	8. RESERVED FOR NUCC USE Value				
ZIPCODE TELEPHONE(Inclui 99401 (996) 865-48	*					
9. OTHER INSURED'S NAME(Last N Value	ame, First Name, Middle Initia	al) 10. IS PATIENT'S CONDITION RELATED TO: Value				
a. OTHER INSURED'S POLICY OR (Value	GROUP NUMBER	a. EMPLOYMENT?(Current or Previous) YES NO				
b. RESERVED FOR NUCC USE Value		b. AUTO ACCIDENT? PLACE (State) VES NO . OTHER ACCIDENT? VES NO 10d. CLAIM CODES (Designated by NUCC)				
c. RESERVED FOR NUCC USE Value						
d. INSURANCE PLAN NAME OR PR Value	OGRAM NAME	Value				
12. PATIENT'S OR AUTHORIZED PE	RSON'S SIGNATURE I author	DMPLETEING & SIGNING THIS FORM rize the release of any medical or other information necessary to process this rmment benifits either to myself or to the party who accepts assignment below.				
SIGNED SIGNATURE ON FIL	, ,	DAT E 10/10/2023				

nagement tronically via Jopari 56)

CMS1500 Page 1 of 1 PICA tar Risk Management omitted Electronically via Jopari yer ID: 41556)

				Olvio 1000 i ago	J . OI I		
1. MEDICARE MEDICAID TRICARE CHAMPVA (Medicare#) (Medicaid#) (ID#/DoD#) (Membe	GROUP HEALTH PLAN er ID#) (ID#)	FECA BLACKLUNG OTHER (ID#) (ID#)	1.a INSURED'S I 556-46-452		(For Program in item 1)	1	
2. PATIENT'S NAME(Last Name, First Name, Middle Initial) ANKIT GUPTA	3. PATIENT'S BIRTH DATE MM DD 03 30	SEX YY 95 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	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other RAJENDRA NAGAR				- -	
CITY	0 1	8. RESERVED FOR NUCC USE CITY STATE				<u>ء</u> َ	
Anatone WA	Value	JSE	Anatone		WA	PATIENT AND INSUBED INFORMATION	
ZIPCODE TELEPHONE(Include Area Code) 99401 (996) 865-4856			ZIPCODE 99401	TELEPHONE(Include / 1996) 865-4856	· · · · · · · · · · · · · · · · · · ·	Ē	
9. OTHER INSURED'S NAME(Last Name, First Name, Middle Initia		ON RELATED TO:	11. INSURED'S F	OLICY GROUP OR FE			
Value	Value a. EMPLOYMENT?(Current)	or Previous)	Value a. INSURED'S D		SEX		
a. OTHER INSURED'S POLICY OR GROUP NUMBER Value		NO PLACE (State)	03		5 M F	<u>2</u>	
b. RESERVED FOR NUCC USE Value		NO L	994218WC98	p. OTHER CLAIM ID (Designated by NUCC) 994218WC981 Value DISTRIBUTION NAME OR PROGRAM NAME			
c. RESERVED FOR NUCC USE		NO	Value	c. INSURANCE PLAN NAME OR PROGRAM NAME Value			
Value	10d. CLAIM CODES (Design Value	nated by NUCC)		OTHER HEALTH BENII No If yes, complete	FIT PLAN? e items 9,9a, and 9d.	- PA	
d. INSURANCE PLAN NAME OR PROGRAM NAME Value							
READ BACK OF FORM BEFORE CO 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I author			authorize payment o	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benifits to the undersigned physician or supplier for			
claim. I also request payment of government benifits either to myself or to gove	ernment benifits either to myself or to the	e party who accepts assignment below.	service described be		••	1	
SIGNED SIGNATURE ON FILE	E 10/10/2	2023	SIGNED				
14.DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15. OTHER DATE	, pp	16. DATES PATIE OCCUPATION	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION			
MM DD YY QUAL. Value Value Value Value	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	MM DD YY Zalue Value Value	FROM	MM DD YY 00 00	TO MM DD 00		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17.a valu	Je	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				
19.ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	17.b NPI valu	ıe	FROM	MM DD YY 00 00 00	TO 00 00		
Value		100111111111111111111111111111111111111	20. OUTSIDE LA	\/alue	Value		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-I A. Value B. Value		ICD Ind. Value Value D. Value	Yes	NO		\dashv	
A. <u>Value</u> B. <u>Value</u> E. Value F. Value	C. Value G. Value	D. Value H. Value	CODE ORIGINAL REF. NO. Value Value			ā	
I. Value J. Value	K. Value	L. Value	23. PRIOR AUTHORIZATION NUMBER Value				
24. A. DATE(S) OF SERVICE B. C. From To PLACE OF AMG	D. PROCEDURES, SERVICE	DIAGNOSIS	F.	G. H. AYS OR EPSDT	I. J. ID QUAL. RENDERIN	NG ER	
MM DD YY MM DD YY	(Explain Unusual Circ	MODIFIER POINTER		UNITS Family Plan	PROVIDE ID.#	R	
01 01 18 01 01 18 01 value value		00 00 00	00 100	00 00	10150006	623	
value value	е		00 00	00 00	NPI 12156286		
00 00 00 00 00 00 value value value value		00 00 00	00 00	00 00	NPI 12156286	623 623	
00 00 00 00 00 00 value value value value		00 00 00	00 00	00 00	NPI 12156286	623	
00 00 00 00 00 value value	e 00 00	00 00 00	00 00	00 00	NPI 12156286	623	
00 00 00 00 00 00 value value value		00 00 00	00 00	00 00	NPI 12156286	623	
00 00 00 00 value value value	е						
	e 00 00 00 PATIENT'S ACCOUNT NO.	00 00 00 27. ACCEPT ASSIGNMENT?	00 00 28. TOTAL CHAR	00 00 RGE 29 . AMOUNT PA	NPI 12156286		
	477db9122800-1	(For govt. claims, see back)					
	SERVICE FACILITY LOCATION IN		0.00	00 \$ 0;.0 OVIDER INFO & PH#(יטו	
INCLUDING DEGRESS OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part	of Industry		Halo Services Inc	•			
Annel Manchana	of Industry of Industry		P.O. Box 1968				
only !	of Industry California		Montebello Calif	fornia 90640)		
	8-4144036 b.		a. 28-41440	28-4144036 b.			
NUCC Instruction Manual available at: WMM DUCC org. PLEASE PRINT OR TYPE APPROVED OMB 0028 1107 form 1500 (02.12)							

