# FACSMILE TRANSMISSION

| **To:** | **From:** Billing & Collection<br><br>CA |
|---|---|
| **Phone:** | **Phone:** (888) 316-4552 * 103 |
| **Fax Phone:** (310) 626-9632 | **Fax Phone:** 18883164552 |

**Note:**

Patient Name: Kendrick, Raymond - 46463, Claim Number: WC608-D60865, Initial Report

**Date:** 03/06/2019

**Pages:** 9

Helmsman Management
Po Box 7203
London, KY 40742

CARRIER

# HEALTH INSURANCE CLAIM FORM

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

PICA PICA

1. MEDICARE (Medicare#) [ ] MEDICAID (Medicaid#) [ ] TRICARE (ID#/DoD#) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (ID#) [ ] FECA BLK LUNG (ID#) [ ] OTHER (ID#) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 999-99-9999

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Kendrick, Raymond

3. PATIENT'S BIRTH DATE MM DD YY: 04 08 1956 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): The Home Depot

5. PATIENT'S ADDRESS (No., Street): 1511 E. Wardlow Rd. #5

CITY: Long Beach STATE: CA

ZIP CODE: 90807 TELEPHONE (Include Area Code): (562) 794-7708

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]

7. INSURED'S ADDRESS (No., Street): 2415 Cherry Ave

CITY: Signal Hill STATE: CA

ZIP CODE: 90755 TELEPHONE (Include Area Code): ( )

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

c. OTHER ACCIDENT? [ ] YES [X] NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: Unknown

a. INSURED'S DATE OF BIRTH MM DD YY: 04 08 1956 SEX M [X] F [ ]

b. OTHER CLAIM ID (Designated by NUCC): Y4 WC608D60865

c. INSURANCE PLAN NAME OR PROGRAM NAME: Helmsman Management

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature On File DATE 3/6/2019

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature On File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 01 2007 QUAL. 439

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M79.1 B. M60.9 C. G89.21 D. F43.0
E. M46.06 F. M54.5 G. M51.16 H. R51
I. G47.9 J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| | 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | New Patient Initial Evaluation (Comprehensive) | | | | | | | | | | ZZ | 111N00000X |
| | 06 25 18 | 06 25 18 | 11 | 01 | 99204 | | ABCDEF | 451.88 | 1 | | NPI | 1780120386 |
| 2 | Doctor's First Report of Occupational Illness or Injury | | | | | | | | | | ZZ | 111N00000X |
| | 06 25 18 | 06 25 18 | 11 | 01 | WC001 | | ABCDEF | 0.00 | 1 | | NPI | 1780120386 |
| 3 | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER: 272582044 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 46463

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 451.88

29. AMOUNT PAID: $ 0.00

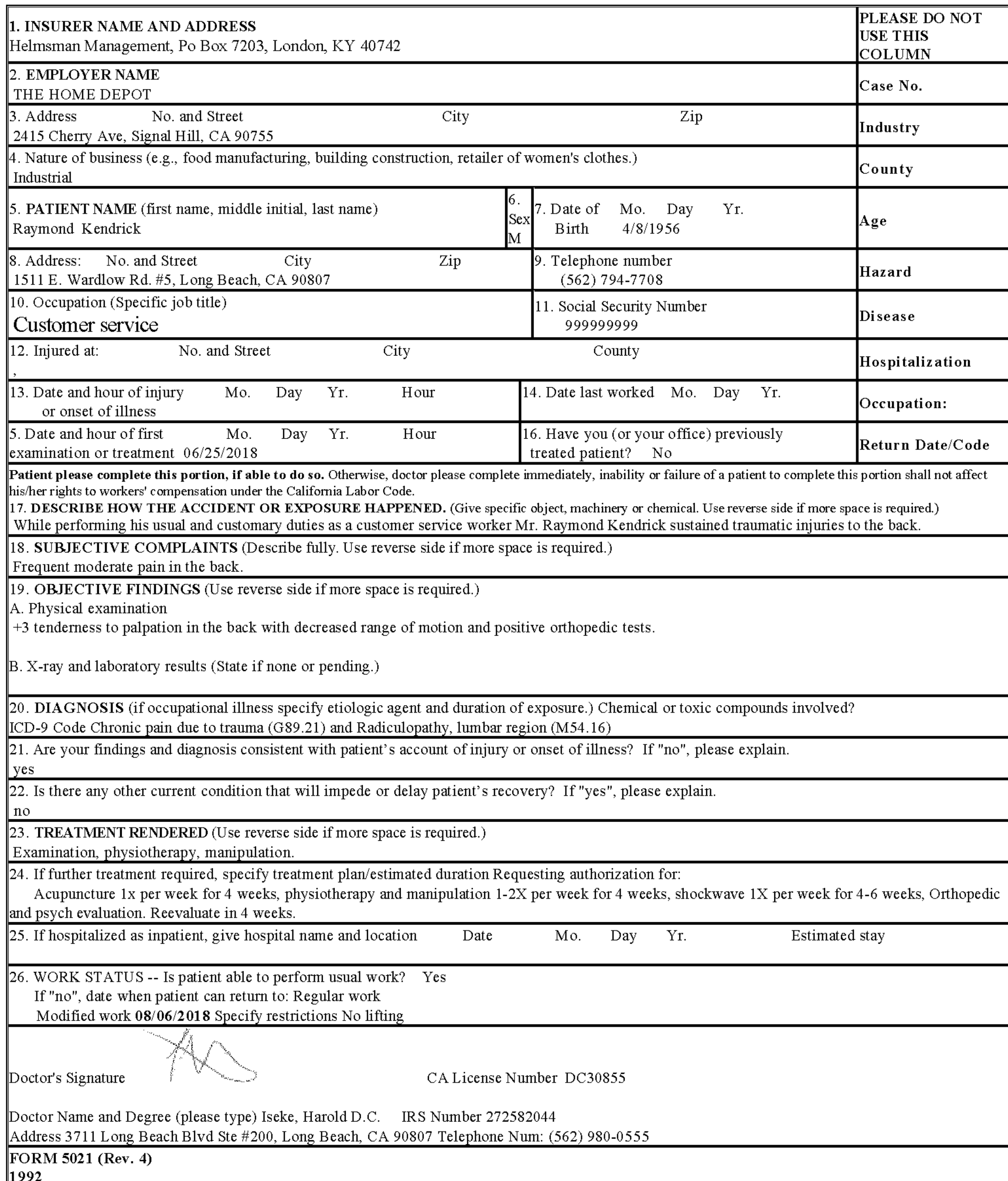
30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Iseke, Harold D.C.
DC30855 SIGNED 3/6/2019 DATE

