SPORTSMED
PHYSICAL THERAPY

December 17, 2024

TO: ACCELERATED - WORKERS COMP
RE: BILLS REPROCESSING DEPARTMENT
33 E BLACKWELL ST.
DOVER, NJ 07801-3976

RE: SCOTT, DEJON
CLAIM # IWC086802
DOI: 01/31/24
DOS: Please refer to the letter below for all outstanding dos
Provider of Service: SPORTSMED PT, LLC TIN#824913997

Dear Adjuster/Reconsiderations Department:

Thank you for your prior payments for services rendered in our office on behalf of Dejon Scott. This is my formal request for reprocessing of our claim for payment for Acupuncture DOS:

DOS 03/11/2024, CHARGE AMOUNT: $1,134.00
DOS 03/13/2024, CHARGE AMOUNT: $884.00
DOS 03/20/2024, CHARGE AMOUNT: $884.00

We ask for reconsideration of the above aforementioned date of service. Our patient came seeking our specialists' help with the current condition, and the patient gradually demonstrated progress through the course of treatment. We strongly feel that our requested services are warranted and necessary in the management of the above patient's condition, please review accordingly and process for payment (please review all the pertinent documentation attached) Acupuncture treatment, as part of an individual's health care, is considered medically necessary and is provided for the purpose of minimizing or eliminating impairments, activity limitations, and/or participation restrictions.

Treating a condition as provided in Article 136 or 156 of the Education Law, in the Workers' Compensation Law, and the Rules of the Chair relative to Occupational/Physical Therapy Practice, all medical treatments costing less than $1000 are pre-authorized.

Chapter 6 of the Laws of 2007, the 2007 workers' compensation reform legislation, amended this statutory provision to increase the threshold for prior authorization from $500 to $1,000. The reform legislation also amended the section to add a provision directing the Chair to issue and maintain a list of pre-authorized procedures costing more than $1,000.

SPORTSMED
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All medical records pertaining to these claims are attached to this remittance and were previously submitted and on file. Please review this additional information and kindly process our claim for payment.

As you can see from our records, treatment was medically necessary and appropriate.

Please feel free to contact me with any questions you might have.

Respectfully,

Sharon Vasquez

Worker's Comp Medical Billing Specialist
SportsMed Physical Therapy
TEL:(551)288-1488 EXT: 488
FAX:(201) 514-1588
svasquez@spineandsportsmed.com

HEALTH INSURANCE CLAIM FORM

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

ACCELERATED INC.-WORKERS COMP
33 E BLACKWELL ST,
DOVER, NJ 07801-3976

CARRIER

PICA ☐ ☐ ☐ PICA ☐ ☐ ☐

PATIENT AND INSURED INFORMATION

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): IWC086802
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SCOTT, DEJON	3. PATIENT'S BIRTH DATE MM DD YY: 10 08 1992 SEX M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial): SCOTT, DEJON
5. PATIENT'S ADDRESS (No., Street): 35 GROVE PLACE	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street): 35 GROVE PLACE
CITY: EAST ORANGE, US STATE: NJ	8. RESERVED FOR NUCC USE	CITY: EAST ORANGE, US STATE: NJ
ZIP CODE: 07017 TELEPHONE (Include Area Code): ( ) -		ZIP CODE: 07017 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: 10 08 1992 SEX M ☒ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: ACCELERATED INC.-WORKERS COMP
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.
SIGNED Signature on File DATE 12/17/24

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: 01 31 24 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
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. 0 A. M25562 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 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. 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	03 11 24 03 11 24	11		99202	25	A	250 00	1		NPI	1104551373
2	03 11 24 03 11 24	11		97814		A	400 00	2		NPI	1104551373
3	03 11 24 03 11 24	11		97813		A	225 00	1		NPI	1104551373
4	03 11 24 03 11 24	11		97140	59	A	150 00	1		NPI	1104551373
5	03 11 24 03 11 24	11		97026	59	A	109 00	1		NPI	1104551373
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
824913997 ☐ ☒	1698596Z67010	☒ YES ☐ NO	$ 1134 00	$ 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (201) 345-6173
Signature on File JOANNE KIM, L.AC SIGNED 12/17/24 DATE	SPORTSMED PT, LLC 1225 STUYVESANT AVENUE UNION, NJ 07083-3837 a. 1841787645 b.	SPORTSMED PT, LLC 266 HARRISTOWN ROAD, SUITE 304 GLEN ROCK, NJ 07452-3354 a. 1841787645 b.

