

Collections: (800) 500-8448
Fax: (626) 932-1775

FAX TRANSMISSION NOTICE

The following faxed document is to: NATALIA FOLEY (310) 626-9632

NAME: Jamie Keltner
COMPANY: State Compensation Ins Fund, P.O. Box 65005. , Fresno, CA 93650-5005

FAX:
FROM: Vanessa Vega Ext. 3568 vvega@expresscci.com

RE: MH Express Pharmacy in the case of

Daniel Doran vs. Benedict & Benedict Plumbing

Claim#: 05814232

WCAB#:AHM / ADJ8760713

MESSAGE:

Per patient request RX-HISTORY 3/17/2016 -10/24/2017

Confidentiality Notice: Health Care Information is personal and sensitive information related to a person's healthcare. Such information is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties under federal and state law. If you have received this fax in error and/or are not the intended recipient, please call us immediately at (800) 500-8448 to receive instruction regarding the destruction or return of this sensitive information.

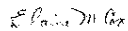
Thursday, January 11, 2018

4903.8(d) Declaration

I declare under penalty of perjury under the laws of the State of California that:

- (1) The services or products described in the bill for services or products were actually provided to the injured employee.
- (2) The billing statement attached to the lien truly and accurately describes the services or products that were provided to the injured employee.

I further declare under penalty of perjury that the above declaration is true and correct and that this declaration was executed on 1/11/2018



ELAINE COX

PROOF OF SERVICE BY MAIL
{1013a,2015.5C.CP.}

RE: DORAN, DANIEL Vs.BENEDICT & BENEDICT PLUMBING

WCAB Number: ,ADJ:8760713

I certify under penalty of perjury that the foregoing billing statement is true and correct to the best of my knowledge per L.C. 5703.


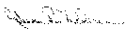
I am employed in the County of Los Angeles, State of California By MH Express Pharmacy, P.O. BOX 1168 MONROVIA, CA 91017-1168
I am over the age of eighteen, and not a party to this action.

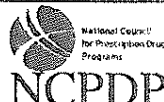
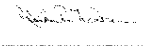
On 1/11/2018 served invoice(s) for dates of services 3/17/2016 to 10/24/2017,


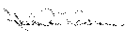
In the above-mentioned case for the lien claimant , MH Express Pharmacy on the interested parties by placing true copies thereof, enclosed in a sealed envelope with the postage thereon fully prepaid, the United States mail in the City of Monrovia, CA, addressed as follows;


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



TARA BATIN


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: <u>03/17/2016</u>		 NCPDP WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div>	
	3-Last: DORAN		4-First: DANIEL			
	5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE			
	7-State: CA		8-Zip: 93545			
CARRIER	16-Jurisdictional State: CA		17-Claim Ref # 05814232		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <div style="text-align: right;">  30-(Signed) _____ 31-(Date) 03/17/2016 </div>	
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005			
	20-City: FRESNO		21-State: CA			
	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING			
PHARMACY	24-Address: 2667 EAST COLORADO		25-City: PASADENA		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	26-State: CA		27-Zip: 91107			
	28-Tel #: (626) 795-5881		29-Contact Name: _____			
	32-ID: 1881712404		33-Qual: 01			
PAYEE	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill		PHARMACY PAYEE	
	36-City: San Dimas		37-State: CA			
	38-Zip: 91773		39-Tel #: (800) 500-8448			
	40-ID: 1437167863		41-Qual: 01			
CLAIM	42-Last: BAKER		43-First: GARY		PHARMACY PAYEE	
	44-Address: 10841 WHITE OAK AVE		45-City: RANCHO CUCAMONGA			
	46-State: CA		47-Zip: 91730-3817			
	48-Tel #: (888) 825-2144		49-ID: 95-4683977			
COMPOUND	50-Qual: 11		51-Name: MH Express Pharmacy		PHARMACY PAYEE	
	52-Address: PO Box 1168		53-City: Monrovia			
	54-State: CA		55-Zip: 91017			
	56-Tel #: (800)500-8448		57-Jurisdiction #1: _____			
58-Jurisdiction #2: _____		59-Jurisdiction #3: _____		60-Jurisdiction #4: _____		
61-Jurisdiction #5: _____		62-Prescription/Service Ref. #		63-Qual		
64-Fil #		65-Date Written mm dd ccyy		66-Date of Service mm dd ccyy		
67-Submission Clarification		68-Prescription Origin		69-Product/Service ID		
70-Qual		71-Quantity Dispensed		72-Days Supply		
73-DAW Code		74-Prior Auth # Submitted		75-PA Type		
76-Description		77-Strength		78-Unit Of Measure		
79-Other Coverage		80-Delay Reason		81-Other Payer ID		
82-Qual		83-Other Payer Date MM DD CCYY		84-Other Payer Rejects		
85-Reason		86-Service		87-Result		
88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code		
91-Dispensing Unit Form Indicator		92-Route of Administration		93-Ingredient Component Count		
94-Product Name		95-Product ID		96-Qual		
97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost		
Pricing (Format 11.234.56)						
100-Usual & Customary Charge		101-Basis of Cost Det.		102-Ingredient Cost Submitted		
103-Dispensing Fee Submitted		104-Other Amount Submitted		105-Sales Tax Submitted		
106-Gross Amount Due (Submitted)		107-Patient Paid Amount		108-Other Payer Amount Paid		
109-Other Payer Patient Resp. Amt.		110-Net Amount Due		111-Other Payer Patient Resp. Amt.		


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: <u>03/17/2016</u>		 NCPDP NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.								
	3-Last: DORAN		4-First: DANIEL					FOR OFFICE USE ONLY 15 (Document Control Number)					
	5-Address: 281 S LAKE VIEW ST		7-State: CA										
CARRIER/EMPLOYER	6-City: LONE PINE		9-Tel #: (760) 258-7545		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  03/17/2016 30-(Signed) _____ 31-(Date) _____								
	8-Zip: 93545		11-D.O.I.: 07/11/2012										
	10-D.O.B.: 06/04/1966		13-Qualifier: 01										
PHARMACY	16-Jurisdictional State: CA		14-Gender: 1		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE								
	17-Claim Ref #: 05814232		18-Name: STATE COMPENSATION INS FUND										
	19-Address: P.O. BOX 65005		21-State: CA										
PAYEE	20-City: FRESNO		22-Zip: 93650-5005		REVERSE SIDE								
	23-Name: BENEDICT & BENEDICT PLUMBING		24-Address: 2667 EAST COLORADO										
	25-City: PASADENA		26-State: CA										
CLAIM	27-Zip: 91107		28-Tel #: (626) 795-5881		FORWARD								
	29-Contact Name:		32-ID: 1881712404										
	33-Qual: 01		40-ID: 1437167863										
COMPOUND	34-Name: MH Express Pharmacy		41-Qual: 01		FORWARD								
	35-Address: 300 N. Lone Hill		42-Last: BAKER										
	36-City: San Dimas		37-State: CA										
38-Zip: 91773		43-First: GARY		FORWARD									
39-Tel #: (800) 500-8448		44-Address: 10841 WHITE OAK AVE											
49-ID: 95-4683977		50-Qual: 11											
51-Name: MH Express Pharmacy		52-Address: PO Box 1168		FORWARD									
53-City: Monrovia		54-State: CA											
55-Zip: 91017		56-Tel #: (800)500-8448											
57-Jurisdiction #1:		58-Jurisdiction #2:		FORWARD									
59-Jurisdiction #3:		60-Jurisdiction #4:											
61-Jurisdiction #5:		62-Prescription/Service Ref #											
63-Qual: 1		64-Fill #: 0		65-Date Written: 03/15/2016		66-Date of Service: 03/17/2016		67-Submission Clarification		68-Prescription Origin			
69-Product/Service ID		70-Qual: 03		71-Quantity Dispensed: 120.00		72-Days Supply: 30		73-DAW Code: 0		74-Prior Auth # Submitted		75-PA Type	
76-Description: GABAPENTIN 600 MG TABLET		77-Strength: 600MG		78-Unit Of Measure: EA		79-Other Coverage: 0		80-Delay Reason		FORWARD			
81-Other Payer ID		82-Qual		83-Other Payer Date: MM DD CCYY		84-Other Payer Rejects		85-Reason / 86-Service / 87-Result					
88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration				93-Ingredient Component Count	
94-Product Name		95-Product ID		96-Qual		97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost			
100-Usual & Customary Charge: \$82.72		101-Basis of Cost Det: 01		102-Ingredient Cost Submitted: \$82.72		103-Dispensing Fee Submitted: \$0.00		104-Other Amount Submitted		105-Sales Tax Submitted: \$0.00		106-Gross Amount Due (Submitted): \$82.72	
107-Patient Paid Amount		108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt		110-Net Amount Due: \$82.72							


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 04/14/2016		 NCPDP NATIONAL COUNCIL FOR PHARMACY PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. FOR OFFICE USE ONLY 15 (Document Control Number)				
	3-Last: DORAN		4-First: DANIEL						
	5-Address: 281 S LAKE VIEW ST		7-State: CA						
	6-City: LONE PINE		8-Tel #: (760) 258-7545						
CARRIER	10-D.O.B. 06/04/1966		11-D.O.I. 07/11/2012		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  04/14/2016 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE				
	12-ID: 554731885		13-Qualifier: 01				14-Gender: 1		
	16-Jurisdictional State: CA		17-Claim Ref # 05814232				18-Name: STATE COMPENSATION INS FUND		
	19-Address: P.O. BOX 65005		20-City: FRESNO				21-State: CA		
EMPLOYER	23-Name: BENEDICT & BENEDICT PLUMBING		24-Address: 2667 EAST COLORADO		25-City: PASADENA				
	25-City: PASADENA		26-State: CA		27-Zip: 91107				
	27-Zip: 91107		28-Tel #: (626) 795-5881		29-Contact Name: _____				
	32-ID: 1881712404		33-Qual: 01		40-ID: 1437167863				
PHARMACY	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill		36-City: San Dimas				
	36-City: San Dimas		37-State: CA		38-Zip: 91773				
	38-Zip: 91773		39-Tel #: (800) 500-8448		41-Qual: 01				
	42-Last: BAKER		43-First: GARY		44-Address: 10841 WHITE OAK AVE				
PAYEE	48-ID: 95-4683977		50-Qual: 11		51-Name: MH Express Pharmacy				
	51-Name: MH Express Pharmacy		52-Address: PO Box 1168		53-City: Monrovia				
	53-City: Monrovia		54-State: CA		55-Zip: 91017				
	55-Zip: 91017		56-Tel #: (800)500-8448		57-Jurisdiction #1: _____				
57-Jurisdiction #1: _____		58-Jurisdiction #2: _____		59-Jurisdiction #3: _____					
59-Jurisdiction #3: _____		60-Jurisdiction #4: _____		61-Jurisdiction #5: _____					
60-Jurisdiction #4: _____		61-Jurisdiction #5: _____							
CLAIM	62-Prescription/Service Ref #		63-Qual	64-Fill #	65-Date Written mm dd cyyy	66-Date of Service mm dd cyyy	67-Submission Clarification	68-Prescription Origin	
	6632390		1	0	04/11/2016	04/14/2016		0	
	69-Product/Service ID		70-Qual	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth # Submitted	75-PA Type	
	16714044802		03	30.00	30	0		0	
	76-Description			77-Strength			78-Unit Of Measure	79-Other Coverage	80-Delay Reason
	AMITRIPTYLINE HCL 50 MG TAB			50MG			EA	0	
81-Other Payer ID		82-Qual	83-Other Payer Date MM DD CYY		84-Other Payer Rejects		DUR / PPS / CODES		
							85-Reason / 86-Service / 87-Result		
88-Level of Effort		89-Procedure Modifier	90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration		
							93-Ingredient Component Count		
COMPOUND	94-Product Name		95-Product ID		96-Qual	97-Ingredient Qty	98-Ingredient Drug Cost	99-Basis Cost	
Pricing (Format 11,234.56)									
100-Usual & Customary Charge		101-Basis of Cost Det.	102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted		
\$93.34		01	\$93.34		\$0.00		\$0.00		
107-Patient Paid Amount		108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.		110-Net Amount Due			
						\$93.34			


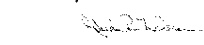
PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 04/14/2016		 NCPDP WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div>	
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	5-Address: 281 S LAKE VIEW ST		7-State: CA			
	6-City: LONE PINE		9-Tel #: (760) 258-7545			
CARRIER	8-Zip: 93545		11-D.O.B.: 07/11/2012		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 30-(Signed) _____ 31-(Date) 04/14/2016 ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	10-D.O.B.: 06/04/1966		13-Qualifier: 01			
	12-I.D.: 554731885		14-Gender: I			
	16-Jurisdictional State: CA		17-Claim Ref #: 05814232			
EMPLOYER	18-Name: STATE COMPENSATION INS FUND		21-State: CA		29-Contact Name: _____	
	19-Address: P.O. BOX 65005		22-Zip: 93650-5005			
	23-Name: BENEDICT & BENEDICT PLUMBING		26-State: CA			
	24-Address: 2667 EAST COLORADO		28-Tel #: (626) 795-5881			
PHARMACY	32-ID: 1881712404		33-Qual: 01		PHARMACY	
	34-Name: MH Express Pharmacy		40-ID: 1437167863			
	35-Address: 300 N. Lone Hill		42-Last: BAKER			
	36-City: San Dimas		43-First: GARY			
PAYEE	37-State: CA		44-Address: 10841 WHITE OAK AVE		PAYEE	
	38-Zip: 91773		45-City: RANCHO CUCAMONGA			
	39-Tel #: (800) 500-8448		46-State: CA			
	49-ID: 95-4683977		50-Qual: 11			
51-Name: MH Express Pharmacy		57-Jurisdiction #1: _____		PAYEE		
52-Address: PO Box 1168		58-Jurisdiction #2: _____				
53-City: Monrovia		59-Jurisdiction #3: _____				
54-State: CA		60-Jurisdiction #4: _____				
55-Zip: 91017		61-Jurisdiction #5: _____		PAYEE		
56-Tel #: (800)500-8448		62-Prescription/Service Ref. #: 6632389				
63-Qual: I		64-Fill #: 0				
65-Date Written: 04/11/2016		66-Date of Service: 04/14/2016				
67-Submission Clarification: _____		68-Prescription Origin: 0		CLAIM		
69-Product/Service ID: 16714033002		70-Quant: 03				
71-Quantity Dispensed: 120.00		72-Days Supply: 30				
73-DAW Code: 0		74-Prior Auth #. Submitted: 0				
75-PA. Type: 0		76-Description: GABAPENTIN 600 MG TABLET		CLAIM		
77-Strength: 600MG		78-Unit Of Measure: EA				
79-Other Coverage: 0		80-Delay Reason: _____				
81-Other Payer ID: _____		82-Other Payer Date: _____				
83-Other Payer Date: _____		84-Other Payer Rejects: _____		COMPOUND		
85-Reason / 86-Service / 87-Result: _____		88-Reason / 86-Service / 87-Result: _____				
89-Procedure Modifier: _____		90-Dosage Form Description Code: _____				
91-Dispensing Unit Form Indicator: _____		92-Route of Administration: _____				
93-Ingredient Component Count: _____		94-Product Name: _____		COMPOUND		
95-Product ID: _____		96-Qual: _____				
97-Ingredient Qty: _____		98-Ingredient Drug Cost: _____				
99-Basis Cost: _____		100-Usual & Customary Charge: \$32.89				
101-Basis of Cost Det.: 01		102-Ingredient Cost Submitted: \$32.89		COMPOUND		
103-Dispensing Fee Submitted: \$0.00		104-Other Amount Submitted: _____				
105-Sales Tax Submitted: \$0.00		106-Gross Amount Due (Submitted): \$32.89				
107-Patient Paid Amount: _____		108-Other Payer Amount Paid: _____				
109-Other Payer Patient Resp. Amt.: _____		110-Net Amount Due: \$32.89		COMPOUND		
Pricing (Format 11,234.56)		111-Net Amount Due: \$32.89				
112-Net Amount Due: \$32.89		113-Net Amount Due: _____				
114-Net Amount Due: _____		115-Net Amount Due: _____				