32. SERVICE FACILITY LOCATION INFORMATION
Harold Iseke Chiropractic Professional Corp
3711 Long Beach Blvd Ste #200
Long Beach, CA 90807
a. 1780120386 b.

33. BILLING PROVIDER INFO & PH # (510) 870-0300
Harold Iseke Chiropractic Professional Corp
3711 Long Beach Blvd #200
Long Beach, CA 90807
a. 1780120386 b.

PHYSICIAN OR SUPPLIER INFORMATION



# STATE OF CALIFORNIA DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

| Form | PLEASE DO NOT USE THIS COLUMN |
|---|---|
| 1. **INSURER NAME AND ADDRESS**<br>Helmsman Management, Po Box 7203, London, KY 40742 | |
| 2. **EMPLOYER NAME**<br>THE HOME DEPOT | Case No. |
| 3. Address No. and Street City Zip<br>2415 Cherry Ave, Signal Hill, CA 90755 | Industry |
| 4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)<br>Industrial | County |
| 5. **PATIENT NAME** (first name, middle initial, last name)<br>Raymond Kendrick — 6. Sex M — 7. Date of Birth Mo. Day Yr. 4/8/1956 | Age |
| 8. Address: No. and Street City Zip<br>1511 E. Wardlow Rd. #5, Long Beach, CA 90807 — 9. Telephone number (562) 794-7708 | Hazard |
| 10. Occupation (Specific job title)<br>Customer service — 11. Social Security Number 999999999 | Disease |
| 12. Injured at: No. and Street City County<br>, | Hospitalization |
| 13. Date and hour of injury or onset of illness Mo. Day Yr. Hour — 14. Date last worked Mo. Day Yr. | Occupation: |
| 5. Date and hour of first examination or treatment Mo. Day Yr. Hour 06/25/2018 — 16. Have you (or your office) previously treated patient? No | Return Date/Code |

**Patient please complete this portion, if able to do so.** Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)
While performing his usual and customary duties as a customer service worker Mr. Raymond Kendrick sustained traumatic injuries to the back.

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)
Frequent moderate pain in the back.

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination
+3 tenderness to palpation in the back with decreased range of motion and positive orthopedic tests.

B. X-ray and laboratory results (State if none or pending.)

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved?
ICD-9 Code Chronic pain due to trauma (G89.21) and Radiculopathy, lumbar region (M54.16)

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? If "no", please explain.
yes

22. Is there any other current condition that will impede or delay patient's recovery? If "yes", please explain.
no

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)
Examination, physiotherapy, manipulation.

24. If further treatment required, specify treatment plan/estimated duration Requesting authorization for:
Acupuncture 1x per week for 4 weeks, physiotherapy and manipulation 1-2X per week for 4 weeks, shockwave 1X per week for 4-6 weeks, Orthopedic and psych evaluation. Reevaluate in 4 weeks.

25. If hospitalized as inpatient, give hospital name and location Date Mo. Day Yr. Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? Yes
If "no", date when patient can return to: Regular work
Modified work **08/06/2018** Specify restrictions No lifting

Doctor's Signature CA License Number DC30855

Doctor Name and Degree (please type) Iseke, Harold D.C. IRS Number 272582044
Address 3711 Long Beach Blvd Ste #200, Long Beach, CA 90807 Telephone Num: (562) 980-0555

**FORM 5021 (Rev. 4)**
**1992**

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

# State of California
# Division of Workers' Compensation
# Request for Authorization for Medical Treatment (DWC for RFA)

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or narrative report substantiating the requested treatment.