SPORTSMED
PHYSICAL THERAPY

SPORTSMEDPT, LLC

☑ IE ☐ RE

Patient Name: SCOTT. DEJON

Date: 03/11/2024

Chief Complaint: L KNEE PAIN

Subjective: A 31-year-old male patient complains of L knee pain. The patient, a police officer, injured his knee while chasing a criminal two years ago—minor swelling on the Distal Quad.

Objective: By palpation, patient has tenderness and tightness in the L knee. Due to the pain, patient has difficulty walking.

Tongue: Color: ☐Pale/ ☐Red/ ☑Pink/ ☐Purple Shape: ☐Scalloped/ ☐Cracks/ ☐Red Tip/ ☐Pointy/ ☐Thick/ ☐Thin/ ☐Large
State: ☑Wet/ ☐Dry/ ☐Greasy Coat: ☐Thick/ ☐Thin/ ☐White/ ☐Yellow / ☐Green

Pulse: ☑Normal/ ☐Rapid/ ☐Slow/ ☐Deficient/ ☐Excess/ ☐Wiry/ ☐String-taught/ ☐Thready/ ☐Choppy/ ☐Empty/ ☑Tense/ ☐Slippery

Pain Level 1-10 (1 Least pain, 10 = Worst pain)

☐ Headaches ( )	- Shoulder ( )	- Hand ( )	- Thoracic ( )	- Thigh ( )	- Foot ( )
- TMJ ( )	- Arm ( )	- Fingers ( )	- Lumbar ( )	L Knee (7--1)	- Toes ( )
- Neck ( )	- Elbow ( )	- Wrist ( )	- Hip ( )	- Ankle ( )	- Chest ( )

Stiffness (☑ Left/ ☐ Right)

Pain is described as: ☑Constant/ ☐Frequent/ ☐Intermi./ ☐Occasi. **Pain Type:** ☐Dull/ ☑Ache/ ☑Sharp/ ☑Sore/ ☐Cramp
- ☐Burning/ ☐Tingling/ ☐Throbbing/ ☐Stabbing/ ☐Shooting/ ☐Spasm/ ☐Polling/ ☐Shocking/ ☐Numbness

Radiating to: ☐Head - / ☐Shoulder - / ☐Arm - / ☐Elbow - / ☐Hand - / ☐Fingers -
- ☐Hip - / ☐Thigh - / ☐Knee - / ☐Foot - / ☐Toes -

Pain is aggravated by: ☐Bending/ ☐Turning/ ☐Lifting/ ☐Raising Arm/ ☐Pulling/ ☐Pushing/ ☐Carrying Heavy Object/
- ☐Prolonged Standing/ ☐Prolonged Sitting/ ☐Driving/ ☐Lying Down/ ☐Getting Up or Lying Position/ ☐Changing Positions/
- ☑Walking/ ☑Going up & down the Stairs/ ☐Movement/ ☐Deep Breathing/ ☐Coughing/ ☐Sneezing/ ☐Weight Bearing/
- ☐Cold/ ☐Humid Weather **Other:** None

Pain is worse: ☐Morning / ☐Afternoon / ☐Evening / ☑Night

Active and passive ROM is restricted in: ☐Flexion / ☐Extension / ☐Lateral Bending / ☐Rotation

Eastern Diagnosis: ☑Qi Stag./ ☑Blood Stasis/ - Deficiency/ ☑Bl syndrome/ ☐Damp accumulation Other:

Treatment Principle: Move Qi/Blood / Tonify Qi/Blood / ☑ Alleviate Pain/ ☑ Disperse Stagnation/ ☐ Drain Dampness

Other: None

Review of Symptoms:

Aversion to: ☐Cold / ☐Heat / ☐Either / ☑Neither **Energy Level:** ☐Poor / ☑Normal

Overall temperature (KD) - Body Temp or Sensation/ - Hands/ - Feet/ Sweaty - / ☐Hot Flesh

LU & KD: ☐Difficult Keeping Eye Open/ ☐Shortness of Breath/ ☐General Weakness/ ☐Catch Cold Easily/
- ☐Low Energy/ ☐Feels Worse after Exercise

Review of Symptoms: (CONTINUE)

