Koruon Daldalyan M.D., Q.M.E

Board Certified, Internal Medicine

Internist Health Clinic

13320 Riverside Dr., Suite 104,
Sherman Oaks, California 91423
Tel: 818.574.6189 Fax: 818.574.6218
kdaldalyan@internisthc.com

June 26, 2023

Natalia Foley, Esq.
Workers Defenders Law Group
751 S. Weir Canyon Rd. Ste 157-455
Anaheim, CA 92808

PATIENT:	Alan Gamino
DOB:	October 4, 1987
OUR FILE #:	2022-171
SSN:	XXX-XX-XXXX
EMPLOYER:	Macy's Inc DBA Bloomingdales LLC 14060 Riverside Dr. Sherman Oaks, CA 91423
WCAB #:	ADJ17287003
CLAIM#:	4A2302G37SD-0001
DATE OF INJURY:	CT: July 24, 2022 to January 20, 2023
DATE OF 1ST VISIT:	March 21, 2023
INSURER:	Sedgwick P.O Box 14522 Lexington, KY 40512
ADJUSTOR:	***
PHONE #:	***

Primary Treating Physician's Progress Report

Dear Ms. Foley,

The patient presents today, June 26, 2023, for reevaluation. The patient continues in treatment for his various medical conditions as noted in this report.

Current Medications:

The patient currently is taking Cyclobenzaprine 10 mg tablet daily, Flurbiprofen 20% topical ointment to apply BID, and Hydroxyzine HCl 25 mg tablet nightly for sleep.

Physical Examination:

The patient is a 35-year-old alert, cooperative and oriented Hispanic male, in no acute distress. The following vital signs and measurements are taken today on examination: Weight: 158 pounds. Blood Pressure: 124/76. Pulse: 70. Respiration: 17. Temperature: 97.9 degrees F. No skin abnormalities were detected. The patient's head is normocephalic and atraumatic. The patient's facial muscles show good contour and symmetry. There is no scleral icterus and no tenderness of the skull noted on examination. Pupils are equally reactive to light and accommodation. Extraocular movements are intact. The throat is clear. Hearing appears to be uninvolved. The nasal passages are clear and the mucosa is normal in appearance. The patient's neck is overall supple with no evidence of lymphadenopathy, thyromegaly or bruits. The patient exhibits good bilateral rib excursion during respiration. Lungs are clear during percussion and auscultation. The heart reveals a regular rate and rhythm and no murmurs are noted. The abdomen is soft, tender without organomegaly. Normoactive bowel sounds are present.

Special Diagnostic Testing:

A pulmonary function test is performed revealing an FVC of 2.07 L (38.3%) and an FEV 1 of 1.29 L (29.7%). There was no change after the administration of Albuterol.

A 12-lead electrocardiogram is performed revealing sinus rhythm and a heart rate of 68 per minute.

A pulse oximetry test is performed today and is recorded at 96%.

Subjective Complaints:

1. Headaches
2. Shortness of Breath
3. Dizziness
4. Wheezing
5. Lightheadedness
6. Swelling of the Ankles
7. Eye Pain
8. Anxiety
9. Visual Difficulty
10. Abdominal Pain
11. Burning Symptoms
12. Difficulty Concentrating
13. Sinus Problems
14. Difficulty Sleeping

15. Sinus Congestion
16. Nausea
17. Difficulty Making Decisions
18. Forgetfulness
19. Hair Loss
20. Postnasal Drip
21. Skin Issues
22. Jaw Pain
23. Weight Gain
24. Intolerance to Heat/Cold
25. Jaw Clenching
26. Weight Loss
27. Chest Pain
28. Urinary Urgency
29. Diaphoresis
30. Heart Palpitations
31. Lymphadenopathy

Objective Findings:

1. Tenderness noted to the paravertebral of the cervical spine and lumbar spine
2. Tenderness noted of bilateral shoulders
3. Tenderness noted of bilateral wrists
4. Tinel's positive of the right ankle
5. Tenderness noted to the epigastric region of the abdomen
6. Bilateral TMJ tenderness
7. An abdominal ultrasound is performed revealing a normal liver, normal gallbladder, and a normal right kidney
8. An ultrasound of the left wrist is performed, evaluation of the median nerve reveals a circumference of 1.59 cm and an area of .13 cm^2
9. An ultrasound of the right wrist is performed today, evaluation of the median nerve reveals a circumference of 1.56 cm and an area of .09 cm^2
10. A pulmonary function test is performed revealing an FVC of 3.99 L (73.9%) and an FEV 1 of 2.98 L (68.5%). There was no change after the administration of Albuterol.
11. A 12-lead electrocardiogram is performed revealing sinus rhythm with PAC(s) and a heart rate of 61 per minute.
12. A pulse oximetry test is performed and is recorded at 97%.
13. Jamar: RT1) 18.8kg 2)11.5kg 3)11.6kg LT 1)11.1kg 2)14.9kg 3)10.7kg
14. Vision test without glasses: OD20/20 OS 20/20 OU 20/27
15. An audiogram is performed and reveals the following:

1,000 Hz	2,000 Hz	3,000 Hz	4,000 Hz

Right:	20	20	15	20
Left:	20	20	15	15

16. A random blood sugar is performed and is recorded at 91 mg/dL.
17. A pulmonary function test is performed revealing an FVC of 2.50 L (46.4%) and an FEV 1 of 1.57 L (36.0%). There was no change after the administration of Albuterol.
18. A 12-lead electrocardiogram is performed revealing sinus rhythm and a heart rate of 74 per minute.
19. A pulmonary function test is performed revealing an FVC of 2.07 L (38.3%) and an FEV 1 of 1.29 L (29.7%). There was no change after the administration of Albuterol. **(6/26/2023)**
20. A 12-lead electrocardiogram is performed revealing sinus rhythm and a heart rate of 68 per minute. **(6/26/2023)**
21. A pulse oximetry test is performed and is recorded at 96%. **(6/26/2023)**

Diagnoses:

1. CERVICAL SPINE STRAIN/SPRAIN
2. THORACIC SPINE STRAIN/SPRAIN
3. LUMBAR SPINE STRAIN/SPRAIN
4. RIGHT SHOULDER STRAIN/SPRAIN
5. TENDINOSIS OF RIGHT ANKLE
6. TENDINOSIS OF LEFT SHOULDER
7. LEFT SHOULDER STRAIN/SPRAIN
8. RIGHT WRIST STRAIN/SPRAIN
9. LEFT WRIST STRAIN/SPRAIN
10. LEFT WRIST CARPAL TUNNEL SYNDROME
11. LEFT KNEE STRAIN/SPRAIN
12. RIGHT ANKLE STRAIN/SPRAIN
13. LEFT ANKLE STRAIN/SPRAIN
14. RIGHT FOOT STRAIN/SPRAIN
15. LEFT FOOT STRAIN/SPRAIN
16. GASTROESOPHAGEAL REFLUX DISEASE
17. ANEMIA, SECONDARY TO BLEEDING FROM GASTRIC ULCER
18. GASTRIC ULCER WITH BLEEDING
19. BLOOD LOSS ANEMIA, SECONDARY TO GASTRIC ULCERATION, STATUS POST BLOOD TRANSFUSION X2
20. IRRITABLE BOWEL SYNDROME WITH ALTERNATING BOUTS OF DIARRHEA AND CONSTIPATION
21. BRUXISM
22. HEADACHES
23. SHORTNESS OF BREATH
24. DIZZINESS

25. WHEEZING
26. LIGHTHEADEDNESS
27. SWELLING OF THE ANKLES
28. EYE PAIN
29. ANXIETY DISORDER
30. VISION DISORDER
31. DIFFICULTY CONCENTRATING
32. SINUS PROBLEMS AND CONGESTION
33. INSOMNIA
34. NAUSEA
35. DIFFICULTY MAKING DECISIONS
36. FORGETFULNESS
37. ALOPECIA
38. POSTNASAL DRIP
39. SKIN ISSUES
40. TMJ SYNDROME
41. FLUCTUATING WEIGHT
42. INTOLERANCE TO HEAT/COLD
43. JAW CLENCHING
44. CHEST PAIN
45. URINARY URGENCY
46. DIAPHORESIS
47. HEART PALPITATIONS
48. LYMPHADENOPATHY

Discussion:

The patient has filed a continuous trauma claim dated 12/5/2022 to 1/24/2023. The patient states he worked in the Men's department at Bloomingdales. He mentions that his job duties included maintaining the floors and performing stocking duties that required lifting boxes weighing upwards of 50 pounds. He states that often he would carry these boxes overhead to place them on the floor. Overtime given the repetitive twisting, pulling, pushing, and lifting he performed, he began to develop musculoskeletal pain and pain in his right foot. He states that his pain initially began in his cervical spine and spread to his thoracic and lumbar spine regions. It later began to develop in both shoulders, arms, and bilateral lower extremities.

The patient began reporting his musculoskeletal complaints to his supervisors and was often instructed to leave early, however, he was never treated through his workplace, therefore he sought treatment on his own. He began taking over the counter medications including Ibuprofen and Motrin for pain management.