☑ New Request ☐ Resubmission – Change in Material Facts

☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health

☐ Check box if request is a written confirmation of a prior oral request.

## Employee Information

Name (Last, First, Middle): Raymond Kendrick

| | |
|---|---|
| Date of Injury (MM/DD/YYYY): 4/1/2007 | Date of Birth (MM/DD/YYYY): 04/08/1956 |
| Claim Number: WC608-D60865 | Employer: THE HOME DEPOT |

## Requesting Physician Information

**Name: Iseke, Harold D.C.**

| | | | |
|---|---|---|---|
| **Practice Name: Harold Iseke Chiropractic Professional Corp** | | **Contact Name:** | |
| **Address: 3711 Long Beach Blvd #200** | | **City: Long Beach** | **State: CA** |
| **Zip Code: 90807** | **Phone: (562) 980-0555** | **Fax Number:** | |
| **Specialty:** | | **License Number: DC30855** | |
| **E-mail Address:** | | | |

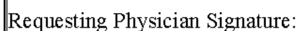
## Claims Administrator Information

| | | | |
|---|---|---|---|
| Company Name: Helmsman Management | | Contact Name: | |
| Address: Po Box 7203 | | City: London | State: KY |
| Zip Code: 40742 | Phone: | Fax Number: | |
| E-mail Address: | | | |

## Requested Treatment (see instructions for guidance; attach additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

| Diagnosis | ICD-Code | Procedure Requested | CPT/HCPCS Code | Other Information: (Frequency, Duration, Quantity, Facility, etc.) |
|---|---|---|---|---|
| Chronic pain due to trauma | G89.21 | ACUPUNCTURE | | 1 x per week for 6 weeks |
| Chronic pain due to trauma | G89.21 | CHIROPRACTIC | | 1-2 per week for 6 weeks |
| Spinal enthesopathy, lumbar region | M46.06 | ACUPUNCTURE | | 1 x per week for 6 weeks |
| Spinal enthesopathy, lumbar region | M46.06 | CHIROPRACTIC | | 1-2 per week for 6 weeks |
| Low back pain | M54.5 | ACUPUNCTURE | | 1 x per week for 6 weeks |

Requesting Physician Signature: 

Date of Request: 06/25/2018

## Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or modified (See Separate decision letter) ☐ Delay (See separate notification of delay)

☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

| | | |
|---|---|---|
| Authorization Number (if Assigned): | | Date: |
| Authorized Agent Name: | | Signature |
| Phone: | Fax Number: | E-mail Address: |

Comments:

DWC Form RFA (version 012014)

| Diagnosis | ICD-Code | Procedure Requested | CPT/HCPCS Code | **Other Information**: (Frequency, Duration, Quantity, Facility, etc.) |
|---|---|---|---|---|
| Low back pain | M54.5 | CHIROPRACTIC | | 1-2 per week for 6 weeks |

Harold Iseke Chiropractic Professional Corp
3711 Long Beach Blvd Ste #200
Long Beach, CA 90807

ELECTRONIC PROOF OF SERVICE

I am a citizen of the United States and a resident of the County of Contra Costa; I am over the age of eighteen years and not a party to the within entitled action; my business address is P.O Box 20758, El Sobrante , CA 94803.

I am readily familiar with Harold Iseke Chiropractic Professional Corp practice for electronic service of correspondence that is maintained on Harold Iseke Chiropractic Professional Corp electronic database.

On 03/06/2019, the within letter(s) were served on the parties in said action, by sending a true copy thereof electronically on the following parties:

**Attn: Bill Review / Claim Examiner**
Helmsman Management
Po Box 7203
London, KY 40742
Phone#: (800) 821-0967 Fax#: (603) 334-0221

**Attn: Applicant Atty**
FOLEY, LAW OFFICE OF NATALIA FOLEY
8306 Wilshire Blvd. Ste 115
Beverly Hills, CA 90211
Phone#: (310) 707-8098 Fax#: (310) 626-9632
Email Add: noleylaw@gmail.com

**Attn: Defense Atty**
Albert & Mackenzie
16600 Sherman Way Suite 150
Van Nuys, CA 91406
Phone#: (818) 650-6900 Fax#: (818) 721-8649

Executed on 03/06/2019, at El Sobrante, California, 94803.

I, Chris Flores, declare under penalty of perjury, under the laws of the STATE OF CALIFORNIA, that the foregoing is true and correct

Electronically Signed By: Chris Flores

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

# Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
Harold Iseke

2 Business name/disregarded entity name, if different from above
Harold Iseke Chiropractic Professional Corporation

3 Check appropriate box for federal tax classification; check only one of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☒ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶
**Note.** For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)
3711 Long Beach Blvd #200

Requester's name and address (optional)

6 City, state, and ZIP code
Long Beach, CA 90807

7 List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
[ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]

or

Employer identification number
27 – 2582044

## Part II Certification

Under penalties of perjury, I certify that:

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

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

**Sign Here** Signature of U.S. person ▶ [signature] Date ▶ 12/16/2016

## General Instructions

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

**Future developments.** Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

## Purpose of Form

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

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

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

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding.* See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.