Sleep (HT): ____ hours ☐ Insomnia/ ☐ Oversleep/ ☐ Easily Awakened/ ☐ Dreams/ ☑ Wake unrefreshed

Cravings: for None

SP/ST: ☑ Normal / ☐ Sudden Weight - / ☐ Bloating/ ☐ Gas/ ☐ ST Gurgling/ ☐ Easily Bruised/ ☐ Pensive/
- ☐ Over Thinking / ☐ Heartburn / ☐ Belching / ☐ Nausea / ☐ Vomiting / ☐ Discomfort

Bowel: ____ day: ☑ Normal / ☐ Constipation / ☐ Loose Stool/ ☐ Hard Stool/ ☐ Diarrhea/ ☐ Burning/ ☐ Blood present/
- ☐ Hemorrhoid

Bladder (KD & BL): ____ day: ☑ Normal/ ☐ Excessive/ ☐ Little Urination/ ☐ Color (Dark/Yellow/Pale)/ ☐ Painful/ ☐ Bloody/
- ☐ Night Urination

Eye: ☑ Normal/ ☐ Poor / ☐ Redness / ☐ Yellowness / ☐ Teary / ☐ Dry / ☐ Twitching : on -

Hearing: ☑ Normal/ ☐ Poor / ☐ Ringing in the ears w/ -

Emotion: ☐ Normal/ ☐ Anxiety / ☐ Depression / ☐ Restlessness / ☐ Irritability / ☑ Stressed

Palpitation: ☐ Yes / ☑ No

Hypertension: ☐ Yes / ☑ No

Menses: _____ yrs. started **Duration:** _____ **Last menses dates:** _____

Pregnant: ☐ Yes / ☐ No **Color:** - **Clots:** - size **Cramps:** ☐ Before/ ☐ During/ ☐ After

Others: None

Treatment:

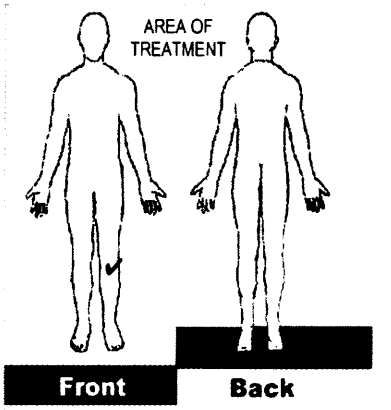
Acupuncture Set	# Needles	E-Stim	CPT Code	Time
1: LI11(E), LI4(E), LV3	6	Yes	97813	15
2: L)BL57(E), BL58(E), B)BL40, BL60	6	Yes	97814	15
3: L)ST34E), SP10(E), GB34, ST36, LV8	5	Yes	97814	15

☑ 97810/97813: Initial 15-minute insertion of needles and personal one-on-one contact with the patient
☑ 97811/97814: Additional 15 minutes re-insertion of needles and personal one-on-one contact with the patient

Other: ☑ Infrared (97026) ☐ Cupping (97139) ☑ Tui na (97140)

Treatment Plan: Continue **Frequency:** 3 times a week

Note:



☑ N/A / ☐ NO-FAULT

This is an initial narrative report regarding the above named who came under my care seeking treatment for injuries sustained in a motor vehicle accident.

D.O.A:

The patient was a ☐ driver / ☐ passenger / ☐ biker / ☐ pedestrian/ ☐ N/A
He/she was in the - seat and - wearing a seatbelt.
Patient's - was struck from the - or struck another -
☐ Past medical history revealed no accidents or injuries actively treated within the six months preceding the above accident that would have an affect on present complaints.

Patient is suffering from post-traumatic "Bi" syndrome. Besides the specific areas of pain described, the patient's energy (qi) & blood circulation are impaired due to the extreme physical and mental stress that resulted from the accident. The patient has / will / start(ed) acupuncture treatment for post-traumatic pain. Needling has / will be used to re-establish normal function. Local points was / will be chosen in the specific areas of pain to release trigger points , remove fluid congestion , and initiate the healing process. Distal point was / will be chosen to stimulate acupuncture meridians along the course of pain and to re-establish proper movement of qi and blood. Special points was / will be selected as necessary to treat headache, dizziness , anxiety , depression, stress and insomnia if indicated.
I recommend the treatment of acupuncture - times per week for weeks for improvement of the conditions indicated.