10/2/23, 4:01 PM MERAKI_RCM

EALTH MOUE WAS STONE								
HEALTH INSURANCE CLAIM FORM					SUBMITTED ELECTRONICALLY VIA DATA DIMENSIONS			
PROVED BY NATIONAL UNIFORM CLAIM COMMITTED PICA	TTEE (NUCC) 02/12					PACE 1 OF 1 PICA T		
MEDICARE MEDICAID TRICARE	CHAMPV	/A GROUP F	ECA OTHER	1a. INSURED'S I.D. NU	AND DESCRIPTION OF THE PROPERTY OF THE PROPERT	(For Program in Item 1)		
(Medicare#) (Medicaid#) (ID#/DoD#)	(Member I	HEALTH PLAN - B	ECA OTHER	a. INGONED G I.D. NO	Willer	(For Frogram in Rem 1)		
PATIENT'S NAME (Last Name, First Name, Middle I		3. PATIENT'S BIRTH DATE	SEX	613-02-9476 4. INSURED'S NAME (I	Last Name, First Name	e. Middle Initial)		
		MM DD YY	M F	The Control of the Co		te no ceremon en en		
PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP	TO INSURED	7. INSURED'S ADDRES	SS (No., Street)			
		Self Spouse Chi	d Other					
12790 MERIT DR STE 200	STATE	8. RESERVED FOR NUCC U	SE	CIT12790 MERIT DR	STE 200	STATE		
TELEPHONE (Inclu	ıde Area Code)™			ZIPDALLAS	TELEPHO	NE (Include Area Code)		
(323) 873-08	27			75251	()		
2514ER INSURED'S NAME (Last Name, First Name	e, Middle Initial)	10. IS PATIENT'S CONDITION	N RELATED TO:	11. 7535 AED'S POLIC	Y GROUP OR FECAT	AJMBER-0027		
OTHER INCHIDENIC BOLLOV OR OROLID MI IMPE		a EMPLOYMENTS (Correct of	a Decidence)	INCLUSION DATE O	E DIDTI!	OFW		
OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current of	NO NO	a. INSURED'S DATE O	YY	SEX F		
RESERVED FOR NUCC USE		b. AUTO ACCIDENT? X		b. OTOSR CLASM ID (Z		X		
		YES	PLACE (State)	Con Control (V	and by NOOC)	^		
RESERVED FOR NUCC USE			x	c. INSURANCE PLAN N	NAME OR PROGRAM	NAME		
		YES	NO	U. HOOT PAIVE I EAR WAINE ON THOUGHAN HAINE				
NSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designa	Md by NUCC)	d. IS THERE ANOTHER	R HEALTH BENEFIT I	PLAN?		
				YES NO If yes, complete items 9, 9a, and 9d.				
READ BACK OF FORM BE PATIENT'S OR AUTHORIZED PERSON'S SIGNAT			formation pageses	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier				
to process this claim. I also request payment of govern				services described t	below.	igned physician or supplier for		
below.				25.000				
SIGNATURE ON FILE		DATE	122	SIGNED				
DATE OF CUSIGNATURE ON FILEURY, or PREG	NANCY (LMP) 15.	OTHER DATE 11/11/20	D YY			CURRENT OCCUPATION MM DD YY		
QUAL.	QO	1 1	-	FROM 18. HOSPITALIZATION		O URRENT SERVICES		
UI 1/ 1/	178			FROM DD		O CURRENT SERVICES		
ADDITIONAL CLAIM INFORMATION (Designated	5000			20. OUTSIDE LAB?	1	CHARGES		
				YES	NO			
INTERPRETING SERVICES - PEREA RAMIREZ	RY Relate A-L to serv	vice line below (24E) ICD Inc	1.	22. RESUBMISSION CODE	ORIGINAL	BEE NO		
В	c. L	D	01	CODE	OTTIGIIVAL	HEIL NO.		
F.	G. L	н	01	23. PRIOR AUTHORIZA	ATION NUMBER			
Z710 J	K. L	L				_		
. A. DATE(S) OF SERVICE B. From To PLACE OF		EDURES, SERVICES, OR SUPP ain Unusual Circumstances)	LIES SEE ATT	ACHED F.	G. H. I. DAYS EPSDT ID.	J. RENDERING		
M DD YY MM DD YY SERVICE	EMG CPT/HCP	PCS MODIFIER	POINTER	\$ CHARGES	OR Family ID. UNITS Plan QUAL	PROVIDER ID. #		
TT SERVICE		1 1 1						
JO IT SERVICE					G reserv	ZZ 1063480192		
JULY THINK DIS THE SERVICE					NPI			
	T1013		A	280	8			
	T1013		A	280				
	T1013		<u>^</u>	280	8			
	T1013		A	280	8			
	T1013		^	280	8			
	T1013		A	280	8 NPI			
	T1013		A	280	8 NPI			
	T1013		A	280	8 NPI			
1 17 17 01 17 17 14			A A SOLOMATIVE		8 NPI			
1 17 17 01 17 17 14	26. PATIENT'S	ACCOUNT NO. 27, ACC	FFT ASSIGNMENT?	28. TOTAL CHARGE	8 NPI NPI NPI NPI 29. AMOUNT F			
01 17 17 01 17 17 11	26. PATIENT'S	ACCOUNT NO. 27, ACC	NO NO	28. TOTAL CHARGE \$	8 NPI NPI NPI NPI NPI 29. AMOUNT F			
FEDERAL TAX I.D. NUMBER SSN EIN SIGNATURE OF PHYSICIAN OR SUPPLIER 1839762/86 DEGREES OR CREDENTIALS X	26. PATIENT'S	ACCOUNT NO. 27, ACC	NO NO	28. TOTAL CHARGE	8 NPI NPI NPI NPI NPI 29. AMOUNT F			
01 17 17 01 17 17 11	26. PATIENT'S	ACCOUNT NO. 27, ACC	NO NO	28. TOTAL CHARGE \$	8 NPI NPI NPI NPI NPI 29. AMOUNT F \$			
FEDERAL TAX I.D. NUMBER SSN EIN SIGNATURE OF PHYSICIAN OR SUPPLIER 1.327278G DEGREES OR CREDENTIALS X (I certify that the statements on the reverse	26. PATIENT'S	ACCOUNT NO. 27, ACC	NO NO	28. TOTAL CHARGE \$	8 NPI NPI NPI NPI 29. AMOUNT F \$ R INFO & PH # (PAID 30. Rsvd for NUCC U		