In 2020 he was hospitalized and provided a blood transfusion given his complaints of severe stomach aches. He was diagnosed with a gastric ulcer after an endoscopy was performed.

The patient was also hospitalized and diagnosed with blood loss anemia which also required a blood transfusion a second time.

The patient states that often there were incidents of the store being robbed, which would cause him a significant amount of stress as the manager would task them out to speak with the individuals robbing the store.

Please be advised that the listed diagnoses represent medical diagnoses and/or a differential diagnosis to a reasonable degree of medical probability based on the history provided to me by the patient and the findings of my examination. I believe that some of these diagnoses are industrial in origin and are either initiated or aggravated by the patient's employment and are, therefore, industrial in origin. Some diagnoses are non-specific and will require further evaluation. I reserve the right to alter my opinions based upon receipt of additional information in the form of prior medical records or other documentary evidence that relates to this case. Please be advised that the denial of the claim by the employer will affect my ability to either confirm or reject any of the stated diagnoses, which will also affect my ability to provide evidentiary support for my opinions. Treatment authorization, if already approved, is appreciated. If treatment has not yet been approved, it is hereby requested.

The various diagnoses listed appear to be consistent with the type of work that would typically cause such abnormalities. I, therefore, believe that the diagnoses listed thus far are AOE/COE.

Disability Status:

The patient is to continue on temporary and total disability for a period of six weeks.

Treatment:

The patient is to continue with his current medications. He is prescribed Hydroxyzine HCl 10 mg tablet daily, Cyclobenzaprine 5 mg tablet daily, and Flurbiprofen 20% topical ointment to apply BID. He will be reevaluated in six weeks.

Attestation:

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

I further declare under penalty of perjury that I, Koruon Daldalyan, M.D., personally performed the evaluation of this patient and the cognitive services necessary to produce this report. The evaluation was performed at the above address. The

time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

The laboratory tests, if taken, were performed by Quest Diagnostics or Metro Lab in Encino, CA.

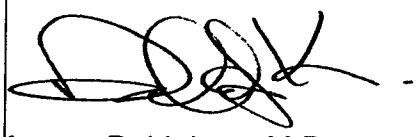
The history was obtained from the patient and the dictated report was transcribed by Adrine Madatyan, transcriptionist.

I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report. This attestation is effective as of January 1, 2020.

Based on Labor Code Statute 4628, a fee of $64.50 per page for a total of 7 pages has been added to cover reasonable costs of the clerical expense necessary to produce this report.

Should you have any questions or concerns regarding the evaluation or treatment provided to this patient or this report, please feel free to contact me.

Sincerely,



Koruon Daldalyan, M.D.
Board Certified, Internal Medicine

Internist Health Clinic
13320 Riverside Drive
Suite 104
SHERMAN OAKS, CA 91423

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CARD NUMBER		CVC	AMOUNT
SIGNATURE		ZIP CODE	EXP . DATE
ACCOUNT #	**STATEMENT DATE**	**DUE UPON RECEIPT**	**SHOW AMOUNT PAID**
8431213	07/17/2023	$0.00	

Gamino, Alan
8220 W. Norton Ave Apt3
WEST HOLLYWOOD, CA 90046

Internist Health Clinic
13320 Riverside Drive
Suite 104
SHERMAN OAKS, CA 91423

ACCOUNT #	CHART #	PATIENT NAME	STATEMENT DATE	CASE	DUE UPON RECEIPT
8431213	2022-171	Gamino, Alan	07/17/2023	Workers Compensation	$0.00

DATE	DESCRIPTION	CHARGES	PATIENT PAYMENTS	ADJ.	INSURANCE PAYMENTS	PENDING INSURANCE	PATIENT BALANCE
06/26/23	99214 OFFICE O/P EST MOD 30-39 MIN DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	500.00	0.00	0.00	0.00	500.00	0.00
06/26/23	WC002 Treating Physician's Progress Report DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	451.50	0.00	0.00	0.00	451.50	0.00
06/26/23	94060 EVALUATION OF WHEEZING DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	250.00	0.00	0.00	0.00	250.00	0.00
06/26/23	94664 EVALUATE PT USE OF INHALER DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	75.00	0.00	0.00	0.00	75.00	0.00
06/26/23	93000 ELECTROCARDIOGRAM COMPLETE DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	215.00	0.00	0.00	0.00	215.00	0.00
06/26/23	94760 MEASURE BLOOD OXYGEN LEVEL DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00 Provider: Daldalyan, Koruon YOUR BALANCE	125.00	0.00	0.00	0.00	125.00	0.00 0.00

DATE	DESCRIPTION	CHARGES	PATIENT PAYMENTS	ADJ.	INSURANCE PAYMENTS	PENDING INSURANCE	PATIENT BALANCE
06/05/23	99214 OFFICE O/P EST MOD 30-39 MIN DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	500.00	0.00	0.00	0.00	500.00	0.00
06/05/23	WC002 Treating Physician's Progress Report DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	451.50	0.00	0.00	0.00	451.50	0.00
06/05/23	94060 EVALUATION OF WHEEZING DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	250.00	0.00	0.00	0.00	250.00	0.00
06/05/23	94664 EVALUATE PT USE OF INHALER DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	75.00	0.00	0.00	0.00	75.00	0.00
06/05/23	93000 ELECTROCARDIOGRAM COMPLETE DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	215.00	0.00	0.00	0.00	215.00	0.00
06/05/23	94760 MEASURE BLOOD OXYGEN LEVEL DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00 Provider: Daldalyan, Koruon YOUR BALANCE	125.00	0.00	0.00	0.00	125.00	0.00 0.00
05/01/23	ML201 Comprehensive Medical-Legal Evaluation DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A MODIFIERS: 92 Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	2015.00	0.00	0.00	0.00	2015.00	0.00
05/01/23	94060 EVALUATION OF WHEEZING DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	250.00	0.00	0.00	0.00	250.00	0.00
05/01/23	94664 EVALUATE PT USE OF INHALER DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	75.00	0.00	0.00	0.00	75.00	0.00
05/01/23	93000 ELECTROCARDIOGRAM COMPLETE DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	215.00	0.00	0.00	0.00	215.00	0.00
05/01/23	94760 MEASURE BLOOD OXYGEN LEVEL DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00 Provider: Daldalyan, Koruon	125.00	0.00	0.00	0.00	125.00	0.00

DATE	DESCRIPTION	CHARGES	PATIENT PAYMENTS	ADJ.	INSURANCE PAYMENTS	PENDING INSURANCE	PATIENT BALANCE
	YOUR BALANCE						0.00
03/21/23	99205 OFFICE O/P NEW HI 60-74 MIN DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	1500.00	0.00	0.00	0.00	1500.00	0.00
03/21/23	97750 PHYSICAL PERFORMANCE TEST DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	600.00	0.00	0.00	0.00	600.00	0.00
03/21/23	97535 SELF CARE MNGMENT TRAINING DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	150.00	0.00	0.00	0.00	150.00	0.00
03/21/23	99483 ASSMT & CARE PLN PT COG IMP DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	800.00	0.00	0.00	0.00	800.00	0.00
03/21/23	76700 US EXAM ABDOM COMPLETE DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	700.00	0.00	0.00	0.00	700.00	0.00
03/21/23	76881 US COMPL JOINT R-T W/IMG DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A MODIFIERS: RT Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	400.00	0.00	0.00	0.00	400.00	0.00
03/21/23	76881 US COMPL JOINT R-T W/IMG DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A MODIFIERS: LT Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	400.00	0.00	0.00	0.00	400.00	0.00
03/21/23	94060 EVALUATION OF WHEEZING DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	250.00	0.00	0.00	0.00	250.00	0.00
03/21/23	94664 EVALUATE PT USE OF INHALER DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	75.00	0.00	0.00	0.00	75.00	0.00
03/21/23	93000 ELECTROCARDIOGRAM COMPLETE DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	215.00	0.00	0.00	0.00	215.00	0.00
03/21/23	94760 MEASURE BLOOD OXYGEN LEVEL DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	125.00	0.00	0.00	0.00	125.00	0.00
03/21/23	99173 VISUAL ACUITY SCREEN DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA	50.00	0.00	0.00	0.00	50.00	0.00

DATE	DESCRIPTION	CHARGES	PATIENT PAYMENTS	ADJ.	INSURANCE PAYMENTS	PENDING INSURANCE	PATIENT BALANCE
	S43.401A						
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/21/23	92557 COMPREHENSIVE HEARING TEST DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	250.00	0.00	0.00	0.00	250.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/21/23	82962 GLUCOSE BLOOD TEST DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	65.00	0.00	0.00	0.00	65.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/21/23	36415 ROUTINE VENIPUNCTURE DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	65.00	0.00	0.00	0.00	65.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
	Provider: Daldalyan, Koruon						
	YOUR BALANCE						0.00
	Total	**11558.00**	**0.00**	**0.00**	**0.00**	**11558.00**	**0.00**

MESSAGES

SSN: N/A
DOI: CT: July 24, 2022 to January 20, 2023
Claim: 4A2302G37SD-0001 / TAX ID: 86-2448871

BALANCE DUE UPON RECEIPT **$ 0.00**

AVAILABLE PATIENT FUND **$ 0.00**

AGING INFORMATION

0 - 30	31 - 60	61 - 90	91 - 120	> 120
$0.00	$0.00	$0.00	$0.00	$0.00

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HEALTH INSURANCE CLAIM FORM

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

PICA

Sedgwick CMS 14450
P.O. BOX 14450
LEXINGTON KY 40512-1415

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): 4A2302G37SD0001
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Gamino Alan			3. PATIENT'S BIRTH DATE MM DD YY: 10 04 1987	SEX: M ☒ F ☐			4. INSURED'S NAME (Last Name, First Name, Middle Initial):
5. PATIENT'S ADDRESS (No., Street): 8220 W. Norton Ave Apt3			6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐				7. INSURED'S ADDRESS (No., Street):
CITY: WEST HOLLYWOOD	STATE: CA		8. RESERVED FOR NUCC USE				CITY: STATE:
ZIP CODE: 90046	TELEPHONE (Include Area Code): (619) 548-2361						ZIP CODE: 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: 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: Sedgwick CMS 14450
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.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE **READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.** 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 Koruon Daldalyan DATE 06/26/2023

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 Koruon Daldalyan

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY; QUAL.	15. OTHER DATE QUAL. 439 MM DD YY 07 24 2022	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		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. S13.4XXA B. S23.9XXA C. S33.5XXA D. S43.401A E. S43.402A F. S63.501A G. S93.401A H. S93.602A I. J. K. L.		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 06 26 23		11		99214		ABCD	500 00	1.0		NPI	1679937643
2 06 26 23		11		WC002		ABCD	451 50	7.0		NPI	1679937643
3 06 26 23		11		94060		ABCD	250 00	1.0		NPI	1679937643
4 06 26 23		11		94664		ABCD	75 00	1.0		NPI	1679937643
5 06 26 23		11		93000		ABCD	215 00	1.0		NPI	1679937643
6 06 26 23		11		94760		ABCD	125 00	1.0		NPI	1679937643

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
862448871	☐	☒	13394200	☒ YES ☐ NO	$ 1616 50	$ 0 00	1616 50

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.)
Koruon Daldalyan 07/17/2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Internist Health Clinic
13320 Riverside Drive Suite 104
SHERMAN OAKS CA 91423-2502
a. b.

33. BILLING PROVIDER INFO & PH # ( )
Koruon Daldalyan
13320 Riverside Drive Suite 104
SHERMAN OAKS CA 91423
a. 1679937643 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
Koruon Daldalyan M.D. Inc.

2 Business name/disregarded entity name, if different from above
Koruon Daldalyan M.D. Inc../ Internist Health Clinic

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☑ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see Instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.
13320 Riverside Drive, Suite 104

Requester's name and address (optional)

6 City, state, and ZIP code
Sherman Oaks, CA 91423

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number
			–			–				

or

Employer identification number
8	6	–	2	4	4	8	8	7	1

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | **Signature of U.S. person** ▶ _____ **Date** ▶ 12/01/2022

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Re: Alan Gamino
Claim No: 4A2302G37SD-0001
WCAB No: ADJ17287003; ADJ17287502
Chart No: 2022-171

PROOF OF SERVICE BY MAIL
(1013a, 2015.5 C.C.P.)
STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am employed in the county of Los Angeles, State of California. I am over the age of 18 and not a party to the within action. My business address is 13320 Riverside Drive, Suite 104, Sherman Oaks, CA 91423.

On July 18, 2023, I served the foregoing document described as:

- Progress Report (06-26-23)
- Itemized Bill (07-17-23)
- 1500 CMS Claim (07-17-23)
- W-9 Form (12-01-22)

On all interested parties in this action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid in the United States mailed at Sherman Oaks, California addressed as follows:

Natalia Foley, Esq.
Workers Defenders Law Group
751 South Weir Canyon Road, Suite 157-455
Anaheim, CA 92808

Law Offices of Fellman & Associates
5777 West Century Boulevard, Suite 1195
Los Angeles, CA 90045

Sedgwick
P.O. Box 14450
Lexington, KY 40512

Executed on July 18, 2023, in Sherman Oaks, California.

I declare under penalty of perjury that the foregoing is true and correct.

Valerie Swartz

Valerie Swartz