ACUPUNCTURIST'S SIGNATURE _____

HEALTH INSURANCE CLAIM FORM

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

ACCELERATED INC.-WORKERS COMP
33 E BLACKWELL ST,
DOVER, NJ 07801-3976

CARRIER

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)
	IWC086802
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SCOTT, DEJON	3. PATIENT'S BIRTH DATE MM DD YY 10 08 1992 SEX M ☒ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial) SCOTT, DEJON	
5. PATIENT'S ADDRESS (No., Street) 35 GROVE PLACE	6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street) 35 GROVE PLACE	
CITY: EAST ORANGE, US — STATE: NJ	8. RESERVED FOR NUCC USE
CITY: EAST ORANGE, US — STATE: NJ	
ZIP CODE: 07017 — TELEPHONE (Include Area Code): ( ) -	
ZIP CODE: 07017 — 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 10 08 1992 SEX M ☒ F ☐	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME ACCELERATED INC.-WORKERS COMP	
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.
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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. 0 A. M25562 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 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. 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 03 13 24 03 13 24	11		97814		A	400 00	2		NPI	1104551373
2 03 13 24 03 13 24	11		97813		A	225 00	1		NPI	1104551373
3 03 13 24 03 13 24	11		97140	59	A	150 00	1		NPI	1104551373
4 03 13 24 03 13 24	11		97026	59	A	109 00	1		NPI	1104551373
5									NPI	
6									NPI	

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
824913997	1698652267010		$ 884 00	$ 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (201) 345-6173
Signature on File JOANNE KIM, L.AC SIGNED 12/17/24 DATE	SPORTSMED PT, LLC 1225 STUYVESANT AVENUE UNION, NJ 07083-3837 a. 1841787645 b.	SPORTSMED PT, LLC 266 HARRISTOWN ROAD, SUITE 304 GLEN ROCK, NJ 07452-3354 a. 1841787645 b.

SPORTSMED PHYSICAL THERAPY

SPORTSMEDPT, LLC

Patient Name: SCOTT, DEJON Date: 03/13/2024

Complaint(s) of (Pain level 1-10):

☐ Headaches ( )	☐ Shoulder L R ( )	☐ Hip L R ( )
☐ TMJ L R ( )	☐ Arm L R ( )	☐ Thigh L R ( )
☐ Neck L R ( )	☐ Elbow L R ( )	☑ Knee ↙ R (6-10)
☐ Thoracic L R ( )	☐ Wrist L R ( )	☐ Ankle L R ( )
☐ Lumbar L R ( )	☐ Hand L R ( )	☐ Foot L R ( )
☐ Chest L R ( )		

Pain described as:

☑ Constant / ☐ Frequent / ☐ Intermittent / ☐ Occasional;
☑ Sharp/☑ Sore/☐ Cramp/☑ Ache/☐ Dull/☑ Stiff/☐ Burning/☐ Numb/☐ Tingling/☐ Throbbing/☐ Spasm/☐ Pulling/☐ Pressure/☐ Shooting;
☑ Non-radiating/ ☐ Radiating to: ☐ Shoulder - ☐ Arm - ☐ Elbow - ☐ Hand - ☐ Fingers -
☐ Hip - ☐ Thigh - ☐ Knee - ☐ Ankle - ☐ Foot -

Response from Last Treatment:

☑ Symptom improved and sustained ☐ Symptom Improved but did not maintain ☐ No improvement in symptoms

Additional Comments: None

Examination: Palpation Revealed:

-	Tenderness/Tightness in:	☐ Cervical - / ☐ Thoracic - / ☐ Lumbar - / ☐ Headache/ ☐ TMJ - along ☐ UB/ ☐ GB/ ☐ SJ/ ☐ SI channels
-	Tenderness/Tightness in:	☐ Shoulder - / ☐ Arm - / ☐ Elbow - / ☐ Wrist - / ☐ Hand - along ☐ LI/ ☐ SJ/ ☐ SI channels
Severe	Tenderness/Tightness in:	☐ Hip - / ☐ Thigh - / ☑ Knee L / ☐ Ankle - / ☐ Foot - along ☑ SP/ ☑ ST/ ☑ GB/ ☑ LV/ ☑ UB/ ☐ KD channels