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 05/12/2016		 NCPDP NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div>		
	3-Last: DORAN		4-First: DANIEL				
	5-Address: 281 S LAKE VIEW ST						
CARRIER	6-City: LONE PINE		7-State: CA		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <div style="display: flex; justify-content: space-between;"> 30-(Signed) 31-(Date) </div>		
	8-Zip: 93545		9-Tel #: (760) 258-7545				
	10-D.O.B: 06/04/1966						
EMPLOYER	12-I.D.: 554731885		13-Qualifier: 01		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE		
	16-Jurisdictional State: CA						
	17-Claim Ref #: 05814232						
PHARMACY	18-Name: STATE COMPENSATION INS FUND				57-Jurisdiction #1: _____ 58-Jurisdiction #2: _____ 59-Jurisdiction #3: _____ 60-Jurisdiction #4: _____ 61-Jurisdiction #5: _____		
	19-Address: P.O. BOX 65005						
	20-City: FRESNO		21-State: CA				
PAYEE	22-Zip: 93650-5005				62-Prescription/Service Ref. #: 6636705 63-Qual: I 64-Fill #: 0 65-Date Written mm dd cyy: 05/09/2016 66-Date of Service mm dd cyy: 05/12/2016 67-Submission Clarification: _____ 68-Prescription Origin: 0 69-Product/Service ID: 16714033202 70-Qual: 03 71-Quantity Dispensed: 120.00 72-Days Supply: 30 73-DAW Code: 0 74-Prior Auth #. Submitted: _____ 75-PA. Type: 0 76-Description: GABAPENTIN 800 MG TABLET 77-Strength: 800MG 78-Unit Of Measure: EA 79-Other Coverage: 0 80-Delay Reason: _____ 81-Other Payer ID: _____ 82-Qual: _____ 83-Other Payer Date MM DD CYY: _____ 84-Other Payer Rejects: _____ 85-Reason / 86-Service / 87-Result: _____ 88-Level of Effort: _____ 89-Procedure Modifier: _____ 90-Dosage Form Description Code: _____ 91-Dispensing Unit Form Indicator: _____ 92-Route of Administration: _____ 93-Ingredient Component Count: _____		
	23-Name: BENEDICT & BENEDICT PLUMBING						
	24-Address: 2667 EAST COLORADO		26-State: CA				
CLAIM	25-City: PASADENA		28-Tel #: (626) 795-5881		94-Product Name: _____ 95-Product ID: _____ 96-Qual: _____ 97-Ingredient Qty: _____ 98-Ingredient Drug Cost: _____ 99-Basis Cost: _____		
	27-Zip: 91107						
	29-Contact Name: _____						
COMPOUND	32-ID: 1881712404		33-Qual: 01		Pricing (Format: 11,234.56) 100-Usual & Customary Charge: \$33.22 101-Basis of Cost Det.: 01 102-Ingredient Cost Submitted: \$33.22 103-Dispensing Fee Submitted: \$0.00 104-Other Amount Submitted: _____ 105-Sales Tax Submitted: \$0.00 106-Gross Amount Due (Submitted): \$33.22 107-Patient Paid Amount: _____ 108-Other Payer Amount Paid: _____ 109-Other Payer Patient Resp. Amt.: _____ 110-Net Amount Due: \$33.22		
	34-Name: MH Express Pharmacy						
	35-Address: 300 N. Lone Hill		37-State: CA				
36-City: San Dimas							
38-Zip: 91773							
39-Tel #: (800) 500-8448							
49-ID: 95-4683977							
51-Name: MH Express Pharmacy							
52-Address: PO Box 1168							
53-City: Monrovia		54-State: CA					
55-Zip: 91017							
56-Tel #: (800)500-8448							


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: <u>05/12/2016</u>		 NCPDP WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div>									
	3-Last: DORAN		4-First: DANIEL											
	5-Address: 281 S LAKE VIEW ST		7-State: CA											
	6-City: LONE PINE		9-Tel #: (760) 258-7545											
CARRIER	10-D.O.B: 06/04/1966		11-D.O.I: 07/11/2012		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) _____ 05/12/2016 30-(Signed) 31-(Date)									
	12-I.D.: 554731885		13-Qualifier: 01				14-Gender: 1							
	16-Jurisdictional State: CA		17-Claim Ref #: 05814232				ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE							
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005											
EMPLOYER	20-City: FRESNO		21-State: CA		23-Name: BENEDICT & BENEDICT PLUMBING 24-Address: 2667 EAST COLORADO 25-City: PASADENA 26-State: CA 27-Zip: 91107 26-Tel #: (626) 795-5881 29-Contact Name:									
	22-Zip: 93650-5005													
PHARMACY	32-ID: 1881712404		33-Qual: 01		40-ID: 1992964423		41-Qual: 01							
	34-Name: MH Express Pharmacy				42-Last: Guerrero									
	35-Address: 300 N. Lone Hill				43-First: Jaime									
	36-City: San Dimas		37-State: CA		44-Address: 10841 WHITE OAK AVE		46-State: CA							
PAYEE	38-Zip: 91773				45-City: RANCHO CUCAMONGA		47-Zip: 91730-3817							
	39-Tel #: (800) 500-8448				48-Tel #: (888) 824-2144									
	49-ID: 95-4683977		50-Qual: 11		57-Jurisdiction #1:									
	51-Name: MH Express Pharmacy				58-Jurisdiction #2:									
52-Address: PO Box 1168				59-Jurisdiction #3:										
53-City: Monrovia		54-State: CA		60-Jurisdiction #4:										
55-Zip: 91017				61-Jurisdiction #5:										
56-Tel #: (800)500-8448														
CLAIM	62-Prescription/Service Ref. #		63-Qual		64-Fill #		65-Date Written mm dd ccyy		66-Date of Service mm dd ccyy		67-Submission Clarification		68-Prescription Origin	
	6636703		1		0		05/09/2016		05/12/2016				0	
	69-Product/Service ID		76-Qual		71-Quantity Dispensed		72-Days Supply		73-DAW Code		74-Prior Auth #. Submitted		75-PA. Type	
	16714044802		03		30.00		30		0				0	
	78-Description				77-Strength				78-Unit Of Measure		79-Other Coverage		80-Delay Reason	
	AMITRIPTYLINE HCL 50 MG TAB				50MG				EA		0			
	81-Other Payer ID		82-Qual		83-Other Payer Date MM DD CCYY		84-Other Payer Rejects		DUR		DUR / PPS / CODES			
											85-Reason / 86-Service / 87-Result			
	88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration		93-Ingredient Component Count			
COMPOUND	94-Product Name		95-Product ID		96-Qual		97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost			
Pricing (Format (1,234.56))														
100-Usual & Customary Charge		101-Basis of Cost Det.		102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted		105-Sales Tax Submitted		106-Gross Amount Due (Submitted)		
\$10.57		01		\$10.57		\$0.00				\$0.00		\$10.57		
107-Patient Paid Amount		108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.		110-Net Amount Due								
						\$10.57								


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 06/10/2016		 NCPDP NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.								
	3-Last: DORAN		4-First: DANIEL										
	5-Address: 281 S LAKE VIEW ST		7-State: CA										
	6-City: LONE PINE		8-Zip: 93545										
CARRIER/EMPLOYER	10-D.O.B.: 06/04/1966		11-D.O.I.: 07/11/2012		FOR OFFICE USE ONLY 15 (Document Control Number)								
	12-I.D.: 554731885		13-Qualifier: 01				SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) _____ 06/10/2016 30-(Signed) 31-(Date)						
	16-Jurisdictional State: CA		17-Claim Ref #: 05814232		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE								
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005										
PHARMACY	20-City: FRESNO		21-State: CA		PHARMACY PAYEE								
	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING										
	24-Address: 2667 EAST COLORADO		25-City: PASADENA										
	26-State: CA		27-Zip: 91107										
CLAIM	28-Tel #: (626) 795-5881		29-Contact Name: _____		PHARMACY PAYEE								
	32-ID: 1881712404		33-Qual: 01										
	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill										
	36-City: San Dimas		37-State: CA										
COMPOUND	38-Zip: 91773		39-Tel #: (800) 500-8448		PHARMACY PAYEE								
	40-ID: 1992964423		41-Qual: 01										
	42-Last: Guerrero		43-First: Jaime										
	44-Address: 10841 WHITE OAK AVE		45-City: RANCHO CUCAMONGA										
46-State: CA		47-Zip: 91730-3817		PHARMACY PAYEE									
48-Tel #: (888) 824-2144		49-ID: 95-4683977											
50-Qual: 11		51-Name: MH Express Pharmacy											
52-Address: PO Box 1168		53-City: Monrovia											
54-State: CA		55-Zip: 91017		PHARMACY PAYEE									
56-Tel #: (800)500-8448		57-Jurisdiction #1: _____											
58-Jurisdiction #2: _____		59-Jurisdiction #3: _____											
60-Jurisdiction #4: _____		61-Jurisdiction #5: _____											
62-Product/Service ID: 16714044802		70-Qual: 03		71-Quantity Dispensed: 30.00		72-Days Supply: 30		73-DAW Code: 0		74-Prior Auth #. Submitted: _____		75-PA Type: 0	
63-Qual: 1		64-File #: 0		65-Date Written: 06/06/2016		66-Date of Service: 06/10/2016		67-Submission Clarification: _____		68-Prescription Origin: 0		76-Description: AMITRIPTYLINE HCL 50 MG TAB	
77-Strength: 50MG		78-Unit Of Measure: EA		79-Other Coverage: 0		80-Delay Reason: _____		81-Other Payer ID: _____		82-Qual: _____		83-Other Payer Date: _____	
84-Other Payer Rejects: _____		85-Reason / 86-Service / 87-Result: _____		88-Level of Effort: _____		89-Procedure Modifier: _____		90-Dosage Form Description Code: _____		91-Dispensing Unit Form Indicator: _____		92-Route of Administration: _____	
93-Ingredient Component Count: _____		94-Product Name: _____		95-Product ID: _____		96-Qual: _____		97-Ingredient Qty: _____		98-Ingredient Drug Cost: _____		99-Basis Cost: _____	
100-Usual & Customary Charge: \$10.57		101-Basis of Cost Det.: 01		102-Ingredient Cost Submitted: \$10.57		103-Dispensing Fee Submitted: \$0.00		104-Other Amount Submitted: _____		105-Sales Tax Submitted: \$0.00		106-Gross Amount Due (Submitted): \$10.57	
107-Patient Paid Amount: _____		108-Other Payer Amount Paid: _____		109-Other Payer Patient Resp. Amt.: _____		110-Net Amount Due: \$10.57		111-Net Amount Due: _____		112-Net Amount Due: _____		113-Net Amount Due: _____	


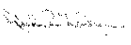
PATIENT CARRIER EMPLOYER PHARMACY PAYEE CLAIM COMPOUND	1-WC/P&C Indicator: WC		2-Date of Billing: 06/10/2016 <small>mm dd ccyy</small>		 <p>NCPDP WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.</p> <div style="border: 1px solid black; padding: 5px; text-align: center;"> <p>FOR OFFICE USE ONLY 15 (Document Control Number)</p> </div> <p>SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</p> <p style="text-align: right;"><i>[Signature]</i> 06/10/2016</p> <p>30-(Signed) _____ 31-(Date) _____</p> <div style="background-color: #cccccc; padding: 5px; text-align: center; font-weight: bold;"> ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE </div>						
	3-Last: DORAN		4-First: DANIEL								
	5-Address: 281 S LAKE VIEW ST										
	6-City: LONE PINE		7-State: CA								
	8-Zip: 93545		9-Tel #: (760) 258-7545								
10-D.O.B.: 06/04/1966		11-D.O.I.: 07/11/2012									
12-I.D.: 554731885		13-Qualifier: 01		14-Gender: 1							
16-Jurisdictional State: CA											
17-Claim Ref #: 05814232											
18-Name: STATE COMPENSATION INS FUND											
19-Address: P.O. BOX 65005											
20-City: FRESNO		21-State: CA									
22-Zip: 93650-5005											
23-Name: BENEDICT & BENEDICT PLUMBING											
24-Address: 2667 EAST COLORADO											
25-City: PASADENA		26-State: CA									
27-Zip: 91107		28-Tel #: (626) 795-5881									
29-Contact Name: _____											
32-ID: 1881712404		33-Qual: 01		40-ID: 1992964423		41-Qual: 01					
34-Name: MH Express Pharmacy				42-Last: Guerrero							
35-Address: 300 N. Lone Hill				43-First: Jaime							
36-City: San Dimas		37-State: CA		44-Address: 10841 WHITE OAK AVE							
38-Zip: 91773		45-City: RANCHO CUCAMONGA				46-State: CA					
39-Tel #: (800) 500-8448		47-Zip: 91730-3817				48-Tel #: (888) 824-2144					
49-ID: 95-4683977		50-Qual: 11		57-Jurisdiction #1: _____		58-Jurisdiction #2: _____		59-Jurisdiction #3: _____		60-Jurisdiction #4: _____	
51-Name: MH Express Pharmacy				61-Jurisdiction #5: _____							
52-Address: PO Box 1168											
53-City: Monrovia		54-State: CA									
55-Zip: 91017											
56-Tel #: (800)500-8448											
62-Prescription/Service Ref. #		63-Qual	64-Fill #	65-Date Written	66-Date of Service	67-Submission Clarification	68-Prescription Origin				
6642234		1	0	06/06/2016	06/10/2016		0				
69-Product/Service ID			70-Qual	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth #. Submitted	75-PA. Type			
16714033202			03	120.00	30	0		0			
76-Description				77-Strength		78-Unil Of Measure	79-Other Coverage	80-Delay Reason			
GABAPENTIN 800 MG TABLET				800MG		EA	0				
81-Other Payer ID		82-Qual	83-Other Payer Date	84-Other Payer Rejects		DUR / PPS / CODES		85-Reason / 86-Service / 87-Result			
			MM. DD. CCYY								
88-Level of Effort	89-Procedure Modifier	90-Dosage Form Description Code		91-Dispensing Unit Form Indicator	92-Route of Administration		93-Ingredient Component Count				
94-Product Name		95-Product ID		96-Qual	97-Ingredient Qty	98-Ingredient Drug Cost		99-Basis Cost			
1											
2											
3											
4											
5											
6											
7											
Pricing (Format 1,234.56)											
100-Usual & Customary Charge		101-Basis of Cost Det.	102-Ingredient Cost Submitted	103-Dispensing Fee Submitted	104-Other Amount Submitted	105-Sales Tax Submitted	106-Gross Amount Due (Submitted)				
\$33.22		01	\$33.22	\$0.00		\$0.00	\$33.22				
107-Patient Paid Amount		108-Other Payer Amount Paid	109-Other Payer Patient Resp. Amt.		110-Net Amount Due						
					\$33.22						


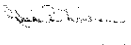
PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: <u>07/05/2016</u>		 NCPDP NATIONAL COUNCIL ON RETAIL PHARMACY WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.									
	3-Last: DORAN		4-First: DANIEL											
5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE		7-State: CA										
8-Zip: 93545		9-Tel #: (760) 258-7545		10-D.O.B.: 06/04/1966										
11-D.O.I.: 07/11/2012		12-I.D.: 554731885		13-Qualifier: 01										
CARRIER	16-Jurisdictional State: CA		17-Claim Ref #: 05814232		FOR OFFICE USE ONLY 15 (Document Control Number)									
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005				SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 							
20-City: FRESNO		21-State: CA		30-(Signed)										
22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING		31-(Date) 07/05/2016										
24-Address: 2667 EAST COLORADO		25-City: PASADENA		26-State: CA										
27-Zip: 91107		28-Tel #: (626) 795-5881		29-Contact Name:										
EMPLOYER	32-ID: 1881712404		33-Qual: 01		40-ID: 1992964423									
	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill		41-Qual: 01									
PHARMACY	36-City: San Dimas		37-State: CA		42-Last: Guerrero									
	38-Zip: 91773		39-Tel #: (800) 500-8448		43-First: Jaime									
44-Address: 10841 WHITE OAK AVE		45-City: RANCHO CUCAMONGA		46-State: CA										
47-Zip: 91730-3817		48-Tel #: (888) 824-2144		49-ID: 95-4683977										
50-Qual: 11		51-Name: MH Express Pharmacy		52-Address: PO Box 1168										
53-City: Monrovia		54-State: CA		55-Zip: 91017										
56-Tel #: (800)500-8448		57-Jurisdiction #1:		58-Jurisdiction #2:										
59-Jurisdiction #3:		60-Jurisdiction #4:		61-Jurisdiction #5:										
CLAIM	62-Prescription/Service Ref #		63-Qual		64-Fill #		65-Date Written		66-Date of Service		67-Submission Clarification		68-Prescription Origin	
	6642235		I		I		06/06/2016		07/05/2016				0	
	69-Product/Service ID		70-Qual		71-Quantity Dispensed		72-Days Supply		73-DAW Code		74-Prior Auth # Submitted		75-PA Type	
	16714044802		03		30.00		30		0				0	
	76-Description				77-Strength				78-Unit Of Measure		79-Other Coverage		80-Delay Reason	
	AMITRIPTYLINE HCL 50 MG TAB				50MG				EA		0			
	81-Other Payer ID		82-Qual		83-Other Payer Date		84-Other Payer Rejects		DUR		DUR / PPS / CODES			
					MM DD CCYY						85-Reason / 86-Service / 87-Result			
	88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration		93-Ingredient Component Count			
COMPOUND	94-Product Name		95-Product ID		96-Qual		97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost			
	1													
	2													
	3													
	4													
	5													
	6													
	7													
Pricing (Format 11.234.56)														
100-Usual & Customary Charge		101-Basis of Cost Det.		102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted		105-Sales Tax Submitted		106-Gross Amount Due (Submitted)		
\$10.57		01		\$10.57		\$0.00				\$0.00		\$10.57		
107-Patient Paid Amount		108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.		110-Net Amount Due								
						\$10.57								


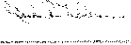
PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 07/05/2016		 NCPDP NATIONAL COMPENSATION/PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.			
	3-Last: DORAN		4-First: DANIEL				FOR OFFICE USE ONLY 15 (Document Control Number)	
	5-Address: 281 S LAKE VIEW ST							
CARRIER	6-City: LONE PINE		7-State: CA		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) _____ 07/05/2016 30-(Signed) 31-(Date)			
	8-Zip: 93545		9-Tel #: (760) 258-7545					
	10-D.O.B: 06/04/1966		11-D.O.I: 07/11/2012					
PHARMACY	12-I.D.: 554731885		13-Qualifier: 01		14-Gender: 1			
	16-Jurisdictional State: CA							
	17-Claim Ref #: 05814232							
PHARMACY	18-Name: STATE COMPENSATION INS FUND							
	19-Address: P.O. BOX 65005							
	20-City: FRESNO		21-State: CA					
PHARMACY	22-Zip: 93650-5005							
	23-Name: BENEDICT & BENEDICT PLUMBING							
	24-Address: 2667 EAST COLORADO							
PHARMACY	25-City: PASADENA		26-State: CA					
	27-Zip: 91107		28-Tel #: (626) 795-5881					
	29-Contact Name: _____							
PHARMACY	32-ID: 1881712404		33-Qual: 01		40-ID: 1992964423			
	34-Name: MH Express Pharmacy		42-Last: Guerrero		41-Qual: 01			
	35-Address: 300 N. Lone Hill		43-First: Jaime		44-Address: 10841 WHITE OAK AVE			
PHARMACY	36-City: San Dimas		37-State: CA					
	38-Zip: 91773		45-City: RANCHO CUCAMONGA		46-State: CA			
	39-Tel #: (800) 500-8448		47-Zip: 91730-3817		48-Tel #: (888) 824-2144			
PHARMACY	49-ID: 95-4683977		50-Qual: 11		57-Jurisdiction #1: _____			
	51-Name: MH Express Pharmacy		58-Jurisdiction #2: _____		59-Jurisdiction #3: _____			
	52-Address: PO Box 1168		59-Jurisdiction #4: _____		60-Jurisdiction #4: _____			
PHARMACY	53-City: Monrovia		54-State: CA					
	55-Zip: 91017		61-Jurisdiction #5: _____		61-Jurisdiction #5: _____			
	56-Tel #: (800)500-8448							
CLAIM	62-Prescription/Service Ref. #		63-Qual.	64-Fill #	65-Date Written mm dd cyyy	66-Date of Service mm dd cyyy		
	6642234		1	1	06/06/2016	07/05/2016		
	69-Product/Service ID		70-Qual	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth #. Submitted	
16714033202		03	60.00	15	0	0		
76-Description		77-Strength		78-Unit Of Measure	79-Other Coverage	80-Delay Reason		
GABAPENTIN 800 MG TABLET		800MG		EA	0			
81-Other Payer ID		82-Qual	83-Other Payer Date MM DD CYY	84-Other Payer Rejects		DUR / PPS / CODES		
						85-Reason / 86-Service / 87-Result		
88-Level of Effort		89-Procedure Modifier	90-Dosage Form Description Code	91-Dispensing Unit Form Indicator	92-Route of Administration			
					93-Ingredient Component Count			
COMPOUND	94-Product Name		95-Product ID		96-Qual	97-Ingredient Qty		
						98-Ingredient Drug Cost		
						99-Basis Cost		
Pricing (Format 11.234.56)								
100-Usual & Customary Charge		101-Basis of Cost Det.	102-Ingredient Submitted Cost	103-Dispensing Fee Submitted	104-Other Amount Submitted	105-Sales Tax Submitted		
\$21.59		01	\$21.59	\$0.00		\$0.00		
107-Patient Paid Amount		108-Gross Amount Due (Submitted)	109-Other Payer Patient Resp. Amt.	110-Net Amount Due				
		\$21.59		\$21.59				


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 07/27/2016		 NCPDP NATIONAL COUNCIL for Prescription Drug Programs WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.																																																																							
	3-Last: DORAN		4-First: DANIEL				FOR OFFICE USE ONLY 15 (Document Control Number)																																																																					
	5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE																																																																									
CARRIER	7-State: CA		8-Zip: 93545		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) _____ 07/27/2016 30-(Signed) 31-(Date)																																																																							
	9-Tel #: (760) 258-7545		10-D.O.B.: 06/04/1966																																																																									
	11-D.O.I.: 07/11/2012		12-I.D.: 554731885																																																																									
EMPLOYER	13-Qualifier: 01		14-Gender: 1		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE																																																																							
	16-Jurisdictional State: CA		17-Claim Ref #: 05814232																																																																									
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005																																																																									
PHARMACY	20-City: FRESNO		21-State: CA		REMITTANCE INFORMATION																																																																							
	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING																																																																									
	24-Address: 2667 EAST COLORADO		25-City: PASADENA																																																																									
PAYEE	26-State: CA		27-Zip: 91107		40-ID: 1992964423 41-Qual: 01 42-Last: Guerrero 43-First: Jaime 44-Address: 10841 WHITE OAK AVE 45-City: RANCHO CUCAMONGA 46-State: CA 47-Zip: 91730-3817 48-Tel #: (888) 824-2144																																																																							
	28-Tel #: (626) 795-5881		29-Contact Name: _____																																																																									
	32-ID: 1881712404		33-Qual: 01																																																																									
CLAIM	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill		57-Jurisdiction #1: _____ 58-Jurisdiction #2: _____ 59-Jurisdiction #3: _____ 60-Jurisdiction #4: _____ 61-Jurisdiction #5: _____																																																																							
	36-City: San Dimas		37-State: CA																																																																									
	38-Zip: 91773		39-Tel #: (800) 500-8448																																																																									
COMPOUND	49-ID: 95-4683977		50-Qual: 11		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>62-Prescription/Service Ref. #</td> <td>63-Qual.</td> <td>64-Fill #</td> <td>65-Date Written mm dd ccyy</td> <td>66-Date of Service mm dd ccyy</td> <td>67-Submission Clarification</td> <td>68-Prescription Origin</td> </tr> <tr> <td>6650256</td> <td>1</td> <td>0</td> <td>07/18/2016</td> <td>07/27/2016</td> <td></td> <td>0</td> </tr> <tr> <td>69-Product/Service ID</td> <td>70-Qual.</td> <td>71-Quantity Dispensed</td> <td>72-Day Supply</td> <td>73-DAW Code</td> <td>74-Prior Auth # Submitted</td> <td>75-PA Type</td> </tr> <tr> <td>16714033202</td> <td>03</td> <td>120.00</td> <td>30</td> <td>0</td> <td></td> <td>0</td> </tr> <tr> <td colspan="2">76-Description</td> <td colspan="2">77-Strength</td> <td>78-Unit Of Measure</td> <td>79-Other Coverage</td> <td>80-Delay Reason</td> </tr> <tr> <td colspan="2">GABAPENTIN 800 MG TABLET</td> <td colspan="2">800MG</td> <td>EA</td> <td>0</td> <td></td> </tr> <tr> <td>81-Other Payer ID</td> <td>82-Qual</td> <td>83-Other Payer Date MM DD CCYY</td> <td colspan="2">84-Other Payer Rejects</td> <td colspan="2">DUR 85-Reason / 86-Service / 87-Result</td> </tr> <tr> <td></td> <td></td> <td></td> <td colspan="2"></td> <td colspan="2"></td> </tr> <tr> <td>88-Level of Effort</td> <td>89-Procedure Modifier</td> <td>90-Dosage Form Description Code</td> <td>91-Dispensing Unit Form Indicator</td> <td colspan="2">92-Route of Administration</td> <td>93-Ingredient Component Count</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td colspan="2"></td> <td></td> </tr> </table>		62-Prescription/Service Ref. #	63-Qual.	64-Fill #	65-Date Written mm dd ccyy	66-Date of Service mm dd ccyy	67-Submission Clarification	68-Prescription Origin	6650256	1	0	07/18/2016	07/27/2016		0	69-Product/Service ID	70-Qual.	71-Quantity Dispensed	72-Day Supply	73-DAW Code	74-Prior Auth # Submitted	75-PA Type	16714033202	03	120.00	30	0		0	76-Description		77-Strength		78-Unit Of Measure	79-Other Coverage	80-Delay Reason	GABAPENTIN 800 MG TABLET		800MG		EA	0		81-Other Payer ID	82-Qual	83-Other Payer Date MM DD CCYY	84-Other Payer Rejects		DUR 85-Reason / 86-Service / 87-Result									88-Level of Effort	89-Procedure Modifier	90-Dosage Form Description Code	91-Dispensing Unit Form Indicator	92-Route of Administration		93-Ingredient Component Count							
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	6650256	1	0	07/18/2016			07/27/2016		0																																																																			
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51-Name: MH Express Pharmacy		52-Address: PO Box 1168		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>94-Product Name</td> <td>95-Product ID</td> <td>96-Qual</td> <td>97-Ingredient Qty</td> <td>98-Ingredient Drug Cost</td> <td>99-Basis Cost</td> </tr> <tr> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>7</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		94-Product Name	95-Product ID	96-Qual	97-Ingredient Qty	98-Ingredient Drug Cost	99-Basis Cost	1						2						3						4						5						6						7																												
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\$36.67	01	\$36.67	\$0.00		\$0.00	\$36.67																																																																						
107-Patient Paid Amount	108-Other Payer Amount Paid	109-Other Payer Patient Resp. Amt.	110-Net Amount Due																																																																									
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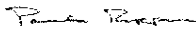
PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 08/10/2016 <small>mm dd ccyy</small>		 NCPDP NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.				
	3-Last: DORAN		4-First: DANIEL						
	5-Address: 281 S LAKE VIEW ST		7-State: CA						
	6-City: LONE PINE		9-Tel #: (760) 258-7545						
CARRIER	10-D.O.B.: 06/04/1966 <small>mm dd ccyy</small>		11-D.O.I.: 07/11/2012 <small>mm dd ccyy</small>		FOR OFFICE USE ONLY 15 (Document Control Number)				
	12-I.D.: 554731885		13-Qualifier: 01				14-Gender: 1		
	16-Jurisdictional State: CA		17-Claim Ref #: 05814232				SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005						
EMPLOYER	20-City: FRESNO		21-State: CA		30-(Signed) _____ 31-(Date) 08/10/2016 ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE				
	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING						
	24-Address: 2667 EAST COLORADO		25-City: PASADENA						
	26-State: CA		27-Zip: 91107						
PHARMACY	28-Tel #: (626) 795-5881		29-Contact Name: _____		RECEIVED PHARMACY				
	32-ID: 1881712404		33-Qual: 01				40-ID: 1992964423		
	34-Name: MH Express Pharmacy		42-Last: Guerrero				41-Qual: 01		
	35-Address: 300 N. Lone Hill		43-First: Jaime				44-Address: 10841 WHITE OAK AVE		
PAYEE	36-City: San Dimas		37-State: CA		45-City: RANCHO CUCAMONGA				
	38-Zip: 91773		39-Tel #: (800) 500-8448		46-State: CA				
	49-ID: 95-4683977		50-Qual: 11		45-Tel #: (888) 824-2144				
	51-Name: MH Express Pharmacy		52-Address: PO Box 1168		57-Jurisdiction #1: _____				
53-City: Monrovia		54-State: CA		58-Jurisdiction #2: _____					
55-Zip: 91017		56-Tel #: (800)500-8448		59-Jurisdiction #3: _____					
58-Jurisdiction #4: _____		58-Jurisdiction #5: _____		60-Jurisdiction #4: _____					
58-Jurisdiction #5: _____		61-Jurisdiction #5: _____		61-Jurisdiction #5: _____					
CLAIM	62-Prescription/Service Ref. #		63-Qual.	64-Fil. #	65-Date Written <small>mm dd ccyy</small>	66-Date of Service <small>mm dd ccyy</small>	67-Submission Clarification	68-Prescription Origin	
	6653306		1	0	07/18/2016	08/10/2016		0	
	69-Product/Service ID		70-Qual.	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth #. Submitted	75-PA. Type	
	16714044802		03	30.00	30	0		0	
	76-Description			77-Strength			78-Unit Of Measure	79-Other Coverage	80-Delay Reason
	AMITRIPTYLINE HCL 50 MG TAB			50MG			EA	0	
	81-Other Payer ID		82-Qual	83-Other Payer Date <small>MM DD CCYY</small>	84-Other Payer Rejects		DUR / PPS / CODES 85-Reason / 86-Service / 87-Result		
	88-Level of Effort		89-Procedure Modifier	90-Dosage Form Description Code	91-Dispensing Unit Form Indicator	92-Route of Administration		93-Ingredient Component Count	
	COMPOUND	94-Product Name		95-Product ID		96-Qual	97-Ingredient Qty	98-Ingredient Drug Cost	99-Basis Cost
Pricing (Format (1,234.56))									
100-Usual & Customary Charge		101-Basis of Cost Det.	102-Ingredient Cost Submitted	103-Dispensing Fee Submitted	104-Other Amount Submitted	105-Sales Tax Submitted	106-Gross Amount Due (Submitted)		
\$10.57		01	\$10.57	\$0.00		\$0.00	\$10.57		
107-Patient Paid Amount		108-Other Payer Amount Paid	109-Other Payer Patient Resp. Amt.	110-Net Amount Due					
				\$10.57					


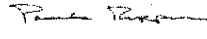
P A T I E N T	1-WC/P&C Indicator: WC		2-Date of Billing: <u>08/19/2016</u>		 NCPDP NATIONAL COUNCIL FOR PHARMACY PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div> SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <div style="text-align: right; margin-top: 10px;">  </div> 30-(Signed) _____ 31-(Date): <u>08/19/2016</u>									
	3-Last: DORAN		4-First: DANIEL											
5-Address: 281 S LAKE VIEW ST														
6-City: LONE PINE		7-State: CA												
8-Zip: 93545		9-Tel #: (760) 258-7545												
C A R R I E R	10-D.O.B: <u>06/04/1966</u>		11-D.O.I: <u>07/11/2012</u>		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE									
	12-I.D.: 554731885		13-Qualifier: <u>01</u>				14-Gender: <u>1</u>							
16-Jurisdictional State: CA														
17-Claim Ref #: 05814232														
18-Name: STATE COMPENSATION INS FUND														
E M P L O Y E R	19-Address: P.O. BOX 65005													
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29-Contact Name:														
P H A R M A C Y	32-ID: 1881712404		33-Qual: 01		40-ID: 1992964423		41-Qual: 01							
	34-Name: MH Express Pharmacy				42-Last: Guerrero									
35-Address: 300 N. Lone Hill				43-First: Jaime										
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38-Zip: 91773		45-City: RANCHO CUCAMONGA				46-State: CA								
39-Tel #: (800) 500-8448		47-Zip: 91730-3817				48-Tel #: (888) 824-2144								
P A Y E E	49-ID: 95-4683977		50-Qual: 11		57-Jurisdiction #1:									
	51-Name: MH Express Pharmacy				58-Jurisdiction #2:									
52-Address: PO Box 1168				59-Jurisdiction #3:										
53-City: Monrovia		54-State: CA		60-Jurisdiction #4:										
55-Zip: 91017		61-Jurisdiction #5:												
56-Tel #: (800)500-8448														
C L A I M	62-Prescription/Service Ref #		63-Qual		64-File #		65-Date Written		66-Date of Service		67-Submission Clarification		68-Prescription Origin	
	6655724		1		0		08/15/2016		08/19/2016				0	
	69-Product/Service ID		70-Qual		71-Quantity Dispensed		72-Days Supply		73-DAW Code		74-Prior Auth # Submitted		75-PA Type	
	16714033202		03		120.00		30		0				0	
	76-Description				77-Strength				78-Unit Of Measure		79-Other Coverage		80-Delay Reason	
	GABAPENTIN 800 MG TABLET				800MG				EA		0			
	81-Other Payer ID		82-Qual		83-Other Payer Date		84-Other Payer Rejects		DUR		DUR / PPS / CODES			
					MM DD CCYY						85-Reason / 86-Service / 87-Result			
	88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration		93-Ingredient Component Count			
C O M P O U N D	94-Product Name		95-Product ID				96-Qual		97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost	
Pricing (Format (1,234.56))														
100-Usual & Customary Charge		101-Basis of Cost Det.		102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted		105-Sales Tax Submitted		106-Gross Amount Due (Submitted)		
\$39.31		01		\$39.31		\$0.00				\$0.00		\$39.31		
107-Patient Paid Amount		108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.		110-Net Amount Due								
						\$39.31								


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 09/13/2016		 NCPDP NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. FOR OFFICE USE ONLY 15 (Document Control Number)		
	3-Last: DORAN		4-First: DANIEL				
	5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE				
CARRIER	7-State: CA		8-Zip: 93545		9-Tel #: (760) 258-7545		
	10-D.O.B.: 06/04/1966		11-D.O.I.: 07/11/2012		12-I.D.: 554731885		
	13-Qualifier: 01		14-Gender: 1		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  30-(Signed) _____ 31-(Date) 09/13/2016		
16-Jurisdictional State: CA		17-Claim Ref #: 05814232		18-Name: STATE COMPENSATION INS FUND			
19-Address: P.O. BOX 65005		20-City: FRESNO		21-State: CA			
EMPLOYER	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING		24-Address: 2667 EAST COLORADO		
	25-City: PASADENA		26-State: CA		27-Zip: 91107		
	28-Tel #: (626) 795-5881		29-Contact Name:		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE		
32-ID: 1881712404		33-Qual: 01		40-ID: 1437167863			
34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill		41-Qual: 01			
PHARMACY	36-City: San Dimas		37-State: CA		42-Last: BAKER		
	38-Zip: 91773		39-Tel #: (800) 500-8448		43-First: GARY		
	44-Address: 10841 WHITE OAK AVE		45-City: RANCHO CUCAMONGA		46-State: CA		
PAYEE	47-Zip: 91730-3817		48-Tel #: (888) 825-2144		57-Jurisdiction #1:		
	49-ID: 95-4683977		50-Qual: 11		58-Jurisdiction #2:		
	51-Name: MH Express Pharmacy		52-Address: PO Box 1168		59-Jurisdiction #3:		
CLAIM	53-City: Monrovia		54-State: CA		60-Jurisdiction #4:		
	55-Zip: 91017		56-Tel #: (800)500-8448		61-Jurisdiction #5:		
	62-Prescription/Service Ref. #		63-Qual.		64-Fill #		
65-Date Written mm dd ccyy		66-Date of Service mm dd ccyy		67-Submission Clarification			
68-Product/Service ID		70-Qual.		71-Quantity Dispensed			
72-Days Supply		73-DAW Code		74-Prior Auth #. Submitted			
75-PA. Type		76-Description		77-Strength			
78-Unit Of Measure		79-Other Coverage		80-Delay Reason			
81-Other Payer ID		82-Qual		83-Other Payer Date MM DD CCYY			
84-Other Payer Rejects		85-Reason		86-Service / 87-Result			
88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code			
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97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost			
100-Usual & Customary Charge		101-Basis of Cost Det.		102-Ingredient Cost Submitted			
103-Dispensing Fee Submitted		104-Other Amount Submitted		105-Sales Tax Submitted			
106-Gross Amount Due (Submitted)		107-Patient Paid Amount		108-Other Payer Amount Paid			
109-Other Payer Patient Resp. Amt.		110-Net Amount Due					

PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 09/13/2016		 NCPDP NATIONAL COUNCIL FOR PROFESSIONAL DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. FOR OFFICE USE ONLY 15 (Document Control Number)			
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	5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE				7-State: CA	
CARRIER	8-Zip: 93545		9-Tel #: (760) 258-7545		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  09/13/2016 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE			
	10-D.O.B: 06/04/1966		11-D.O.I.: 07/11/2012					
	12-I.D.: 554731885		13-Qualifier: 01				14-Gender: 1	
EMPLOYER	16-Jurisdictional State: CA		17-Claim Ref #: 05814232		23-Name: BENEDICT & BENEDICT PLUMBING 24-Address: 2667 EAST COLORADO 25-City: PASADENA 26-State: CA 27-Zip: 91107 28-Tel #: (626) 795-5881 29-Contact Name: _____			
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005					
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PHARMACY	32-ID: 1881712404		33-Qual: 01		40-ID: 1992964423		41-Qual: 01	
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PAYEE	38-Zip: 91773		39-Tel #: (800) 500-8448		46-State: CA		47-Zip: 91730-3817	
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	51-Name: MH Express Pharmacy		52-Address: PO Box 1168		53-City: Monrovia		54-State: CA	
55-Zip: 91017		56-Tel #: (800)500-8448		58-Jurisdiction #2: _____		59-Jurisdiction #3: _____		
60-Jurisdiction #4: _____		61-Jurisdiction #5: _____		62-Prescription/ Service Ref. #		63-Qual.		
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85-Reason / 86-Service / 87-Result		88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code		
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99-Basis Cost		100-Usual & Customary Charge		101-Basis of Cost Det.		102-Ingredient Cost Submitted		
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107-Patient Paid Amount		108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.		110-Net Amount Due		

P A T I E N T	1-WC/P&C Indicator: WC		2-Date of Billing: 10/11/2016		 <p>National Council for Prescription Drug Programs</p> <p>NCPDP</p> <p>WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009</p> <p>© 2008-2009. All rights reserved.</p> <p>FOR OFFICE USE ONLY 15 (Document Control Number)</p>																																				
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C A R R I E R	10-D.O.B.: 06/04/1966		11-D.O.I.: 07/11/2012		<p>SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</p> <p><i>[Signature]</i> 10/11/2016</p> <p>30-(Signed) 31-(Date)</p> <p>ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE</p>																																				
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	16-Jurisdictional State: CA		21-State: CA																																						
	17-Claim Ref #: 05814232		22-Zip: 93650-5005																																						
E M P L O Y E R	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005		<p>23-Name: BENEDICT & BENEDICT PLUMBING</p> <p>24-Address: 2667 EAST COLORADO</p> <p>25-City: PASADENA</p> <p>26-State: CA</p> <p>27-Zip: 91107</p> <p>28-Tel #: (626) 795-5881</p> <p>29-Contact Name:</p>																																				
	20-City: FRESNO		21-State: CA																																						
	32-ID: 1881712404		33-Qual: 01																																						
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P H A R M A C Y	36-City: San Dimas		37-State: CA		<p>40-ID: 1437167863</p> <p>41-Qual: 01</p> <p>42-Last: BAKER</p> <p>43-First: GARY</p> <p>44-Address: 10841 WHITE OAK AVE</p> <p>45-City: RANCHO CUCAMONGA</p> <p>46-State: CA</p> <p>47-Zip: 91730-3817</p> <p>48-Tel #: (888) 825-2144</p>																																				
	38-Zip: 91773		39-Tel #: (800) 500-8448																																						
	49-ID: 95-4683977		50-Qual: 11																																						
	51-Name: MH Express Pharmacy		52-Address: PO Box 1168																																						
P A Y E E	53-City: Monrovia		54-State: CA		<p>57-Jurisdiction #1:</p> <p>58-Jurisdiction #2:</p> <p>59-Jurisdiction #3:</p> <p>60-Jurisdiction #4:</p> <p>61-Jurisdiction #5:</p>																																				
	55-Zip: 91017		56-Tel #: (800)500-8448																																						
	62-Prescription/Service Ref. #		63-Qual.				64-Fill #		65-Date Written mm dd ccyy		66-Date of Service mm dd ccyy		67-Submission Clarification		68-Prescription Origin																										
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C L A I M	69-Product/Service ID		70-Qual.		71-Quantity Dispensed		72-Days Supply		73-DAW Code		74-Prior Auth # Submitted		75-PA Type																												
	16714033202		03		120.00		30		0				0																												
	76-Description				77-Strength				78-Unit Of Measure		79-Other Coverage		80-Delay Reason																												
	GABAPENTIN 800 MG TABLET				800MG				EA		0																														
	81-Other Payer ID		82-Qual		83-Other Payer Date MM DD CCYY		84-Other Payer Rejects		DUR		DUR / PPS / CODES 85-Reason / 86-Service / 87-Result																														
	86-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration			93-Ingredient Component Count																													
C O M P O U N D	94-Product Name		95-Product ID				96-Qual		97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost																												
<p>Pricing (Format 1,234.56)</p> <table border="1"> <tr> <td>100-Usual & Customary Charge</td> <td>101-Basis of Cost Det.</td> <td>102-Ingredient Cost Submitted</td> <td>103-Dispensing Fee Submitted</td> <td>104-Other Amount Submitted</td> <td>105-Sales Tax Submitted</td> <td>106-Gross Amount Due (Submitted)</td> </tr> <tr> <td>\$1,062.21</td> <td>01</td> <td>\$1,062.21</td> <td>\$7.25</td> <td></td> <td>\$0.00</td> <td>\$1,062.21</td> </tr> <tr> <td>107-Patient Paid Amount</td> <td>108-Other Payer Amount Paid</td> <td>109-Other Payer Patient Resp. Amt.</td> <td colspan="4">110-Net Amount Due</td> </tr> <tr> <td></td> <td></td> <td></td> <td colspan="4">\$1,062.21</td> </tr> </table>														100-Usual & Customary Charge	101-Basis of Cost Det.	102-Ingredient Cost Submitted	103-Dispensing Fee Submitted	104-Other Amount Submitted	105-Sales Tax Submitted	106-Gross Amount Due (Submitted)	\$1,062.21	01	\$1,062.21	\$7.25		\$0.00	\$1,062.21	107-Patient Paid Amount	108-Other Payer Amount Paid	109-Other Payer Patient Resp. Amt.	110-Net Amount Due							\$1,062.21			
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			\$1,062.21																																						

P A T I E N T	1-WC/P&C Indicator: WC		2-Date of Billing: <u>10/19/2016</u>		 NCPDP NATIONAL COUNCIL for Prescription Drug Programs WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.	
	3-Last: DORAN		4-First: DANIEL			
	5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE			
C A R R I E R	7-State: CA		8-Zip: 93545		FOR OFFICE USE ONLY 15 (Document Control Number)	
	9-Tel #: (760) 258-7545		10-D.O.B: <u>06/04/1966</u>			
	11-D.O.I: <u>07/11/2012</u>		12-I.D.: 554731885			
E M P L O Y E R	13-Qualifier: 01		14-Gender: 1		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  10/19/2016 30-(Signed) 10/19/2016 31-(Date)	
	16-Jurisdictional State: CA		17-Claim Ref #: 05814232			
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005			
P H A R M A C Y	20-City: FRESNO		21-State: CA		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING			
	24-Address: 2667 EAST COLORADO		25-City: PASADENA			
P A Y E E	26-State: CA		27-Zip: 91107		A T T E S T A T I O N	
	28-Tel #: (626) 795-5881		29-Contact Name:			
	32-ID: 1881712404		33-Qual: 01			
P H A R M A C Y	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill		A T T E S T A T I O N	
	36-City: San Dimas		37-State: CA			
	38-Zip: 91773		39-Tel #: (800) 500-8448			
P A Y E E	40-ID: 1437167863		41-Qual: 01		A T T E S T A T I O N	
	42-Last: BAKER		43-First: GARY			
	44-Address: 10841 WHITE OAK AVE		45-City: RANCHO CUCAMONGA			
P A Y E E	46-State: CA		47-Zip: 91730-3817		A T T E S T A T I O N	
	48-Tel #: (888) 825-2144		49-ID: 95-4683977			
	50-Qual: 11		51-Name: MH Express Pharmacy			
C L A I M	52-Address: PO Box 1168		53-City: Monrovia		A T T E S T A T I O N	
	54-State: CA		55-Zip: 91017			
	56-Tel #: (800)500-8448		57-Jurisdiction #1:			
C L A I M	58-Jurisdiction #2:		59-Jurisdiction #3:		A T T E S T A T I O N	
	60-Jurisdiction #4:		61-Jurisdiction #5:			
	62-Prescription Service Ref. #		63-Qual:			
C L A I M	64-Fill #		65-Date Written		A T T E S T A T I O N	
	66-Date of Service		67-Submission Clarification			
	68-Prescription Origin		69-Product/Service ID			
C L A I M	70-Qual:		71-Quantity Dispensed		A T T E S T A T I O N	
	72-Days Supply		73-DAW Code			
	74-Prior Auth #. Submitted		75-PA. Type			
C L A I M	76-Description		77-Strength		A T T E S T A T I O N	
	78-Unit Of Measure		79-Other Coverage			
	80-Delay Reason		81-Other Payer ID			
C L A I M	82-Qual		83-Other Payer Date		A T T E S T A T I O N	
	84-Other Payer Rejects		85-Reason / 86-Service / 87-Result			
	88-Level of Effort		89-Procedure Modifier			
C L A I M	90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		A T T E S T A T I O N	
	92-Route of Administration		93-Ingredient Component Count			
	94-Product Name		95-Product ID			
C L A I M	96-Qual		97-Ingredient Qty		A T T E S T A T I O N	
	98-Ingredient Drug Cost		99-Basis Cost			
	100-Usual & Customary Charge		101-Basis of Cost Det.			
C L A I M	102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		A T T E S T A T I O N	
	104-Other Amount Submitted		105-Sales Tax Submitted			
	106-Gross Amount Due (Submitted)		107-Patient Paid Amount			
C L A I M	108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.		A T T E S T A T I O N	
	110-Net Amount Due		111-Net Amount Due			
	112-Net Amount Due		113-Net Amount Due			


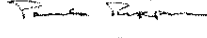
PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 11/07/2016		 NCPDP NATIONAL Council for Prescription Drug Programs WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.			
	3-Last: DORAN		4-First: DANIEL				FOR OFFICE USE ONLY 15 (Document Control Number)	
	5-Address: 281 S LAKE VIEW ST							
CARRIER	6-City: LONE PINE		7-State: CA		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  11/07/2016 30-(Signed) _____ 31-(Date) _____			
	8-Zip: 93545		9-Tel #: (760) 258-7545					
	10-D.O.B: 06/04/1966		11-D.O.I: 07/11/2012					
EMPLOYER	12-I.D.: 554731885		13-Qualifier: 01		14-Gender: 1			
	16-Jurisdictional State: CA							
	17-Claim Ref #: 05814232							
PHARMACY	18-Name: STATE COMPENSATION INS FUND							
	19-Address: P.O. BOX 65005							
	20-City: FRESNO		21-State: CA					
PAYEE	22-Zip: 93650-5005							
	23-Name: BENEDICT & BENEDICT PLUMBING							
	24-Address: 2667 EAST COLORADO							
PHARMACY	25-City: PASADENA		26-State: CA					
	27-Zip: 91107		28-Tel #: (626) 795-5881					
	29-Contact Name:							
PHARMACY	32-ID: 1881712404		33-Qual: 01		40-ID: 1437167863			
	34-Name: MH Express Pharmacy		42-Last: BAKER		41-Qual: 01			
	35-Address: 300 N. Lone Hill		43-First: GARY		44-Address: 10841 WHITE OAK AVE			
PHARMACY	36-City: San Dimas		37-State: CA		45-City: RANCHO CUCAMONGA			
	38-Zip: 91773		46-State: CA		47-Zip: 91730-3817			
	39-Tel #: (800) 500-8448		48-Tel #: (888) 825-2144		49-Name: MH Express Pharmacy			
PHARMACY	51-Name: MH Express Pharmacy		50-Qual: 11		57-Jurisdiction #1:			
	52-Address: PO Box 1168		53-City: Monrovia		58-Jurisdiction #2:			
	53-City: Monrovia		54-State: CA		59-Jurisdiction #3:			
PHARMACY	55-Zip: 91017		56-Tel #: (800)500-8448		60-Jurisdiction #4:			
	62-Prescription/Service Ref. #		63-Qual:		64-Fill #			
	65-Date Written		66-Date of Service		67-Submission Clarification			
68-Prescription Origin		69-Product/Service ID		70-Qual:				
71-Quantity Dispensed		72-Days Supply		73-DAW Code				
74-Prior Auth # Submitted		75-PA Type		76-Description				
77-Strength		78-Unit Of Measure		79-Other Coverage				
80-Delay Reason		81-Other Payer ID		82-Qual:				
83-Other Payer Date		84-Other Payer Rejects		85-Reason / 86-Service / 87-Result				
88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code				
91-Dispensing Unit Form Indicator		92-Route of Administration		93-Ingredient Component Count				
94-Product Name		95-Product ID		96-Qual:				
97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost				
Pricing (Format 1.234.56)								
100-Usual & Customary Charge		101-Basis of Cost Det.		102-Ingredient Cost Submitted				
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106-Gross Amount Due (Submitted)		107-Patient Paid Amount		108-Other Payer Amount Paid				
109-Other Payer Patient Resp. Amt.		110-Net Amount Due						


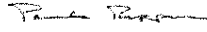
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	3-Last: DORAN		4-First: DANIEL											
	5-Address: 281 S LAKE VIEW ST		7-State: CA											
CARRIER	6-City: LONE PINE		8-Zip: 93545		9-Tel #: (760) 258-7545									
	10-D.O.B.: 06/04/1966 <small>mm dd ccyy</small>		11-D.O.I.: 07/11/2012 <small>mm dd ccyy</small>		13-Qualifier: 01									
	12-I.D.: 554731885		14-Gender: 1		FOR OFFICE USE ONLY 15 (Document Control Number)									
16-Jurisdictional State: CA		17-Claim Ref #: 05814232												
18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005												
EMPLOYER	20-City: FRESNO		21-State: CA		22-Zip: 93650-5005									
	23-Name: BENEDICT & BENEDICT PLUMBING		24-Address: 2667 EAST COLORADO		25-City: PASADENA									
	26-State: CA		27-Zip: 91107		28-Tel #: (626) 795-5881									
PHARMACY	32-ID: 1881712404		33-Qual: 01		40-ID: 1437167863									
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PAYEE	38-Zip: 91773		39-Tel #: (800) 500-8448		44-Address: 10841 WHITE OAK AVE									
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53-City: Monrovia		54-State: CA		47-Zip: 91730-3817										
55-Zip: 91017		56-Tel #: (800)500-8448		48-Tel #: (888) 825-2144										
57-Jurisdiction #1:		58-Jurisdiction #2:		59-Jurisdiction #3:										
60-Jurisdiction #4:		61-Jurisdiction #5:												
CLAIM	62-Prescription/Service Ref. #		63-Qual.		64-Fill #		65-Date Written <small>mm dd ccyy</small>		66-Date of Service <small>mm dd ccyy</small>		67-Submission Clarification		68-Prescription Origin	
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	69-Product/Service ID		70-Qual.		71-Quantity Dispensed		72-Days Supply		73-DAW Code		74-Prior Auth # Submitted		75-PA Type	
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	76-Description				77-Strength				78-Unit Of Measure		79-Other Coverage		80-Delay Reason	
	AMITRIPTYLINE HCL 50 MG TAB				50MG				EA		0			
	81-Other Payer ID		82-Qual		83-Other Payer Date <small>MM DD CCYY</small>		84-Other Payer Rejects		DUR		85-Reason / 86-Service / 87-Result			
	88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration		93-Ingredient Component Count			
	COMPOUND	94-Product Name		95-Product ID				96-Qual		97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost
1														
2														
3														
4														
5														
6														
7														
Pricing (Format 11,234.56)														
100-Usual & Customary Charge		101-Basis of Cost Del.		102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted		105-Sales Tax Submitted		106-Gross Amount Due (Submitted)		
\$85.93		01		\$85.93		\$7.25				\$0.00		\$85.93		
107-Patient Paid Amount		108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.		110-Net Amount Due								
						\$85.93								


SIGNATURE OF PROVIDER
 (I certify that the statements on the reverse apply to this bill and are made a part thereof.)


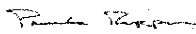
[Signature] 11/14/2016
 30-(Signed) 31-(Date)


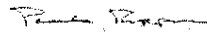
ATTENTION PROVIDER!
 PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE


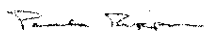
PATIENT CARRIER EMPLOYER PHARMACY PAYEE CLAIM COMPOUND	1-WC/F&C Indicator: WC		2-Date of Billing: <u>12/05/2016</u>		 NCPDP NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div> SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  12/05/2016 30-(Signed) _____ 31-(Date) _____ <div style="background-color: #cccccc; padding: 5px; text-align: center; font-weight: bold;"> ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE </div>			
	3-Last: DORAN		4-First: DANIEL					
	5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE				7-State: CA	
	8-Zip: 93545		9-Tel #: (760) 258-7545				10-D.O.B: <u>06/04/1966</u>	
11-D.O.I: <u>07/11/2012</u>		12-I.D.: 554731885		13-Qualifier: 01		14-Gender: 1		
16-Jurisdictional State: CA		17-Claim Ref #: 05814232		18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005		
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28-Tel #: (626) 795-5881		29-Contact Name: _____		32-ID: 1881712404		33-Qual: 01		
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38-Zip: 91773		39-Tel #: (800) 500-8448		40-ID: 1437167863		41-Qual: 01		
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70-Qual		71-Quantity Dispensed		72-Days Supply		73-DAW Code		
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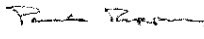
PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: <u>12/21/2016</u>		 NCPDP NATIONAL COUNCIL ON THE FUTURE OF DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.		
	3-Last: DORAN		4-First: DANIEL				
	5-Address: 281 S LAKE VIEW ST		7-State: CA				
CARRIER	6-City: LONE PINE		8-Zip: 93545		9-Tel #: (760) 258-7545		
	10-D.O.B: <u>06/04/1966</u>		11-D.O.I: <u>07/11/2012</u>		13-Qualifier: 01		
	12-I.D.: 554731885		14-Gender: I		FOR OFFICE USE ONLY 15 (Document Control Number)		
16-Jurisdictional State: CA		17-Claim Ref #: 05814232		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  12/21/2016 30-(Signed) _____ 31-(Date) _____			
18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005					
20-City: FRESNO		21-State: CA					
EMPLOYER	23-Name: BENEDICT & BENEDICT PLUMBING		24-Address: 2667 EAST COLORADO		25-City: PASADENA		
	26-State: CA		27-Zip: 91107		28-Tel #: (626) 795-5881		
	29-Contact Name:		30-(Signed)		31-(Date)		
PHARMACY	32-ID: 1881712404		33-Qual: 01		40-ID: 1437167863		
	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill		42-Last: BAKER		
	36-City: San Dimas		37-State: CA		43-First: GARY		
PAYEE	38-Zip: 91773		39-Tel #: (800) 500-8448		44-Address: 10841 WHITE OAK AVE		
	49-ID: 95-4683977		50-Qual: 11		45-City: RANCHO CUCAMONGA		
	51-Name: MH Express Pharmacy		52-Address: PO Box 1168		46-State: CA		
53-City: Monrovia		54-State: CA		47-Zip: 91730-3817			
55-Zip: 91017		56-Tel #: (800)500-8448		48-Tel #: (888) 825-2144			
CLAIM	62-Prescription/Service Ref #		63-Qual		64-Fill #		
	65-Date Written mm dd cyyy		66-Date of Service mm dd cyyy		67-Submission Clarification		
	68-Prescription Origin		69-Product/Service ID		70-Qual		
	71-Quantity Dispensed		72-Days Supply		73-DAW Code		
	74-Prior Auth # Submitted		75-PA Type		76-Description		
	77-Strength		78-Unit Of Measure		79-Other Coverage		
	80-Delay Reason		81-Other Payer ID		82-Qual		
	83-Other Payer Date MM DD CYY		84-Other Payer Rejects		85-Reason / 86-Service / 87-Result		
	88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code		
	91-Dispensing Unit Form Indicator		92-Route of Administration		93-Ingredient Component Count		
COMPOUND	94-Product Name		95-Product ID		96-Qual		
	97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost		
	100-Usual & Customary Charge		101-Basis of Cost Det.		102-Ingredient Cost Submitted		
	103-Dispensing Fee Submitted		104-Other Amount Submitted		105-Sales Tax Submitted		
	106-Gross Amount Due (Submitted)		107-Patient Paid Amount		108-Other Payer Amount Paid		
	109-Other Payer Patient Resp. Amt		110-Net Amount Due		111-Net Amount Due		
	112-Net Amount Due		113-Net Amount Due		114-Net Amount Due		


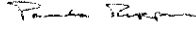
PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: <u>01/24/2017</u>		 NCPDP NATIONAL COUNCIL FOR PHARMAGENCY PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.				
	3-Last: DORAN		4-First: DANIEL						
	5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE				7-State: CA		
	8-Zip: 93545		9-Tel #: (760) 258-7545				10-D.O.B: 06/04/1966		
CARRIER	11-D.O.I: 07/11/2012		13-Qualifier: 01		14-Gender: 1				
	16-Jurisdictional State: CA		17-Claim Ref #: 05814232		FOR OFFICE USE ONLY 15 (Document Control Number)				
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005						
	20-City: FRESNO		21-State: CA						
22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING							
EMPLOYER	24-Address: 2667 EAST COLORADO		25-City: PASADENA		26-State: CA				
	27-Zip: 91107		28-Tel #: (626) 795-5881		29-Contact Name:				
	30-(Signed) <i>[Signature]</i>		31-(Date) 01/24/2017		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE				
	32-ID: 1881712404		33-Qual: 01						
34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill							
36-City: San Dimas		37-State: CA							
PHARMACY	38-Zip: 91773		39-Tel #: (800) 500-8448		40-ID: 1437167863				
	41-Last: BAKER		42-First: GARY		43-Address: 10841 WHITE OAK AVE				
	44-City: RANCHO CUCAMONGA		45-State: CA		46-Address: 10841 WHITE OAK AVE				
	47-Zip: 91730-3817		48-Tel #: (888) 825-2144		49-ID: 95-4683977				
PAYEE	50-Qual: 11		51-Name: MH Express Pharmacy		52-Address: PO Box 1168				
	53-City: Monrovia		54-State: CA		55-Zip: 91017				
	56-Tel #: (800)500-8448		57-Jurisdiction #1:		58-Jurisdiction #2:				
	59-Jurisdiction #3:		60-Jurisdiction #4:		61-Jurisdiction #5:				
CLAIM	62-Prescription/Service Ref. #		63-Qual.	64-Fill #	65-Date Written mm dd ccyy	66-Date of Service mm dd ccyy	67-Submission Clarification	68-Prescription Origin	
	99514174		I	1	12/04/2016	01/24/2017		0	
	69-Product/Service ID		70-Qual.	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth #. Submitted	75-PA. Type	
	16714044802		03	30.00	30	0		0	
	76-Description			77-Strength		78-Unit Of Measure	79-Other Coverage	80-Delay Reason	
	AMITRIPTYLINE HCL 50 MG TAB			50MG		EA	0		
	81-Other Payer ID		82-Qual	83-Other Payer Date MM DD CCYY		84-Other Payer Rejects		DUR / PPS / CODES	
								85-Reason / 86-Service / 87-Result	
	88-Level of Effort	89-Procedure Modifier	90-Dosage Form Description Code		91-Dispensing Unit Form Indicator	92-Route of Administration		93-Ingredient Component Count	
COMPOUND	94-Product Name		95-Product ID		96-Qual	97-Ingredient Qty	98-Ingredient Drug Cost	99-Basis Cost	
Pricing (Format (1,234.56))									
100-Usual & Customary Charge		101-Basis of Cost Det.		102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted	
\$85.93		01		\$85.93		\$7.25		\$0.00	
105-Sales Tax Submitted		106-Gross Amount Due (Submitted)		107-Patient Paid Amount		108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.	
\$0.00		\$85.93						\$85.93	
110-Net Amount Due									
\$85.93									


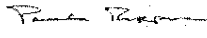
PATIENT	1-WC/F&C Indicator: WC		2-Date of Billing: <u>01/24/2017</u>		 NATIONAL COUNCIL for Prescription Drug Programs NCPDP WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div>		
	3-Last: <u>DORAN</u>	4-First: <u>DANIEL</u>					
	5-Address: <u>281 S LAKE VIEW ST</u>						
CARRIER	6-City: <u>LONE PINE</u>	7-State: <u>CA</u>			SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <div style="text-align: right;">  <u>01/24/2017</u> 30-(Signed) _____ 31-(Date) _____ </div>		
	8-Zip: <u>93545</u>	9-Tel #: <u>(760) 258-7545</u>					
	10-D.O.B: <u>06/04/1966</u>	11-D.O.I: <u>07/11/2012</u>					
EMPLOYER	12-I.D.: <u>554731885</u>	13-Qualifier: <u>01</u>	14-Gender: <u>1</u>				
	16-Jurisdictional State: <u>CA</u>						
	17-Claim Ref #: <u>05814232</u>						
PHARMACY	18-Name: <u>STATE COMPENSATION INS FUND</u>				ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE		
	19-Address: <u>P.O. BOX 65005</u>						
	20-City: <u>FRESNO</u>	21-State: <u>CA</u>					
PAYEE	23-Name: <u>BENEDICT & BENEDICT PLUMBING</u>						
	24-Address: <u>2667 EAST COLORADO</u>						
	25-City: <u>PASADENA</u>	26-State: <u>CA</u>					
PHARMACY	32-ID: <u>1881712404</u>	33-Qual: <u>01</u>			40-ID: <u>1437167863</u>	41-Qual: <u>01</u>	
	34-Name: <u>MH Express Pharmacy</u>				42-Last: <u>BAKER</u>		
	35-Address: <u>300 N. Lone Hill</u>				43-First: <u>GARY</u>		
PAYEE	51-Name: <u>MH Express Pharmacy</u>		50-Qual: <u>11</u>		57-Jurisdiction #1:		
	52-Address: <u>PO Box 1168</u>				58-Jurisdiction #2:		
	53-City: <u>Monrovia</u>		54-State: <u>CA</u>		59-Jurisdiction #3:		
CLAIM	62-Prescription/Service Ref. #		63-Qual:	64-Fil. #	65-Date Written	66-Date of Service	
	<u>99514175</u>		<u>1</u>	<u>1</u>	<u>12/04/2016</u>	<u>01/24/2017</u>	
	69-Product/Service ID		70-Qual:	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth #. Submitted
COMPOUND	<u>16714033202</u>		<u>03</u>	<u>120.00</u>	<u>30</u>	<u>0</u>	
	76-Description		77-Strength		78-Unit Of Measure	79-Other Coverage	80-Delay Reason
	<u>GABAPENTIN 800 MG TABLET</u>		<u>800MG</u>		<u>EA</u>	<u>0</u>	
COMPOUND	81-Other Payer ID		82-Qual:	83-Other Payer Date	84-Other Payer Rejects		
				<u>MM DD CCYY</u>			
88-Level of Effort		89-Procedure Modifier	90-Dosage Form Description Code	91-Dispensing Unit Form Indicator	92-Route of Administration		
93-Ingredient Component Count							
Pricing (Format (1.234.56))							
100-Usual & Customary Charge	101-Basis of Cost Det.	102-Ingredient Cost Submitted	103-Dispensing Fee Submitted	104-Other Amount Submitted	105-Sales Tax Submitted	106-Gross Amount Due (Submitted)	
<u>\$1,062.21</u>	<u>01</u>	<u>\$1,062.21</u>	<u>\$7.25</u>		<u>\$0.00</u>	<u>\$1,062.21</u>	
107-Patient Paid Amount	108-Other Payer Amount Paid	109-Other Payer Patient Resp. Amt.	110-Net Amount Due				
			<u>\$1,062.21</u>				


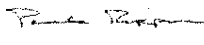
	1-WC/P&C Indicator: WC	2-Date of Billing: 02/20/2017	 NCPDP NATIONAL COUNCIL ON THE PHARMACY AND DRUG PROGRAMS					
PATIENT	3-Last: DORAN	4-First: DANIEL	WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. FOR OFFICE USE ONLY 15 (Document Control Number)					
	5-Address: 281 S LAKE VIEW ST							
	6-City: LONE PINE	7-State: CA						
	8-Zip: 93545	9-Tel #: (760) 258-7545						
	10-D.O.B: 06/04/1966	11-D.O.I: 07/11/2012	SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  02/20/2017 30-(Signed) _____ 31-(Date) _____					
12-I.D.:	554731885	13-Qualifier: 01				14-Gender: 1		
16-Jurisdictional State: CA								
17-Claim Ref #: 05814232								
CARRIER	18-Name: STATE COMPENSATION INS FUND		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE					
	19-Address: P.O. BOX 65005							
	20-City: FRESNO	21-State: CA						
	22-Zip: 93650-5005							
EMPLOYER	23-Name: BENEDICT & BENEDICT PLUMBING		REMOVED TO COVER 20-CO-2017					
	24-Address: 2667 EAST COLORADO							
	25-City: PASADENA	26-State: CA						
	27-Zip: 91107	28-Tel #: (626) 795-5881						
PHARMACY	32-ID: 1881712404	33-Qual: 01	40-ID: 1992964423	41-Qual: 01				
	34-Name: MH Express Pharmacy		42-Last: Guerrero					
	35-Address: 300 N. Lone Hill		43-First: Jaime					
	36-City: San Dimas	37-State: CA	44-Address: 10841 WHITE OAK AVE					
	38-Zip: 91773		45-City: RANCHO CUCAMONGA					
	39-Tel #: (800) 500-8448		46-State: CA					
			47-Zip: 91730-3817					
			48-Tel #: (888) 824-2144					
PAYEE	49-ID: 95-4683977	50-Qual: 11	57-Jurisdiction #1:					
	51-Name: MH Express Pharmacy		58-Jurisdiction #2:					
	52-Address: PO Box 1168		59-Jurisdiction #3:					
	53-City: Monrovia	54-State: CA	60-Jurisdiction #4:					
	55-Zip: 91017		61-Jurisdiction #5:					
	56-Tel #: (800)500-8448							
CLAIM	62-Prescription/Service Ref. #	63-Qual.	64-Fill #	65-Date Written mm dd ccyy	66-Date of Service mm dd ccyy	67-Submission Clarification	68-Prescription Origin	
	99533766	1	0	01/29/2017	02/20/2017		0	
	69-Product/Service ID	70-Qual.	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth #. Submitted	75-PA. Type	
	16714033202	03	120.00	30	0		0	
	76-Description		77-Strength		78-Unit Of Measure	79-Other Coverage	80-Delay Reason	
	GABAPENTIN 800 MG TABLET		800MG		EA	0		
	81-Other Payer ID	82-Qual.	83-Other Payer Date MM DD CCYY	84-Other Payer Rejects		DUR / PPS / CODES		
						85-Reason / 86-Service / 87-Result		
	88-Level of Effort	89-Procedure Modifier	90-Dosage Form Description Code	91-Dispensing Unit Form Indicator	92-Route of Administration		93-Ingredient Component Count	
COMPONENT	94-Product Name	95-Product ID	96-Qual	97-Ingredient Qty	98-Ingredient Drug Cost	99-Basis Cost		
	1							
	2							
	3							
	4							
	5							
	6							
	7							
Pricing (Format (1,234.56))								
100-Usual & Customary Charge	101-Basis of Cost Det.	102-Ingredient Cost Submitted	103-Dispensing Fee Submitted	104-Other Amount Submitted	105-Sales Tax Submitted	106-Gross Amount Due (Submitted)		
\$1,062.21	01	\$1,062.21	\$7.25		\$0.00	\$1,062.21		
107-Patient Paid Amount	108-Other Payer Amount Paid	109-Other Payer Patient Resp. Amt.	110-Net Amount Due					
			\$1,062.21					


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 02/21/2017		 NCPDP NATIONAL COUNCIL FOR PHARMACY PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div>					
	3-Last: DORAN		4-First: DANIEL							
	5-Address: 281 S LAKE VIEW ST		7-State: CA							
	6-City: LONE PINE		9-Tel #: (760) 258-7545							
CARRIER	8-Zip: 93545		10-D.O.B: 06/04/1966		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  02/21/2017 30-(Signed) _____ 31-(Date) _____ <div style="background-color: #cccccc; padding: 5px; text-align: center; font-weight: bold;"> ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE </div>					
	11-P.O.I: 07/11/2012		13-Qualifier: 01							
	12-I.D.: 554731885		14-Gender: 1							
	16-Jurisdictional State: CA		17-Claim Ref #: 05814232							
JOYER	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005		23-Name: BENEDICT & BENEDICT PLUMBING 24-Address: 2667 EAST COLORADO 25-City: PASADENA 26-State: CA 27-Zip: 91107 28-Tel #: (626) 795-5881 29-Contact Name: _____					
	20-City: FRESNO		21-State: CA							
	22-Zip: 93650-5005									
PHARMACY	32-ID: 1881712404		33-Qual: 01		PHARMACY					
	34-Name: MH Express Pharmacy		40-ID: 1992964423							
	35-Address: 300 N. Lone Hill		41-Qual: 01							
	36-City: San Dimas		42-Last: Guerrero							
PAYEE	37-State: CA		43-First: Jaime		PAYEE					
	38-Zip: 91773		44-Address: 10841 WHITE OAK AVE							
	39-Tel #: (800) 500-8448		45-City: RANCHO CUCAMONGA							
			46-State: CA							
49-ID: 95-4683977		50-Qual: 11		47-Zip: 91730-3817						
51-Name: MH Express Pharmacy		57-Jurisdiction #1: _____		48-Tel #: (888) 824-2144						
52-Address: PO Box 1168		58-Jurisdiction #2: _____		59-Jurisdiction #3: _____						
53-City: Monrovia		54-State: CA		60-Jurisdiction #4: _____						
55-Zip: 91017		61-Jurisdiction #5: _____		61-Jurisdiction #5: _____						
56-Tel #: (800)500-8448										
CLAIM	62-Prescription/Service Ref. #		63-Qual	64-File #	65-Date Written mm dd cyyy	66-Date of Service mm dd cyyy	67-Submission Clarification	68-Prescription Origin		
	99533765		1	0	01/29/2017	02/21/2017		0		
	69-Product/Service ID		70-Qual	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth # Submitted	75-PA Type		
	16714044802		03	30.00	30	0		0		
	76-Description				77-Strength		78-Unit Of Measure	79-Other Coverage	80-Delay Reason	
	AMITRIPTYLINE HCL 50 MG TAB				50MG		EA	0		
	81-Other Payer ID		82-Qual	83-Other Payer Date MM DD CYY Y		84-Other Payer Rejects		DUR / PPS / CODES		
								85-Reason / 86-Service / 87-Result		
	88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration	93-Ingredient Component Count
COMPOND	94-Product Name		95-Product ID		96-Qual	97-Ingredient Qty	98-Ingredient Drug Cost	99-Basis Cost		
Pricing (Format 1,234.56)										
100-Usual & Customary Charge		101-Basis of Cost Det.		102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted		
\$85.93		01		\$85.93		\$7.25		\$0.00		
105-Sales Tax Submitted		106-Gross Amount Due (Submitted)		107-Patient Paid Amount		108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.		
\$0.00		\$85.93						\$85.93		
								110-Net Amount Due		
								\$85.93		


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: <u>03/15/2017</u> <small>mm dd cyyr</small>		 NCPDP NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div>	
	3-Last: DORAN		4-First: DANIEL			
	5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE			
	7-State: CA		8-Zip: 93545			
CARRIER/EMPLOYER	10-D.O.B: <u>06/04/1966</u> <small>mm dd cyyr</small>		9-Tel #: <u>(760) 258-7545</u>		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  03/15/2017 30-(Signed) _____ 31-(Date) _____ <div style="background-color: #cccccc; padding: 5px; text-align: center; font-weight: bold;"> ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE </div>	
	12-I.D.: 554731885		11-D.O.I: <u>07/11/2012</u> <small>mm dd cyyr</small>			
	13-Qualifier: 01		14-Gender: 1			
	16-Jurisdictional State: CA		17-Claim Ref #: 05814232			
PHARMACY	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005		PHARMACY	
	20-City: FRESNO		21-State: CA			
	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING			
	24-Address: 2667 EAST COLORADO		25-City: PASADENA			
PAYEE	26-State: CA		27-Zip: 91107		PAYEE	
	28-Tel #: (626) 795-5881		29-Contact Name:			
	32-ID: 1881712404		33-Qual: 01			
	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill			
CLAIM	36-City: San Dimas		37-State: CA		CLAIM	
	38-Zip: 91773		39-Tel #: (800) 500-8448			
	40-ID: 1992964423		41-Qual: 01			
	42-Last: Guerrero		43-First: Jaime			
COMPOUND	44-Address: 10841 WHITE OAK AVE		45-City: RANCHO CUCAMONGA		COMPOUND	
	46-State: CA		47-Zip: 91730-3817			
	48-Tel #: (888) 824-2144		49-ID: 95-4683977			
	50-Qual: 11		51-Name: MH Express Pharmacy			
52-Address: PO Box 1168		53-City: Monrovia		54-State: CA		
55-Zip: 91017		56-Tel #: (800)500-8448		57-Jurisdiction #1:		
58-Jurisdiction #2:		59-Jurisdiction #3:		60-Jurisdiction #4:		
61-Jurisdiction #5:		62-Prescription/Service Ref #		63-Qual		
64-Fill #		65-Date Written mm dd cyyr		66-Date of Service mm dd cyyr		
67-Submission Clarification		68-Prescription Origin		69-Product/Service ID		
70-Qual		71-Quantity Dispensed		72-Days Supply		
73-DAW Code		74-Prior Auth # Submitted		75-PA Type		
76-Description		77-Strength		78-Unit Of Measure		
79-Other Coverage		80-Delay Reason		81-Other Payer ID		
82-Qual		83-Other Payer Data MM DD CCYY		84-Other Payer Rejects		
85-Reason / 86-Service / 87-Result		88-Level of Effort		89-Procedure Modifier		
90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration		
93-Ingredient Component Count		94-Product Name		95-Product ID		
96-Qual		97-Ingredient Qty		98-Ingredient Drug Cost		
99-Basis Cost		100-Usual & Customary Charge		101-Basis of Cost Del.		
102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted		
105-Sales Tax Submitted		106-Gross Amount Due (Submitted)		107-Patient Paid Amount		
108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt		110-Net Amount Due		
111-Net Amount Due		112-Net Amount Due		113-Net Amount Due		


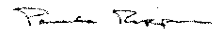
PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 03/16/2017		 NCPDP NATIONAL COUNCIL FOR PROFESSIONAL DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div>		
	3-Last: DORAN		4-First: DANIEL				
	5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE				
	7-State: CA		8-Zip: 93545				
CARRIER	10-D.O.B.: 06/04/1966		9-Tel #: (760) 258-7545		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  03/16/2017 30-(Signed) _____ 31-(Date)		
	12-I.D.: 554731885		11-D.O.I.: 07/11/2012				
	13-Qualifier: 01		14-Gender: 1				
	16-Jurisdictional State: CA		17-Claim Ref #: 05814232				
EMPLOYER	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE		
	20-City: FRESNO		21-State: CA				
	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING				
	24-Address: 2667 EAST COLORADO		25-City: PASADENA				
PHARMACY	26-State: CA		27-Zip: 91107		PHARMACY		
	28-Tel #: (626) 795-5881		29-Contact Name:				
	32-ID: 1881712404		33-Qual: 01				
	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill				
PAYEE	36-City: San Dimas		37-State: CA		PAYEE		
	38-Zip: 91773		39-Tel #: (800) 500-8448				
	40-ID: 1992964423		41-Qual: 01				
	42-Last: Guerrero		43-First: Jaime				
44-Address: 10841 WHITE OAK AVE		45-City: RANCHO CUCAMONGA		PAYEE			
46-State: CA		47-Zip: 91730-3817					
48-Tel #: (888) 824-2144		49-ID: 95-4683977					
50-Qual: 11		51-Name: MH Express Pharmacy					
52-Address: PO Box 1168		53-City: Monrovia		CLAIM			
54-State: CA		55-Zip: 91017					
56-Tel #: (800)500-8448		57-Jurisdiction #1:					
58-Jurisdiction #2:		59-Jurisdiction #3:					
60-Jurisdiction #4:		61-Jurisdiction #5:		COMPOUND			
62-Prescription/Service Ref. #		63-Qual.				64-Fill #	
65-Date Written mm dd ccyy		66-Date of Service mm dd ccyy				67-Submission Clarification	
68-Prescription Origin		69-Product/Service ID				70-Qual.	
71-Quantity Dispensed		72-Days Supply		73-DAW Code			
74-Prior Auth #. Submitted		75-PA. Type		76-Description			
77-Strength		78-Unit Of Measure		79-Other Coverage			
80-Delay Reason		81-Other Payer ID		82-Qual.			
83-Other Payer Date MM DD CCYY		84-Other Payer Rejects		85-Reason / 86-Service / 87-Result			
88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code			
91-Dispensing Unit Form Indicator		92-Route of Administration		93-Ingredient Component Count			
94-Product Name		95-Product ID		96-Qual.			
97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost			
100-Usual & Customary Charge		101-Basis of Cost Det.		102-Ingredient Cost Submitted			
103-Dispensing Fee Submitted		104-Other Amount Submitted		105-Sales Tax Submitted			
106-Gross Amount Due (Submitted)		107-Patient Paid Amount		108-Other Payer Amount Paid			
109-Other Payer Patient Resp. Amt.		110-Net Amount Due					


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 03/31/2017		 NCPDP NATIONAL CENTER FOR PRESCRIPTION DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.			
	3-Last: DORAN		4-First: DANIEL					
	5-Address: 281 S LAKE VIEW ST							
	6-City: LONE PINE		7-State: CA					
CARRIER	8-Zip: 93545		9-Tel #: (760) 258-7545		FOR OFFICE USE ONLY 15 (Document Control Number) SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  03/31/2017 30-(Signed) _____ 31-(Date) _____			
	10-D.O.B: 06/04/1966		11-D.O.I: 07/11/2012					
	12-I.D.: 554731885		13-Qualifier: 01				14-Gender: 1	
	16-Jurisdictional State: CA							
EMPLOYER	17-Claim Ref #: 05814232		18-Name: STATE COMPENSATION INS FUND		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE			
	19-Address: P.O. BOX 65005							
	20-City: FRESNO		21-State: CA					
	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING					
PHARMACY	24-Address: 2667 EAST COLORADO		25-City: PASADENA		26-State: CA			
	27-Zip: 91107		28-Tel #: (626) 795-5881		29-Contact Name: _____			
	32-ID: 1881712404		33-Qual: 01		40-ID: 1437167863			
	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill		41-Qual: 01			
PAYEE	36-City: San Dimas		37-State: CA		42-Last: BAKER			
	38-Zip: 91773		39-Tel #: (800) 500-8448		43-First: GARY			
	44-Address: 5211 E. WASHINGTON BLVD.				45-City: COMMERCE			
	46-State: CA				47-Zip: 90040			
48-Tel #: (323) 980-9002		49-ID: 95-4683977		50-Qual: 11		57-Jurisdiction #1: _____		
51-Name: MH Express Pharmacy		52-Address: PO Box 1168		53-City: Monrovia		54-State: CA		
55-Zip: 91017		56-Tel #: (800)500-8448		58-Jurisdiction #2: _____		59-Jurisdiction #3: _____		
60-Jurisdiction #4: _____		61-Jurisdiction #5: _____		62-Prescription/Service Ref. #		63-Qual		
64-Fill #		65-Date Written		66-Date of Service		67-Submission Clarification		
68-Prescription Origin		69-Product/Service ID		70-Qual		71-Quantity Dispensed		
72-Days Supply		73-DAW Code		74-Prior Auth # Submitted		75-PA Type		
76-Description		77-Strength		78-Unit Of Measure		79-Other Coverage		
80-Delay Reason		81-Other Payer ID		82-Qual		83-Other Payer Date		
84-Other Payer Rejects		85-Reason / 86-Service / 87-Result		88-Level of Effort		89-Procedure Modifier		
90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration		93-Ingredient Component Count		
94-Product Name		95-Product ID		96-Qual		97-Ingredient Qty		
98-Ingredient Drug Cost		99-Basis Cost		100-Usual & Customary Charge		101-Basis of Cost Det.		
102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted		105-Sales Tax Submitted		
106-Gross Amount Due (Submitted)		107-Patient Paid Amount		108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.		
110-Net Amount Due		111-Net Amount Due		112-Net Amount Due		113-Net Amount Due		


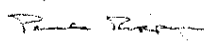
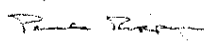
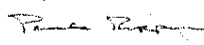
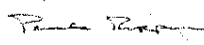
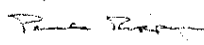
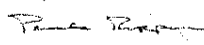
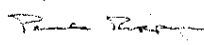
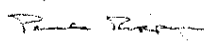
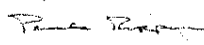
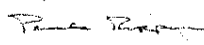
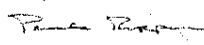
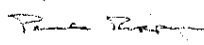
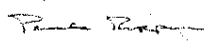
P A T I E N T	1-WC/P&C Indicator: WC		2-Date of Billing: 04/10/2017		 National Council for Prescription Drug Programs NCPDP WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div>			
	3-Last: DORAN		4-First: DANIEL					
	5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE					7-State: CA
C A R R I E R	8-Zip: 93545		9-Tel #: (760) 258-7545		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  04/10/2017 30-(Signed) _____ 31-(Date) _____ <div style="background-color: #cccccc; padding: 5px; text-align: center; font-weight: bold;"> ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE </div>			
	10-D.O.B: 06/04/1966		11-D.O.I: 07/11/2012					
	12-I.D.: 554731885		13-Qualifier: 01					14-Gender: 1
E M P L O Y E R	16-Jurisdictional State: CA		17-Claim Ref #: 05814232		16-Name: STATE COMPENSATION INS FUND 19-Address: P.O. BOX 65005 20-City: FRESNO 21-State: CA 22-Zip: 93650-5005			
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005					
	20-City: FRESNO		21-State: CA					
P H A R M A C Y	23-Name: BENEDICT & BENEDICT PLUMBING		24-Address: 2667 EAST COLORADO		23-Name: BENEDICT & BENEDICT PLUMBING 24-Address: 2667 EAST COLORADO 25-City: PASADENA 26-State: CA 27-Zip: 91107 28-Tel #: (626) 795-5881 29-Contact Name: _____			
	25-City: PASADENA		26-State: CA					
	27-Zip: 91107		28-Tel #: (626) 795-5881					
P A Y E R	32-ID: 1881712404		33-Qual: 01		40-ID: 1437167863		41-Qual: 01	
	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill		42-Last: BAKER		43-First: GARY	
	36-City: San Dimas		37-State: CA		44-Address: 5211 E. WASHINGTON BLVD.		45-City: COMMERCE	
C L A I M	38-Zip: 91773		39-Tel #: (800) 500-8448		46-State: CA		47-Zip: 90040	
	48-Tel #: (323) 980-9002		49-ID: 95-4683977		50-Qual: 11		57-Jurisdiction #1:	
	51-Name: MH Express Pharmacy		52-Address: PO Box 1168		53-City: Monrovia		54-State: CA	
C O M P O U N D	55-Zip: 91017		56-Tel #: (800)500-8448		58-Jurisdiction #2:		59-Jurisdiction #3:	
	60-Jurisdiction #4:		61-Jurisdiction #5:		62-Prescription/ Service Ref. #		63-Qual.	
	64-FIH #		65-Date Written mm dd ccyy		66-Date of Service mm dd ccyy		67-Submission Clarification	
68-Prescription Origin		69-Product/Service ID		70-Qual.		71-Quantity Dispensed		
72-Days Supply		73-DAW Code		74-Prior Auth # Submitted		75-PA Type		
76-Description		77-Strength		78-Unit Of Measure		79-Other Coverage		
80-Delay Reason		81-Other Payer ID		82-Qual		83-Other Payer Date MM DD CCYY		
84-Other Payer Rejects		85-Reason / 86-Service / 87-Result		88-Level of Effort		89-Procedure Modifier		
90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration		93-Ingredient Component Count		
94-Product Name		95-Product ID		96-Qual		97-Ingredient Qty		
98-Ingredient Drug Cost		99-Basis Cost		100-Usual & Customary Charge		101-Basis of Cost Det.		
102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted		105-Sales Tax Submitted		
106-Gross Amount Due (Submitted)		107-Patient Paid Amount		108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.		
110-Net Amount Due		111-Net Amount Due		112-Net Amount Due		113-Net Amount Due		


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: <u>04/12/2017</u> <small>mm dd cyy</small>		 NCPDP NATIONAL COUNCIL FOR PHARMACY DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div>				
	3-Last: DORAN		4-First: DANIEL						
	5-Address: 281 S LAKE VIEW ST								
CARRIER	6-City: LONE PINE		7-State: CA		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>[Signature]</i> 04/12/2017 30-(Signed) 31-(Date)				
	8-Zip: 93545		9-Tel #: (760) 258-7545						
	10-D.O.B. <u>06/04/1966</u> <small>mm dd cyy</small>		11-D.O.I.: <u>07/11/2012</u> <small>mm dd cyy</small>						
EMPLOYER	12-I.D.: 554731885		13-Qualifier: 01		14-Gender: 1				
	16-Jurisdictional State: CA		17-Claim Ref #: 05814232						
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005						
PHARMACY	20-City: FRESNO		21-State: CA						
	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING						
	24-Address: 2667 EAST COLORADO		25-City: PASADENA						
PAYEE	26-State: CA		27-Zip: 91107		28-Tel #: (626) 795-5881				
	29-Contact Name:		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE						
	32-ID: 1881712404						33-Qual: 01		40-ID: 1437167863
34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill					41-Qual: 01		
PHARMACY	36-City: San Dimas		37-State: CA						
	38-Zip: 91773		39-Tel #: (800) 500-8448		42-Last: BAKER				
	43-First: GARY		44-Address: 5211 E. WASHINGTON BLVD.		45-City: COMMERCE				
PAYEE	46-State: CA		47-Zip: 90040		48-Tel #: (323) 980-9002				
	49-ID: 95-4683977		50-Qual: 11		57-Jurisdiction #1:				
	51-Name: MH Express Pharmacy		52-Address: PO Box 1168		58-Jurisdiction #2:				
CLAIM	53-City: Monrovia		54-State: CA						
	55-Zip: 91017		56-Tel #: (800)500-8448		59-Jurisdiction #3:				
	60-Jurisdiction #4:		61-Jurisdiction #5:		62-Prescription/ Service Ref. #				
COMPOUND	63-Qual: 1		64-Fill #: 0		65-Date Written <small>mm dd cyy</small> 03/27/2017				
	66-Date of Service <small>mm dd cyy</small> 04/12/2017		67-Submission Clarification		68-Prescription Origin				
	69-Product/Service ID		70-Qual: 03		71-Quantity Dispensed				
72-Days Supply		73-DAW Code		74-Prior Auth #. Submitted					
75-PA. Type		76-Description		77-Strength					
78-Unit Of Measure		79-Other Coverage		80-Delay Reason					
81-Other Payer ID		82-Qual		83-Other Payer Date <small>MM DD CYY</small>					
84-Other Payer Rejects		85-Reason / 86-Service / 87-Result		88-Level of Effort					
89-Procedure Modifier		90-Dosage Form Description Code		91-Dispensing Unit Form Indicator					
92-Route of Administration		93-Ingredient Component Count							
94-Product Name		95-Product ID		96-Qual					
97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost					
100-Usual & Customary Charge		101-Basis of Cost Det.		102-Ingredient Cost Submitted					
103-Dispensing Fee Submitted		104-Other Amount Submitted		105-Sales Tax Submitted					
106-Gross Amount Due (Submitted)		107-Patient Paid Amount		108-Other Payer Amount Paid					
109-Other Payer Patient Resp. Amt.		110-Net Amount Due		111-Net Amount Due					

PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 05/22/2017		 NCPDP NATIONAL COUNCIL FOR PHARMACY PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. FOR OFFICE USE ONLY 15 (Document Control Number)			
	3-Last: DORAN		4-First: DANIEL					
	5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE				7-State: CA	
CARRIER/EMPLOYER	8-Zip: 93545		9-Tel #: (760) 258-7545		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Paul R...</i> 05/22/2017 30-(Signed) 31-(Date)			
	10-D.O.B.: 06/04/1966		11-D.O.I.: 07/11/2012					
	12-I.D.: 554731885		13-Qualifier: 01				14-Gender: 1	
PHARMACY	16-Jurisdictional State: CA		17-Claim Ref #: 05814232		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE			
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005					
	20-City: FRESNO		21-State: CA					
PAYEE	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING					
	24-Address: 2667 EAST COLORADO		25-City: PASADENA					
	26-State: CA		27-Zip: 91107					
PHARMACY	28-Tel #: (626) 795-5881		29-Contact Name:					
	32-ID: 1881712404		33-Qual: 01					
	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill					
PHARMACY	36-City: San Dimas		37-State: CA					
	38-Zip: 91773		39-Tel #: (800) 500-8448					
	40-ID: 1437167863		41-Qual: 01					
PHARMACY	42-Last: BAKER		43-First: GARY					
	44-Address: 5211 E. WASHINGTON BLVD.		45-City: COMMERCE					
	46-State: CA		47-Zip: 90040					
PHARMACY	48-Tel #: (323) 980-9002		49-ID: 95-4683977					
	50-Qual: 11		51-Name: MH Express Pharmacy					
	52-Address: PO Box 1168		53-City: Monrovia					
PHARMACY	54-State: CA		55-Zip: 91017					
	56-Tel #: (800)500-8448		57-Jurisdiction #1:					
	58-Jurisdiction #2:		59-Jurisdiction #3:					
PHARMACY	60-Jurisdiction #4:		61-Jurisdiction #5:					
	62-Prescription/Service Ref. #		63-Qual				64-Fill #	
	65-Date Written		66-Date of Service				67-Submission Clarification	
PHARMACY	68-Product/Service ID		69-Qual		70-Quantity Dispensed			
	71-Days Supply		72-CAW Code		73-Prior Auth # Submitted			
	74-PA Type		75-Reason		76-Result			
PHARMACY	76-Description		77-Strength		78-Unit Of Measure			
	79-Other Coverage		80-Delay Reason		81-Other Payer ID			
	82-Qual		83-Other Payer Date		84-Other Payer Rejects			
PHARMACY	85-Reason / 86-Service / 87-Result		88-Level of Effort		89-Procedure Modifier			
	90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration			
	93-Ingredient Component Count		94-Product Name		95-Product ID			
PHARMACY	96-Qual		97-Ingredient Qty		98-Ingredient Drug Cost			
	99-Basis Cost		100-Usual & Customary Charge		101-Basis of Cost Det.			
	102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted			
PHARMACY	105-Sales Tax Submitted		106-Gross Amount Due (Submitted)		107-Patient Paid Amount			
	108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.		110-Net Amount Due			
	111-Net Amount Due		112-Net Amount Due		113-Net Amount Due			

PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 06/20/2017		 NCPDP NATIONAL COUNCIL FOR PHARMACY DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.		
	3-Last: DORAN		4-First: DANIEL				
CARRIER	5-Address: 281 S LAKE VIEW ST		7-State: CA		FOR OFFICE USE ONLY 15 (Document Control Number)		
	6-City: LONE PINE		9-Tel #: (760) 258-7545				
EMPLOYER	8-Zip: 93545		11-D.O.I.: 07/11/2012		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  06/20/2017 30-(Signed) _____ 31-(Date) _____		
	10-D.O.B: 06/04/1966		13-Qualifier: 01				
PHARMACY	16-Jurisdictional State: CA		17-Claim Ref #: 05814232		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE		
	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005				
PAYEE	20-City: FRESNO		21-State: CA		PRESCRIPTION MONITORING		
	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING				
CLAIM	24-Address: 2667 EAST COLORADO		25-City: PASADENA		DUR		
	26-State: CA		27-Zip: 91107				
COMPOUND	28-Tel #: (626) 795-5881		29-Contact Name:		DUR		
	32-ID: 1881712404		33-Qual: 01				
34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill		40-ID: 1437167863		41-Qual: 01	
36-City: San Dimas		37-State: CA		42-Last: BAKER		43-First: GARY	
38-Zip: 91773		39-Tel #: (800) 500-8448		44-Address: 5211 E. WASHINGTON BLVD.		45-City: COMMERCE	
49-ID: 95-4683977		50-Qual: 11		46-State: CA		47-Zip: 90040	
51-Name: MH Express Pharmacy		52-Address: PO Box 1168		48-Tel #: (323) 980-9002		57-Jurisdiction #1:	
53-City: Monrovia		54-State: CA		55-Zip: 91017		58-Jurisdiction #2:	
56-Tel #: (800)500-8448		59-Jurisdiction #3:		60-Jurisdiction #4:		61-Jurisdiction #5:	
62-Product/Service ID		70-Qual		71-Quantity Dispensed		72-Days Supply	
63-Qual: 1		64-Flit #: 1		65-Date Written: 05/21/2017		66-Date of Service: 06/20/2017	
67-Submission Clarification		68-Product/Service ID		73-DAW Code		74-Prior Auth # Submitted	
69-Submission Clarification: 0		68-Product/Service ID: 16714033202		70-Qual: 03		71-Quantity Dispensed: 120.00	
76-Description		77-Strength		78-Unif Of Measure		79-Other Coverage	
76-Description: GABAPENTIN 800 MG TABLET		77-Strength: 800MG		78-Unif Of Measure: EA		79-Other Coverage: 0	
81-Other Payer ID		82-Qual		83-Other Payer Date		84-Other Payer Rejects	
81-Other Payer ID: _____		82-Qual: _____		83-Other Payer Date: MM DD CCYY		84-Other Payer Rejects: _____	
85-Reason		86-Service		87-Result		88-Level of Effort	
85-Reason: _____		86-Service: _____		87-Result: _____		88-Level of Effort: _____	
89-Procedure Modifier		90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration	
89-Procedure Modifier: _____		90-Dosage Form Description Code: _____		91-Dispensing Unit Form Indicator: _____		92-Route of Administration: _____	
93-Ingredient Component Count		94-Product Name		95-Product ID		96-Qual	
93-Ingredient Component Count: _____		94-Product Name: _____		95-Product ID: _____		96-Qual: _____	
97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost		100-Usual & Customary Charge	
97-Ingredient Qty: _____		98-Ingredient Drug Cost: _____		99-Basis Cost: _____		100-Usual & Customary Charge: \$1,062.77	
101-Basis of Cost Det.		102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted	
101-Basis of Cost Det.: 01		102-Ingredient Cost Submitted: \$1,062.77		103-Dispensing Fee Submitted: \$7.25		104-Other Amount Submitted: _____	
105-Sales Tax Submitted		106-Gross Amount Due (Submitted)		107-Patient Paid Amount		108-Other Payer Amount Paid	
105-Sales Tax Submitted: \$0.00		106-Gross Amount Due (Submitted): \$1,062.77		107-Patient Paid Amount: _____		108-Other Payer Amount Paid: _____	
109-Other Payer Patient Resp. Amt.		110-Net Amount Due		110-Net Amount Due		110-Net Amount Due	
109-Other Payer Patient Resp. Amt: _____		110-Net Amount Due: \$1,062.77		110-Net Amount Due: \$1,062.77		110-Net Amount Due: \$1,062.77	

PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: <u>06/26/2017</u> <small>mm dd ccyy</small>		 NCPDP NATIONAL COUNCIL FOR PHARMACY DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.																																																																								
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	12-I.D. 554731885		13-Qualifier: 01				SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>_____</i> 06/26/2017 30-(Signed) 31-(Date)																																																																						
	16-Jurisdictional State: CA																																																																												
17-Claim Ref # 05814232				ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE																																																																									
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						\$95.55																																																																							


PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 07/20/2017		 NCPDP NATIONAL COUNCIL FOR PHARMACY PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved. <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold;"> FOR OFFICE USE ONLY 15 (Document Control Number) </div>	
	3-Last: DORAN		4-First: DANIEL			
	5-Address: 281 S LAKE VIEW ST					
	6-City: LONE PINE		7-State: CA			
CARRIER	8-Zip: 93545		9-Tel #: (760) 258-7545		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  07/20/2017 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	10-D.O.B: 06/04/1966		11-D.O.I: 07/11/2012			
	12-I.D.: 554731885		13-Qualifier: 01			
	14-Gender: 1					
EMPLOYER	16-Jurisdictional State: CA				SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  07/20/2017 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	17-Claim Ref #: 05814232					
	18-Name: STATE COMPENSATION INS FUND					
	19-Address: P.O. BOX 65005					
PHARMACY	20-City: FRESNO		21-State: CA		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  07/20/2017 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	22-Zip: 93650-5005		23-Name: BENEDICT & BENEDICT PLUMBING			
	24-Address: 2667 EAST COLORADO					
	25-City: PASADENA		26-State: CA			
PAYEE	27-Zip: 91107		28-Tel #: (626) 795-5881		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  07/20/2017 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	29-Contact Name:		32-ID: 1881712404			
	33-Qual: 01		34-Name: MH Express Pharmacy			
	35-Address: 300 N. Lone Hill		36-City: San Dimas			
CLAIM	37-State: CA		38-Zip: 91773		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  07/20/2017 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	39-Tel #: (800) 500-8448		40-ID: 1437167863			
	41-Qual: 01		42-Last: BAKER			
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	55-Zip: 91017		56-Tel #: (800)500-8448			
	57-Jurisdiction #1:		58-Jurisdiction #2:			
	59-Jurisdiction #3:		60-Jurisdiction #4:			
COMPOUND	61-Jurisdiction #5:		62-Prescription/Service Ref. #		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  07/20/2017 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	63-Qual: 1		64-File #: 2			
	65-Date Written mm dd ccyy: 05/21/2017		66-Date of Service mm dd ccyy: 07/20/2017			
	67-Submission Clarification		68-Prescription Origin			
COMPOUND	69-Product/Service ID		70-Qual: 03		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  07/20/2017 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	71-Quantity Dispensed: 120.00		72-Days Supply: 30			
	73-DAW Code: 0		74-Prior Auth #. Submitted			
	75-PA. Type: 0		76-Reason / 86-Service / 87-Result			
COMPOUND	77-Description: GABAPENTIN 800 MG TABLET		78-Strength: 800MG		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  07/20/2017 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	79-Unit Of Measure: EA		80-Delay Reason: 0			
	81-Other Payer ID		82-Other Payer Date MM DD CCYY			
	83-Other Payer Rejects		84-Other Payer Rejects			
COMPOUND	85-Reason / 86-Service / 87-Result		88-Level of Effort		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  07/20/2017 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
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	91-Dispensing Unit Form Indicator		92-Route of Administration			
	93-Ingredient Component Count		94-Product Name			
COMPOUND	95-Product ID		96-Qual		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  07/20/2017 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	97-Ingredient Qty		98-Ingredient Drug Cost			
	99-Basis Cost		100-Usual & Customary Charge			
	101-Basis of Cost Det.		102-Ingredient Cost Submitted			
COMPOUND	103-Dispensing Fee Submitted		104-Other Amount Submitted		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  07/20/2017 30-(Signed) _____ 31-(Date) _____ ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE	
	105-Sales Tax Submitted		106-Gross Amount Due (Submitted)			
	107-Patient Paid Amount		108-Other Payer Amount Paid			
	109-Other Payer Patient Resp. Amt.		110-Net Amount Due			
Pricing (Format (1,234.56))						
100-Usual & Customary Charge: \$1,062.77		101-Basis of Cost Det.: 01		102-Ingredient Cost Submitted: \$1,062.77		
103-Dispensing Fee Submitted: \$7.25		104-Other Amount Submitted: \$0.00		105-Sales Tax Submitted: \$0.00		
106-Gross Amount Due (Submitted): \$1,062.77		107-Patient Paid Amount: \$1,062.77		108-Other Payer Amount Paid: \$0.00		
109-Other Payer Patient Resp. Amt.: \$0.00		110-Net Amount Due: \$1,062.77		111-Total Amount Due: \$1,062.77		


