THE DENTAL TRAUMA CENTER

CORPORATE OFFICE
12243 SOUTH HAWTHORNE BOULEVARD, HAWTHORNE, CA 90250-3831
(310) 644-6456 • FAX (310) 644-5963

Joseph Schames, D.M.D., QME
Mayer Schames, D.D.S., QME
David Schames, D.D.S., QME

Please note:
If payment of this bill is denied, we will pursue provisions under L.C. 4603.2. Also, demand is hereby made for service of all medical reports relating to this claim, pursuant to CCR 10635 (c)(2).

June 21, 2023

Re: Ivan Androsov v Macy's Inc dba Bloomingdales
DOI: CT 1/14/22 – 1/03/23
Claim #: Unknown
Case #: ADJ 17289751

SUPPLEMENTAL REPORT BY THE EXAMINING DOCTOR IN DENTISTRY

The following is a **Supplemental Report** in my area of expertise, for the above named patient who was treated at this office for injuries sustained on the date indicated above.

Please refer to my prior examination report detailing the patient's history and physical findings, as well as the treatment program instituted.

The patient was seen in my office on **6/21/2023,** where the patient was provided with a daytime Occlusal Orthotic, which is the standard of care treatment for Bruxism, and/or Myofascial Pain of the Facial Musculature to relax the musculature, and or to decrease intercapsular pressure within the TMJ, and/or to protect the teeth from Bruxism. This appliance is fabricated and customized in our in-house dental laboratory, and is a multiple day process, inclusive of in-person adjustments as necessary.

If I can be of any further assistance, or if you have any questions, please contact our office.

PLEASE NOTE: Labor Code 5402 (b)(c), requires the employer to authorize all appropriate medical care up to $10,000 until the liability for the claimed injury is accepted or rejected. As of 6/01/04, Labor Code 5814 mandates a 25% penalty on the amount of payment unreasonably delayed (10% if self-imposed). Accordingly, it would be requested that the defendant please provide immediate payment.

I request that the claims adjuster please provide copies of all medical records, personnel records, investigative reports or any other relevant discovery materials. These data are essential to evaluating complex matters of causation and apportionment. It would also be appreciated if the claims adjuster would provide notification of any scheduled dental Agreed Medical Examinations, defense dental QME examinations or panel dental QME examinations, and/or any reluctance to make reimbursement for a comprehensive permanent and stationary evaluation from this office. I request that the adjuster please advise this office if the applicant is not an employee, was the initial aggressor, did not timely report the injury, filed a fraudulent claim or was otherwise not legally eligible for benefits. I request that the adjuster please also submit any information relevant to any important upcoming court dates, in particular any expedited hearings or Mandatory Settlement Conferences;

and please provide notification of any dentist's depositions.

If there are any valid objections such that there would not be authorization for the requested treatment at this office, I request that the adjuster please report the basis for such denial within seven days.

DISCLOSURE NOTICE

To the best of my knowledge, the evaluation and the time performing it were in accordance with the guidelines of the Industrial Medical Council of Administrative Director to the extent that those guidelines exist.

"The undersigned declares under penalty of perjury that to the best of my knowledge, this facility is not in violation of L.C. 5703 or L.C. 139.3. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."

Sincerely,

Mayer Schames DDS

Mayer Schames, DDS
Fellow: International College of Craniomandibular Orthopaedics
Clinical Director: White Memorial Craniofacial Pain TMJ Clinic

DATE: June 21, 2023
County of Los Angeles

PROOF OF SERVICE BY MAIL - 1013a 2015,5 C.C.P.

RE: Ivan Androsov , 1300 Larrabee St Apt 2, , West Hollywood, CA 90069 WCAB#: Adj17289751

I am employed in the County of Los Angeles, State of California; I am over the age of eighteen years and I am not a party to the within action; my business address is: 12243 Hawthorne Blvd., Hawthorne, California, 90250.

On July 24, 2023 I served the following:

(X) Supplemental Report Report Dated 06/21/2023
(X) ADA Dental Claim Forms and Summary Bill Dated 07/19/2023

On the interested parties in this action by placing the true copy thereof, enclosed in asealed envelope with postage thereon fully prepaid, in the United States mail at Hawthorne, California, addresses as follows:

APPLICANT ATTORNEY: Workers Defenders Law Group, 751 S Weir Canyon Rd Ste 157-4, Anaheim, Ca
92808

INSURANCE CARRIER: Sedgwick Cms Lexington, PO BOX 14522, Lexington, KY 40512

NOTICE TO THE CARRIER: If your defense attorney is not listed above, please consider this our request that you provide us with the name, address, and phone number of your defense counsel immediately.

I certify (or declare,) under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

Executed on 07/24/2023 at Hawthorne, California

Signature of Declarant:_____

Full Name of Declarant:____Stephanie Mosqueda_____