Swelling noted in: None

Tongue: Color: ☐ Pale/ ☐ Red/ ☑ Pink/ ☐ Purple Shape: ☐ Scalloped/ ☐ Center Crack/ ☐ Horizontal Cracks/ ☐ Red tip
State: ☐ Greasy/ ☑ Wet/ ☐ Dry Coat: ☐ Thick/ ☐ Thin/ ☐ White/ ☐ Yellow/ ☐ Grey

Eastern Diagnosis: ☑ Qi ☑ Blood stagnation/ ☐ Deficiency/ ☑ BI syndrome/ ☐ Damp accumulation/ ☐ Other:

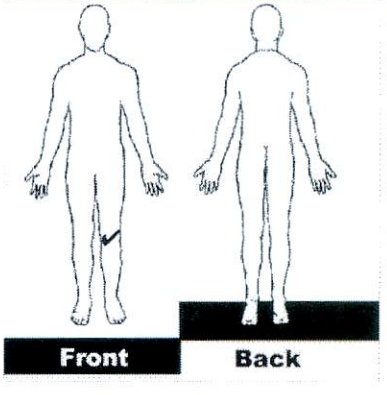
Western Diagnosis: L KNEE PAIN

Treatment Principle: ☑ Move Qi/ ☑ Tonify Qi/Blood / ☑ Disperse stagnation/ ☐ Drain Dampness/ ☐ Other:
Treatment Goals: ☑ Alleviate Pain/ ☑ Improve functional capacities/ ☑ Reduce tenderness and tightness

Treatment: Acupuncture: Set	# Needles	E Stim	CPT Code	Time
1: LI11(E), LI4(E), LV3	6	YES	97813	15
2: L)BL57(E), BL58(E), B0BL40, BL60	6	YES	97814	15
3: L)ST34(E), SP10(E),, GB34, ST36, LV8	5	YES	97814	15

☑ 97810/97813: Initial 15-minute insertion of needles and personal one-on-one contact with the patient
☑ 97811/97814: Additional 15 minutes re-insertion of needles and personal one-on-one contact with the patient

Area of Treatment:



Others: ☑ InfraRed (97026) ☐ Cupping (97139) ☑ TuiNa (97140)

Response to treatment:

☑ Improved in Pain (Mild/Moderate/Significant) ☑ Improved in Comfort
☑ Improved in Strength ☑ Improved in Mobility ☑ Improved in ADL's

Treatment Plan: Continue **Treatment:** 3 times per week

Comments: None

Acupuncturist's Signature:

HEALTH INSURANCE CLAIM FORM

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

ACCELERATED INC.-WORKERS COMP
33 E BLACKWELL ST,
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ZIP CODE: 07017 — TELEPHONE (Include Area Code): ( ) -	
ZIP CODE: 07017 — 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 10 08 1992 SEX M ☒ F ☐	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME ACCELERATED INC.-WORKERS COMP	
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.
SIGNED Signature on File DATE 12/17/24

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 01 31 24 QUAL. 431	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. 0 A. M25562 B. C. D. E. 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 03 20 24	03 20 24	11		97814		A	400 00	2		NPI	1104551373
2 03 20 24	03 20 24	11		97813		A	225 00	1		NPI	1104551373
3 03 20 24	03 20 24	11		97140	59	A	150 00	1		NPI	1104551373
4 03 20 24	03 20 24	11		97026	59	A	109 00	1		NPI	1104551373
5										NPI	
6										NPI	

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 $ 884 00	29. AMOUNT PAID $ 0 00	30. Rsvd for NUCC Use
824913997	1710573Z67010				

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (201) 345-6173
Signature on File JOANNE KIM, L.AC SIGNED 12/17/24 DATE	SPORTSMED PT, LLC 1225 STUYVESANT AVENUE UNION, NJ 07083-3837 a. 1841787645 b.	SPORTSMED PT, LLC 266 HARRISTOWN ROAD, SUITE 304 GLEN ROCK, NJ 07452-3354 a. 1841787645 b.