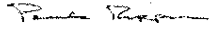
PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 07/24/2017 <small>mm dd cyy</small>		 NCPDP NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.		
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CARRIER	5-Address: 281 S LAKE VIEW ST		6-City: LONE PINE		7-State: CA		
	8-Zip: 93545		9-Tel #: (760) 258-7545		10-D.O.B.: 06/04/1966		
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	14-Gender: I		16-Jurisdictional State: CA		17-Claim Ref #: 05814232		
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CLAIM	68-Prescription Origin		69-Product/Service ID		70-Qual		
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CLAIM	88-Level of Effort		89-Procedure Modifier		90-Dosage Form Description Code		
	91-Dispensing Unit Form Indicator		92-Route of Administration		93-Ingredient Component Count		
COMPOUND	94-Product Name		95-Product ID		96-Qual		
	97-Ingredient Qty		98-Ingredient Drug Cost		99-Basis Cost		
Pricing (Format 1,234.56)							
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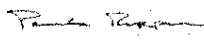
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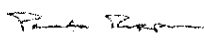
SIGNATURE OF PROVIDER
 (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Paul Brown 07/24/2017
 30-(Signed) 31-(Date)


ATTENTION PROVIDER
PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE

PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: 08/15/2017		 NCPDP NATIONAL COUNCIL FOR PHARMACY DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.																																																																							
	3-Last: DORAN		4-First: DANIEL																																																																									
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	8-Zip: 93545		9-Tel #: (760) 258-7545																																																																									
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	3-Last: DORAN		4-First: DANIEL							
	5-Address: 281 S LAKE VIEW ST		7-State: CA							
	6-City: LONE PINE		9-Tel #: (760) 258-7545							
CARRIER/EMPLOYER	8-Zip: 93545		10-D.O.B.: 06/04/1966		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  30-(Signed) _____ 31-(Date) 08/18/2017 <div style="background-color: #cccccc; padding: 5px; text-align: center;"> ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE </div>					
	11-D.O.I.: 07/11/2012		13-Qualifier: 01							
	12-I.D.: 554731885		14-Gender: 1							
	16-Jurisdictional State: CA		17-Claim Ref #: 05814232							
PHARMACY	18-Name: STATE COMPENSATION INS FUND		19-Address: P.O. BOX 65005		20-City: FRESNO 21-State: CA 22-Zip: 93650-5005 23-Name: BENEDICT & BENEDICT PLUMBING 24-Address: 2667 EAST COLORADO 25-City: PASADENA 26-State: CA 27-Zip: 91107 28-Tel #: (626) 795-5881 29-Contact Name: _____					
	32-ID: 1881712404		33-Qual: 01							
	34-Name: MH Express Pharmacy		35-Address: 300 N. Lone Hill							
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PAYEE	38-Zip: 91773		39-Tel #: (800) 500-8448		40-ID: 1992964423 41-Qual: 01 42-Last: Guerrero 43-First: Jaime 44-Address: 10841 WHITE OAK AVE 45-City: RANCHO CUCAMONGA 46-State: CA 47-Zip: 91730-3817 48-Tel #: (888) 824-2144 49-ID: 95-4683977 50-Qual: 11 51-Name: MH Express Pharmacy 52-Address: PO Box 1168 53-City: Monrovia 54-State: CA 55-Zip: 91017 56-Tel #: (800)500-8448 57-Jurisdiction #1: _____ 58-Jurisdiction #2: _____ 59-Jurisdiction #3: _____ 60-Jurisdiction #4: _____ 61-Jurisdiction #5: _____					
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\$1,191.62	01	\$1,191.62	\$7.25		\$0.00	\$1,191.62				
107-Patient Paid Amount	108-Other Payer Amount Paid	109-Other Payer Patient Resp. Amt.	110-Net Amount Due							
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PATIENT	1-WC/P&C Indicator: WC		2-Date of Billing: <u>08/22/2017</u> <small>mm dd cyy</small>		 NCPDP NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM Version 1.1 - 05/2009 © 2008-2009. All rights reserved.												
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EMPLOYER	23-Name: BENEDICT & BENEDICT PLUMBING		24-Address: 2667 EAST COLORADO		25-City: PASADENA		26-State: CA		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE								
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	36-City: San Dimas		37-State: CA				
	38-Zip: 91773		39-Tel #: (800) 500-8448				
40-ID: 1992964423		41-Qual: 01		42-Last: Guerrero		43-First: Jaime	
44-Address: 10841 WHITE OAK AVE		45-City: RANCHO CUCAMONGA		46-State: CA		47-Zip: 91730-3817	
48-Tel #: (888) 824-2144		49-ID: 95-4683977		50-Qual: 11		51-Name: MH Express Pharmacy	
52-Address: PO Box 1168		53-City: Monrovia		54-State: CA		55-Zip: 91017	
56-Tel #: (800)500-8448		57-Jurisdiction #1:		58-Jurisdiction #2:		59-Jurisdiction #3:	
60-Jurisdiction #4:		61-Jurisdiction #5:		62-Prescription/Service Ref #		63-Qual	
64-Fill #		65-Date Written mm dd ccyy		66-Date of Service mm dd ccyy		67-Submission Clarification	
68-Prescription Origin		69-Product/Service ID		70-Qual		71-Quantity Dispensed	
72-Days Supply		73-DAW Code		74-Prior Auth # Submitted		75-PA Type	
76-Description		77-Strength		78-Unit Of Measure		79-Other Coverage	
80-Delay Reason		81-Other Payer ID		82-Qual		83-Other Payer Date MM DD CCYY	
84-Other Payer Rejects		85-Reason / 86-Service / 87-Result		88-Level of Effort		89-Procedure Modifier	
90-Dosage Form Description Code		91-Dispensing Unit Form Indicator		92-Route of Administration		93-Ingredient Component Count	
94-Product Name		95-Product ID		96-Qual		97-Ingredient Qty	
98-Ingredient Drug Cost		99-Basis Cost		100-Usual & Customary Charge		101-Basis of Cost Det.	
102-Ingredient Cost Submitted		103-Dispensing Fee Submitted		104-Other Amount Submitted		105-Sales Tax Submitted	
106-Gross Amount Due (Submitted)		107-Patient Paid Amount		108-Other Payer Amount Paid		109-Other Payer Patient Resp. Amt.	
110-Net Amount Due		111-Total Amount Due		112-Total Amount Due		113-Total Amount Due	

1-WC/P&C Indicator: **WC** 2-Date of Billing: **09/21/2017**

3-Last: **DORAN** 4-First: **DANIEL**

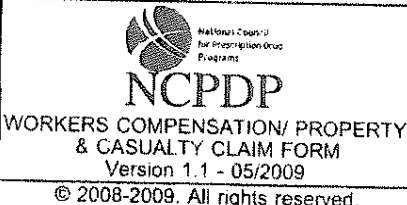
5-Address: **281 S LAKE VIEW ST**

6-City: **LONE PINE** 7-State: **CA**

8-Zip: **93545** 9-Tel #: **(760) 258-7545**

10-D.O.B. **06/04/1966** 11-D.O.I. **07/11/2012**

12-I.D. **554731885** 13-Qualifier: **01** 14-Gender: **1**



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15 (Document Control Number)

16-Jurisdictional State: **CA**

17-Claim Ref # **05814232**

18-Name: **STATE COMPENSATION INS FUND**

19-Address: **P.O. BOX 65005**

20-City: **FRESNO** 21-State: **CA**

22-Zip: **93650-5005**

SIGNATURE OF PROVIDER
 (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

[Signature] 09/21/2017
 30-(Signed) 31-(Date)

23-Name: **BENEDICT & BENEDICT PLUMBING**

24-Address: **2667 EAST COLORADO**

25-City: **PASADENA** 26-State: **CA**

27-Zip: **91107** 28-Tel #: **(626) 795-5881**

29-Contact Name:

ATTENTION PROVIDER!
PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE

32-ID: **1881712404** 33-Qual: **01**

34-Name: **MH Express Pharmacy**

35-Address: **300 N. Lone Hill**

36-City: **San Dimas** 37-State: **CA**

38-Zip: **91773**

39-Tel #: **(800) 500-8448**

40-ID: **1992964423** 41-Qual: **01**

42-Last: **Guerrero**

43-First: **Jaime**

44-Address: **10841 WHITE OAK AVE**

45-City: **RANCHO CUCAMONGA** 46-State: **CA**

47-Zip: **91730-3817**

48-Tel #: **(888) 824-2144**

49-ID: **95-4683977** 50-Qual: **11**

51-Name: **MH Express Pharmacy**

52-Address: **PO Box 1168**

53-City: **Monrovia** 54-State: **CA**

55-Zip: **91017**

56-Tel #: **(800)500-8448**

57-Jurisdiction #1:

58-Jurisdiction #2:

59-Jurisdiction #3:

60-Jurisdiction #4:

61-Jurisdiction #5:

62-Prescription/Service Ref #	63-Qual	64-Fill #	65-Date Written mm dd cyy	66-Date of Service mm dd cyy	67-Submission Clarification	68-Prescription Origin
99608049	1	0	08/14/2017	09/21/2017		0
69-Product/Service ID	70-Qual	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth # Submitted	75-PA Type
50458086001	03	60.00	30	0		0
76-Description			77-Strength		78-Unit Of Measure	79-Other Coverage
NUCYNTA ER 50 MG TABLET			50MG		EA	0
80-Delay Reason	81-Other Payer ID					
	82-Qual	83-Other Payer Date MM DD CCYY	84-Other Payer Rejects		DUR / PPS / CODES	
	85-Reason / 86-Service / 87-Result					
88-Level of Effort	89-Procedure Modifier	90-Dosage Form Description Code	91-Dispensing Unit Form Indicator	92-Route of Administration		93-Ingredient Component Count

94-Product Name	95-Product ID	96-Qual	97-Ingredient Qty	98-Ingredient Drug Cost	99-Basis Cost
1					
2					
3					
4					
5					
6					
7					

Pricing (Format 11,234.56)						
100-Usual & Customary Charge	101-Basis of Cost Det.	102-Ingredient Cost Submitted	103-Dispensing Fee Submitted	104-Other Amount Submitted	105-Sales Tax Submitted	106-Gross Amount Due (Submitted)
\$1,191.62	01	\$1,191.62	\$7.25		\$0.00	\$1,191.62
107-Patient Paid Amount	108-Other Payer Amount Paid	109-Other Payer Patient Resp. Amt.	110-Net Amount Due			
			\$1,191.62			

1-WC/P&C Indicator: WC 2-Date of Billing: 09/25/2017

3-Last: DORAN 4-First: DANIEL

5-Address: 281 SLAKE VIEW ST

6-City: LONE PINE 7-State: CA

8-Zip: 93545 9-Tel #: (760) 258-7545

10-D.O.B: 06/04/1966 11-D.O.I: 07/11/2012

12-I.D.: 554731885 13-Qualifier: 01 14-Gender: 1

16-Jurisdictional State: CA

17-Claim Ref #: 05814232

18-Name: STATE COMPENSATION INS FUND

19-Address: P.O. BOX 65005

20-City: FRESNO 21-State: CA

22-Zip: 93650-5005


23-Name: BENEDICT & BENEDICT PLUMBING

24-Address: 2667 EAST COLORADO

25-City: PASADENA 26-State: CA

27-Zip: 91107 28-Tel #: (626) 795-5881

29-Contact Name:



NCPDP
NATIONAL COUNCIL
FOR PRESCRIPTION DRUG
PROGRAMS

**WORKERS COMPENSATION/ PROPERTY
& CASUALTY CLAIM FORM**
Version 1.1 - 05/2009

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[Signature] 09/25/2017

30-(Signed) 31-(Date)

**ATTENTION PROVIDER!
PLEASE READ ATTESTATION
STATEMENT ON REVERSE SIDE**

32-ID: 1881712404 33-Qual: 01

34-Name: MH Express Pharmacy

35-Address: 300 N. Lone Hill

36-City: San Dimas 37-State: CA

38-Zip: 91773

39-Tel #: (800) 500-8448

49-ID: 95-4683977 50-Qual: 11

51-Name: MH Express Pharmacy

52-Address: PO Box 1168

53-City: Monrovia 54-State: CA

55-Zip: 91017

56-Tel #: (800)500-8448

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42-Last: Guerrero

43-First: Jaime

44-Address: 10841 WHITE OAK AVE

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48-Tel #: (888) 824-2144

57-Jurisdiction #1:

58-Jurisdiction #2:

59-Jurisdiction #3:

60-Jurisdiction #4:

61-Jurisdiction #5:

62-Prescription/Service Ref. #	63-Qual.	64-Fill #	65-Date Written mm dd cyy	66-Date of Service mm dd cyy	67-Submission Clarification	68-Prescription Origin
99601446	1	1	08/13/2017	09/25/2017		0
69-Product/Service ID	70-Qual.	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth #. Submitted	75-PA. Type
16714044802	03	30.00	30	0		0
76-Description			77-Strength		78-Unit Of Measure	79-Other Coverage
AMITRIPTYLINE HCL 50 MG TAB			50MG		EA	0
81-Other Payer ID	82-Qual	83-Other Payer Date MM DD CYY	84-Other Payer Rejects		85-Reason / 86-Service / 87-Result	
88-Level of Effort		89-Procedure Modifier	90-Dosage Form Description Code	91-Dispensing Unit Form Indicator	92-Route of Administration	93-Ingredient Component Count

94-Product Name	95-Product ID	96-Qual	97-Ingredient Qty	98-Ingredient Drug Cost	99-Basis Cost
1					
2					
3					
4					
5					
6					
7					

Pricing (Format 1,234.56)						
100-Usual & Customary Charge	101-Basis of Cost Det.	102-Ingredient Cost Submitted	103-Dispensing Fee Submitted	104-Other Amount Submitted	105-Sales Tax Submitted	106-Gross Amount Due (Submitted)
\$69.40	01	\$69.40	\$7.25		\$0.00	\$69.40
107-Patient Paid Amount	108-Other Payer Amount Paid	109-Other Payer Patient Resp. Amt.	110-Net Amount Due			
			\$69.40			

PATIENT CARRIER EMPLOYER PHARMACY PAYEE CLAIM COMPONENT

1-WC/F&C Indicator: **WC** 2-Date of Billing: **10/24/2017**
mm dd cyy

3-Last: **DORAN** 4-First: **DANIEL**

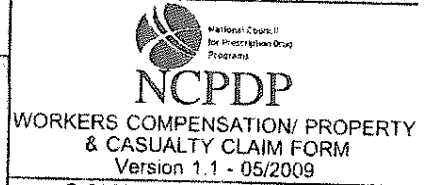
5-Address: **281 S LAKE VIEW ST**

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10-D.O.B.: **06/04/1966** 11-D.O.I.: **07/11/2012**
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12-I.D.: **554731885** 13-Qualifier: **01** 14-Gender: **1**



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19-Address: **P.O. BOX 65005**

20-City: **FRESNO** 21-State: **CA**

22-Zip: **93650-5005**

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27-Zip: **91107** 28-Tel #: **(626) 795-5881**

29-Contact Name:

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59-Jurisdiction #3:

60-Jurisdiction #4:

61-Jurisdiction #5:

62-Prescription/Service Ref #	63-Qual	64-Fill #	65-Date Written <small>mm dd cyy</small>	66-Date of Service <small>mm dd cyy</small>	67-Submission Clarification	68-Prescription Origin
99601446	1	2	08/13/2017	10/24/2017		0
69-Product/Service ID	70-Qual	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth # Submitted	75-PA Type
16714044802	03	30.00	30	0		0
76-Description			77-Strength		78-Unit Of Measure	79-Other Coverage
AMITRIPTYLINE HCL 50 MG TAB			50MG		EA	0
80-Delay Reason	85-Reason / 86-Service / 87-Result					
81-Other Payer ID	82-Qual	83-Other Payer Date <small>MM DD CCYY</small>	84-Other Payer Rejects		DUR / PPS / CODES	
DUR						
88-Level of Effort	89-Procedure Modifier	90-Dosage Form Description Code	91-Dispensing Unit Form Indicator	92-Route of Administration		93-Ingredient Component Count

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107-Patient Paid Amount	108-Other Payer Amount Paid	109-Other Payer Patient Resp. Amt.	110-Net Amount Due			
			\$69.40			

PATIENT
 CARRIER
 PROVIDER
 PHARMACY
 PAYEE
 CLAIM
 COMPONENT