SPORTSMED PHYSICAL THERAPY

SPORTSMEDPT, LLC

Patient Name: SCOTT, DEJON Date: 03/20/2024

Complaint(s) of (Pain level 1-10):

☐ Headaches ( )	☐ Shoulder L R ( )	☐ Hip L R ( )
☐ TMJ L R ( )	☐ Arm L R ( )	☐ Thigh L R ( )
☐ Neck L R ( )	☐ Elbow L R ( )	☑ Knee ↙ R (5-10)
☐ Thoracic L R ( )	☐ Wrist L R ( )	☐ Ankle L R ( )
☐ Lumbar L R ( )	☐ Hand L R ( )	☐ Foot L R ( )
☐ Chest L R ( )		

Pain described as:

☑ Constant / ☐ Frequent / ☐ Intermittent / ☐ Occasional;
☑ Sharp/ ☑ Sore/ ☐ Cramp/ ☑ Ache/ ☐ Dull/ ☑ Stiff/ ☐ Burning/ ☐ Numb/ ☐ Tingling/ ☐ Throbbing/ ☐ Spasm/ ☐ Pulling/ ☐ Pressure/ ☐ Shooting;
☑ Non-radiating/ ☐ Radiating to: ☐ Shoulder - ☐ Arm - ☐ Elbow - ☐ Hand - ☐ Fingers -
☐ Hip - ☐ Thigh - ☐ Knee - ☐ Ankle - ☐ Foot -

Response from Last Treatment:

☑ Symptom improved and sustained ☐ Symptom Improved but did not maintain ☐ No improvement in symptoms

Additional Comments: None

Examination: Palpation Revealed:

-	Tenderness/Tightness in:	☐ Cervical - / ☐ Thoracic - / ☐ Lumbar - / ☐ Headache/ ☐ TMJ - along ☐ UB/ ☐ GB/ ☐ SJ/ ☐ SI channels
-	Tenderness/Tightness in:	☐ Shoulder - / ☐ Arm - / ☐ Elbow - / ☐ Wrist - / ☐ Hand - along ☐ LI/ ☐ SJ/ ☐ SI channels
Severe	Tenderness/Tightness in:	☐ Hip - / ☐ Thigh - / ☑ Knee L / ☐ Ankle - / ☐ Foot - along ☑ SP/ ☑ ST/ ☑ GB/ ☑ LV/ ☑ UB/ ☐ KD channels

Swelling noted in: None

Tongue: Color: ☐ Pale/ ☐ Red/ ☑ Pink/ ☐ Purple Shape: ☐ Scalloped/ ☐ Center Crack/ ☐ Horizontal Cracks/ ☐ Red tip
State: ☐ Greasy/ ☑ Wet/ ☐ Dry Coat: ☐ Thick/ ☐ Thin/ ☐ White/ ☐ Yellow/ ☐ Grey

Eastern Diagnosis: ☑ Qi ☑ Blood stagnation/ ☐ Deficiency/ ☑ BI syndrome/ ☐ Damp accumulation/ ☐ Other:

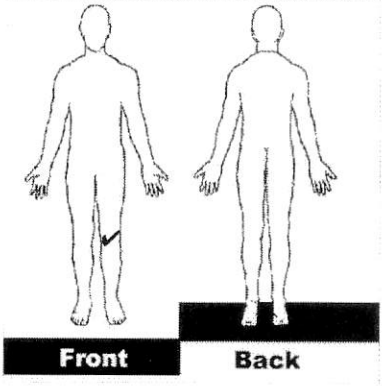
Western Diagnosis: L KNEE PAIN

Treatment Principle: ☑ Move Qi/ ☑ Tonify Qi/Blood/ ☑ Disperse stagnation/ ☐ Drain Dampness/ ☐ Other:
Treatment Goals: ☑ Alleviate Pain/ ☑ Improve functional capacities/ ☑ Reduce tenderness and tightness

Treatment: Acupuncture: Set	# Needles	E Stim	CPT Code	Time
1: LI11(E), LI4(E), LV3	6	YES	97813	15
2: L)BL57(E), BL58(E), B0BL40, BL60	6	YES	97814	15
3: L)ST34(E), SP10(E),, GB34, ST36, LV8	5	YES	97814	15

☑ 97810/97813: Initial 15-minute insertion of needles and personal one-on-one contact with the patient
☑ 97811/97814: Additional 15 minutes re-insertion of needles and personal one-on-one contact with the patient

Area of Treatment:



Others: ☑ InfraRed (97026) ☐ Cupping (97139) ☑ TuiNa (97140)

Response to treatment:

☑ Improved in Pain (Mild/Moderate/Significant) ☑ Improved in Comfort
☑ Improved in Strength ☑ Improved in Mobility ☑ Improved in ADL's

Treatment Plan: Continue **Treatment:** 3 times per week

Comments: None

Acupuncturist's Signature: