PROOF OF SERVICE BY MAIL (1013a.2015.5. C.C.P.)

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the county aforesaid; I am over the age of eighteen years and not a party to the within entitled action; my business address is 2107 N. Broadway, Suite 207, Santa Ana, CA 92706.

On 3/22/2022, I served the within progress report(s) dated 11-29-21

and bill regarding

Sandra Roquemore

2.15.22

on the appropriate parties in said action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Santa Ana, California, addressed as follows:

Workers Defenders Law Group 8018 E.Santa Ana Cyn #100-215 Anaheim Hills, CA 92808

Ted Tribble PSY.D. 4344 Latham Street Ste. 120 Riverside, CA 92501

Claim#:

Attn.

Accident Fund Ins. Co. of America P.O. Box 40790 Lansing, MI 48901 CL#:UW2000031101 Attn.: Patricia Carruther

Next Level Administrators P.O. Box 1061 Bradenton, FL 34206 Claim #: Attn.

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

Executed on 3/22/2022, at Santa Ana, California.

By:

Alina Flores

cc: File

State of California

Additional pages attached \square

Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or IMC 81556

☐ Periodic Report (required 45 days after last report) ☐ Change in treatment	nt plan Discharged
☐ Change-in work status ☐ Need for referral or consultation ☐ Info. Reque	ested by:
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ C	Other: <u>UR REQUESTED</u>
Patient:	- · · · · · · · · · · · · · · · · · · ·
_ast Roquemore First Sandra M.I	Sex Female DOB 02/11/1955
Address 1763 Exposition Blvd City Los Angeles	State Zip 90018
Occupation 564-92-3586	Phone () (213)677-8002
Claims Administrator: Name Accident Fund Ins. Co. of America Claim Numb	er CL#:UW2000031101
Accident Fund IIIs. Co. of America	State Zip 48901
P.U. BOX 40/90	48901
Employer name: American Guard Services (DBA) Employer	Phone: ()
The information below must be provided. You may use this form or you may substitu	ite or append a narrative report.
Subjective Complaints:	
Ms. Roquemore reports pain in her lower back, legs, and feet, and numbra	ess and tingling in her feet. She has
physical limitations and difficulties ambulating. She uses a cane/walker.	She has difficulties performing her
activities of daily living. She experiences difficulty controlling her emotion	ons. (Continue on 2 page)
Objective findings: (Include significant physical examination, laboratory, imaging, o	or other diagnostic findings.)
Anxious mood and nervous.	
Diagnosis:	
Major Depressive Dis., Single Episode, Severe w/o	ICD-9 F32.2
2. Generalized Anxiety Disorder	ICD-9 F41.1
3. Insomnia Related to Other Mental Disorder	ICD-9
Treatment Plan: (Include treatment rendered to date. List methods, frequency and Specify consultation/referral, surgery, and hospitalization. Identify each physician and physician and physical thereby, many many many many many many many many	d non-physician provider. Specify
type, frequency and duration of physical medicine services (e.g., physical therapy, m codes is encouraged. Have there been any changes in treatment plan? If so, why?	ampulation, acupuncture. 336 of 1
Cognitive Behavioral Group Psychotherapy 1x week for 6 weeks. Relaxat	tion Training/Hypnotherapy 1x
week for 6 weeks. Follow up in 45 days. Continue with current treatment	plan. (Continue on 2 nd page)
Work Status: From the psychological standpoint, this patient is psychiatrically temp	oorarily totally disabled until 01/14/2022.
Restrictions: To be determined when patient reaches MMI Status.	
Primary Treating Physician: (original signature, do not stamp) Date of	exam: November 29, 2021
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and	that I have not violated Labor Code § 139.3.
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Cal. Lic. # PSY12317/PSY31773
Orginataro.	Date: 11/29/2021
LACCULCU at.	Specialty: Psychology
140100110. 110100, 11110, 9112111010	Phone: (714) 972-0040
Next report due no later than	
DWC Form PR-2 (Rev. 1/1/99)	(Use additional pages, if necessary)

Primary Treating Physician's Progress Report (PR-2)

RE: Sandra Roquemore Date: November 29, 2021

Page 2 of 2

Subjective Complaints:

She tends to socially isolate and withdraw from others. She feels sad, irritable, fearful, nervous, restless, anxious, depressed, and helpless. She has difficulty communicating. She experiences crying episodes and, at times, she feels like crying. She has a decreased appetite and reports she has lost approximately 3 pounds. She fears he worst happening. She endorses sleep difficulties, including distressing dreams. She feels tired and has low energy throughout the day. She experiences intrusive recollections and flashbacks. She has a decreased sexual desire. She is bothered by headaches. She reports gastrointestinal disturbances, including diarrhea and constipation. She has shown improvement in her overall mood and motivation.

Treatment Plan:

The treatment to be provided by Dr. Flores and Registered Psychological Assistants, Jennifer Lightner-Farrell and Ting F. Chiu.

Psychological Testing:

Burns Depression Checklist score: 42 (moderate depression) Burns Anxiety Inventory score: 33 (severe anxiety)

Psychological testing administered today: 31 minutes (testing time includes administration, scoring, and interpretation).

Disclosure:

The patient was informed of and consented to the use of telehealth services.

Scoring and interpretation of the psychological testing were conducted by Dr. Flores/Psychological Assistants, Jennifer Lightner-Farrell/Ting F. Chiu.

Time spent for this service: 25 minutes face to face time with the patient via telemedicine.

Time spent preparing this report: 1.15 hours preparing, transcribing, and editing this report.

I have reviewed the medical records and collateral records. X 15 mins.

REQUEST FOR AUTHORIZATION

X 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 Employee Informat	
Employee Information	
Employee Name (Last, First, Middle): Roquemore, Sandra ROQSA000	
<u>Date of Injury (MM/DD/YYYY): 11/03/2020</u> <u>Date of Birth (MM/DD/YYYY): 02/11/1955</u>	5
Claim Number:CL#:UW2000031101 Employer: American Guard Services (DBA)	
Provider Information	
Provider Name: Nelson J. Flores, PH.D.	
Practice Name: Psychological Assessment Serv. Contact Name: Ted Tribble PSY.D.	
Address: 2107 N Broadway Ste 207 City: Santa Ana State	: CA
Zip Code: 92706 Phone: 714-972-0040 Fax Number: 714-972-0477	
Provider Specialty: Psychology NPI Number: 1831237981	s
E-mail Address:	
Claims Administrator Information	0
Claims Administrator Name: Accident Fund Ins. Co. of America Contact Name:	
Address: P.O. Box 40790 City: Lansing State	: MI
Zip Code: 48901 Phone: (877)563-4636 Fax Number: (941) 444 17110	
E-mail Address:	
Requested Treatment (see instructions for guidance; attached additional pages if necessary)	
Either state the requested treatment in the below space or indicate the specific page number(s) of the accompanying	ng medical
report on which the requested treatment can be found. Up to five (5) procedures may be entered; attach additional ron a separate sheet.	<u>requests</u>
Diagnosis ICD-Code Procedure Requested CPT/HCPCS Other Informa (Frequency, Du Quantity, Facility	uration
Major Depressive Dis., Single F32.2 Group Medical Psychotherapy 90853 1X WK X WKS, TOTAL	SESSIONS
Generalized Anxiety Disorder F41.1 Group Medical Psychotherapy 90853 ""	
Insomnia F51.05 Group Medical Psychotherapy 90853	
Pain Dis. w/Related Psychologi F45.42 Group Medical Psychotherapy 90853 " "	
Treating Physician Signature: Date: 2/15/2022	
Claims Administrator 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)
Authorization Number (if assigned): Date:	
Authorized Agent Name: Signature:	
Phone: Fax Number: E-mail Address:	
Comments:	

REQUEST FOR AUTHORIZATION

		<u>r's First Report of Occupa</u> C Form PR-2, or narrative				
Expedited Review: 0	Check box if emplo	hange in Material Facts byee faces an imminent and rmation of a prior oral reque		ous threat to his or	her health	
Employee Information	1					
Employee Name (Last,	First, Middle): Ro	aquemore Sandra	RC	OSA000		
Date of Injury (MM/DD/	YYYY): 11/03/202	10		of Birth (MM/DD/Y	<u>YYY):</u> 02/	11/1955
Claim Number:CL#:UW	/2000031101		Empl	loyer: American C	ard Services	(DBA)
Provider Information						
Provider Name: Nelson	J. Flores, PH.D.					
Practice Name:psycho		ent Serv.	Cont	act Name: Ted Tr	ibble PSV D	
Address: 2107 N Broad	way Ste 207		City:	Santa Ana	171716 1 (3 1 . 1)	State: CA
<u>Zip Code:</u> 92706	Phone: 71	14-972-0040	Fax 1	Number: 714-972	2-0477	
Provider Specialty: Psy			NPIN	Number:		
E-mail Address:				183123	7981	
Claims Administrator	Information					
Claims Administrator N	ame: Accident	t Fund Ins. Co. of America	Conta	act Name:		
Address: P.O. Box 407	90	. Tunu ms. Co. or America	<u>City:</u> Lansing			State: MI
				ax Number:		
E-mail Address:	(8)	7)303-1030				
		for guidance; attached a				
Either state the requeste	ed treatment in the	e below space or indicate the	ne spe	ecific page number	(s) of the accon	npanying medical
report on which the requ	<u>uested treatment c</u>	can be found. Up to five (5)	proce	dures may be ente	ered; attach add	litional requests
on a separate sheet.					T	
<u>Diagnosis</u>	ICD-Code	Procedure Requested	<u>1</u>	CPT/HCPCS Code	(Freque	Information: ncy, Duration , Facility, etc.)
Major Depressive Dis., Single	F32.2	Medical Hypnotherapy/Relaxatio	on Tra	90880	1X WK X LWKS	s, TOTAL 4 SESSIONS
Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxatio	n Tra	90880		" "
Insomnia	F51.05	Medical Hypnotherapy/Relaxatio				
moonina	1 0 1100	Woododi Tiyphotherapy/Ttelaxatic	on Ira	90880		" "
Pain Dis. w/Related Psychologi	F45.42	Medical Hypnotherapy/Relaxatio		90880		""
		Medical Hypnotherapy/Relaxatio				
	F45.42			90880	te: 2/15/2022	
Pain Dis. w/Related Psychologi Treating Physician Sign Claims Administrator	F45.42 ature: Response	Medical Hypnotherapy/Relaxatio		90880	te: 2/15/2022	
Pain Dis. w/Related Psychologi Treating Physician Sign Claims Administrator	F45.42 ature: Response ed or Modified (Se	Medical Hypnotherapy/Relaxatio	on Tra	90880		n ii
Treating Physician Sign Claims Administrator Approved Denic	F45.42 ature: Response ed or Modified (Se at has been previo	Medical Hypnotherapy/Relaxatio	on Tra	90880 Da Delay (See separa		n ii
Pain Dis. w/Related Psychologi Treating Physician Sign Claims Administrator Approved Denic Requested treatmen	F45.42 ature: Response ed or Modified (Se at has been previous	Medical Hypnotherapy/Relaxatio	on Tra or trea	Dai Delay (See separatment is disputed ate:		n ii
Treating Physician Sign Claims Administrator Approved Denic Requested treatmen Authorization Number (i	F45.42 ature: Response ed or Modified (Se at has been previous	Medical Hypnotherapy/Relaxation ee separate decision letter) usly denied Liability for	on Tra or trea Da Sign	90880 Da Delay (See separa		n ii
Treating Physician Sign Claims Administrator Approved Denic Requested treatment Authorization Number (i	F45.42 ature: Response ed or Modified (Se thas been previous f assigned):	Medical Hypnotherapy/Relaxation ee separate decision letter) usly denied Liability for	on Tra or trea Da Sign	Delay (See separatment is disputed ate: gnature:		n ii

State of California



REQUEST FOR AUTHORIZATION

		C Form PR-2, or narrative			Form DLSR 5021, a Treating he requested treatment.	
X New Request F	Resubmission – C	hange in Material Facts				
		<u>oyee faces an imminent an</u> rmation of a prior oral requ		ous threat to his or h	ner health	
Employee Information			Triples as special			
Employee Name (Last,	First, Middle): Po	guamara Sandra	DC	00000		
Employee Name (Last, Date of Injury (MM/DD/	YYYY): 11/03/202	90 Sandra	Date	OSA000 of Birth (MM/DD/Y)	<u>YYY):</u> 02/11/1955	
Claim NumberCL#:UW					ard Services (DBA)	
Provider Information			The state of the s		and Services (DBA)	
Provider Name; Nelson	L Flores PH D					
Practice Name Psychol	ogical Assessme	nt Serv	Cont	tact Name: Ted Trib	hle DCV D	
Address: 2107 N Broad	way Ste 207		City:	Santa Ana	State: CA	
<u>Zip Code:</u> 92706	Phone: 71	4-972-0040		Number: 714-972-		
Provider Specialty: Psyc	hology		NPI	Number:	· · · ·	
E-mail Address:				18312379	981	
Claims Administrator	<u>Information</u>					
Claims Administrator Na	ame:	Fund Inc. Co. CA.	Cont	act Name:		
Accident Fund Ins. Co. of America City: Zip Codo: P.O. Box 40790 Phone: Accident Fund Ins. Co. of America City: Lansing				State: MI		
Zip Code: 48901 Phone: (877)563-4636			Fax Number:			
E-mail Address:	(87	7)303-4030				
Requested Treatment	(see instructions	for guidance; attached a	additio	onal pages if neces	sary)	
Either state the requeste	ed treatment in the	e below space or indicate t	he spe	ecific page number(s	s) of the accompanying medical	
report on which the requ	uested treatment o	can be found. Up to five (5)	proce	edures may be enter	ed; attach additional requests	
on a separate sheet.						
Diagnosia	ICD Code	Daniel Daniel		CPT/HCPCS	Other Information:	
<u>Diagnosis</u>	ICD-Code	Procedure Requested	1	Code	(Frequency, Duration	
					Quantity, Facility, etc.)	
Major Depressive Dis., Single	F32.2	Telephone Services, 21-30 m		99443	ONCE IN 45 DAYS	
Generalized Anxiety Disorder	F41.1	Telephone Services, 21-30 m	nin.	99443	н п	
Insomnia	F51.05	Telephone Services, 21-30 m	in.	99443	п. п	
Pain Dis. w/Related Psychologi	F45.42	Telephone Services, 21-30 m	in.	99443		
		7				
Treating Physician Signa	ature:	- Ila		Date	2: 2/15/2022	
Claims Administrator I		0,	(Automa)		MILE STATE OF THE	
Approved Denie Requested treatmen	ed or Modified (Se t has been previou	e separate decision letter) usly denied Liability for		Delay (See separate atment is disputed	e notification of delay)	
Authorization Number (it			T			
Authorized Agent Name			<u>Date:</u> <u>Signature:</u>			
Phone:	Fax Num	nber:		mail Address:		
Comments:						



Message Sent: 81880274 | 3/3/2022 2:57:49 PM PST

1 message

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RE: Roquemore, Sandra

Pages: 6

Comments:

11/29/21 PR-2 and RFAs

Ph. 714-972-0040 Fax 714-972-0477

^{*}Collections*

^{*}Psychological Assessment Services *

REQUEST FOR AUTHORIZATION

		r's First Report of Occup C Form PR-2, or narrativ						
Expedited Review: 0	Check box if emplo	nange in Material Facts byee faces an imminent ar mation of a prior oral requ		ous threat to hi	is or h	er health		
Employee Information	1		W 10 10 10 10 10 10 10 10 10 10 10 10 10					
Employee Name (Last,	First, Middle): Ro	quemore, Sandra	ROC	QSA000				
Date of Injury (MM/DD/	YYYY): 11/03/2020	0		e of Birth (MM/[DD/YY	<u>YY):</u> 02/1	1/1955	
Claim Number:			Emp	oloyer: Americ	an Gu	ard Services (DBA)	
Provider Information								
Provider Name Nelson	J. Flores, Ph.D							
Practice Name: Psycho	logical Assessme	nt Serv.	Conf	tact Name: Te	d Trib	ble PSY.D.		
Address: 2107 N Broad	lway Ste 207			: Santa Ana			State:	CA
<u>Zip Code:</u> 92706		4-972-0040	Fax	Number: 714	4-972-	0477		
Provider Specialty: Psyc	chology		NPI	Number: 183	312379	981		
E-mail Address:								
Claims Administrator			a di cadecondosco					
Claims Administrator Na	THE X LEVE	el Administrators	Cont	tact Name:				
Address: P.O. Box 106			City:	Bradenton			State:	FL
Zip Code: 34206	Phone: (94	1)281-3494	Fax			1-6200		
E-mail Address:						1		
Requested Treatment	(see instructions	for guidance; attached	additio	onal pages if r	neces	sary)		
report on which the requ	ested treatment in the	e below space or indicate to an be found. Up to five (5	he spe	ecific page nun	nber(s) of the accom	panying	medical
on a separate sheet.	icsted treatment of	an be found. Op to five (5)	<u>proce</u>	edures may be	entere	<u>au, allach addi</u>	tional re	quests
						Other I	oformati	
<u>Diagnosis</u>	ICD-Code	Procedure Requeste	d	CPT/HCPC	S	(Frequer	nformation ncy, Dura	
				Code		Quantity, Facility, etc.)		
Major Depressive Dis., Single	F32.2	Group Medical Psychothera	ny	90853		1X WK X PWKS	, TOTAL	Q SESSIONS
Generalized Anxiety Disorder	F41.1	Group Medical Psychothera		90853		TA THE ATTENDED	""	TOLOGIO!
Insomnia	F51.05	Group Medical Psychothera		90853			" "	
Pain Dis. w/Related Psychologi	F45.42	Group Medical Psychothera		90853			" "	
		1	P.					
Treating Physician Signa	ature:	Man			Date	2/15/2022		
Claims Administrator I								
Approved Denie		e separate decision letter) usly denied		Delay (See se atment is dispu		e notification of	delay)	
Authorization Number (it	f assigned):			ate:				
Authorized Agent Name				ignature:				
Phone:	Fax Num	ber:		-mail Address:				
Comments:								

REQUEST FOR AUTHORIZATION

		r's First Report of Occup. C Form PR-2, or narrative					
Expedited Review: C	Check box if employed	hange in Material Facts byee faces an imminent and rmation of a prior oral reque		ous threat to hi	s or h	er health	
Employee Information	1						
Employee Name (Last,	First, Middle): Ro	guemore, Sandra	ROQ	SA000			
Date of Injury (MM/DD/			Date	of Birth (MM/D	D/YY	<u>YY):</u> 02/	11/1955
Claim Number:			Emp	loyer: America	an Gu	ard Services	(DBA)
Provider Information					-		
Provider NameNelson,	J. Flores, Ph.D						
Practice Name:Psychol		ent Serv.	Cont	act Name: Ted	d Trib	ble PSY.D.	
Address: 2107 N Broad	way Ste 207			Santa Ana			State: CA
<u>Zip Code:</u> 92706		4-972-0040	Fax I	Number: 714	-972-	0477	
Provider Specialty: Psyc	chology		NPIN	Number: 183	12379	081	
E-mail Address:							
Claims Administrator	Information						V (MAX 194 PA)
Claims Administrator Na	ame: Next Lev	el Administrators	Cont	act Name:			
Address: P.O. Box 1061			City:	Bradenton			State: FL
<u>Zip Code:</u> 34206	Phone:(94	1)281-3494	Fax N	Number: (94	1)444	l-6200	
E-mail Address:				ì			
		for guidance; attached a					
report on which the requ	ed treatment in the	e below space or indicate to can be found. Up to five (5)	ne spe	ecific page nun	nber(s	s) of the accor	npanying medical
on a separate sheet.	dested treatment	can be found. Op to live (5)	proce	edures may be	enter	ed; allach add	aitional requests
						Other	Information:
<u>Diagnosis</u>	ICD-Code	Procedure Requested	1	CPT/HCPC	S		ency, Duration
				Code			<u>, Facility, etc.)</u>
Major Depressive Dis., Single	F32.2	Medical Hypnotherapy/Relaxation	n Tra	90880		1X WK X WK	s, total $\underline{arphi}_{ ext{sessions}}$
Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxation	n Tra	90880			н н
Insomnia	F51.05	Medical Hypnotherapy/Relaxation	n Tra	90880			rr 11
Pain Dis. w/Related Psychologi	F45.42	Medical Hypnotherapy/Relaxation	n Tra	90880			" "
	- 4						
· 1		COREC					
Treating Physician Sign	ature:	Vilva			Date	e: 2/15/2022	
Claims Administrator		\					
Approved Denie		ee separate decision letter)		Delay (See se atment is dispu		e notification of	of delay)
Authorization Number (i	f assigned):		T	ate:			
Authorized Agent Name				gnature:			
Phone:	Fax Nur	nber:		mail Address:			
Comments:							

REQUEST FOR AUTHORIZATION

This form must accor Physician's Prog		's First Report of Oc Form PR-2, or narra						
Expedited Review: 0	Check box if emplo	lange in Material Fact: yee faces an imminen mation of a prior oral r	t and ser	rious threat to his or	her health			
Employee Information	1							
Employee Name (Last,	First, Middle): Ro	quemore, Sandra	RO	QSA000				
<u>Date of Injury (MM/DD/YYYY): 11/03/2020</u> <u>Date of Birth (MM/DD/YYYY): 02/11/1955</u>								
<u>Claim Number:</u> <u>Employer:</u> American Guard Services (DBA)								
Provider Information								
Provider Name: Nelson	J. Flores, Ph.D							
Practice Name: Psycho	logical Assessme	nt Serv.	Cor	ntact Name: Ted T	ribble PSY.D.			
Address: 2107 N Broad	way Ste 207			<u>/:</u> Santa Ana		State: CA		
<u>Zip Code:</u> 92706		4-972-0040	Fax	Number: 714-97	72-0477			
Provider Specialty: Psy	chology		NPI	Number: 18312	37981			
E-mail Address:								
Claims Administrator	<u>Information</u>		1000					
Claims Administrator N	NEXI LEV	el Administrators	Cor	ntact Name:				
Address: P.O. Box 106	1		City	<u>City:</u> Bradenton <u>State:</u> FL				
Zip Code: 34206	Phone: (94	1)281-3494	Fax	Number: (941)	444-6200			
E-mail Address:								
Requested Treatment								
Either state the request report on which the requon a separate sheet.	ed treatment in the uested treatment c	below space or indicate an be found. Up to five	ate the sp e (5) proc	pecific page numbe pedures may be ent	r(s) of the accon ered; attach add	npanying medical itional requests		
<u>Diagnosis</u>	ICD-Code	Procedure Reque	ested	CPT/HCPCS Code	(Freque	nformation: ncy, Duration , Facility, etc.)		
Major Depressive Dis., Single	F32.2	Telephone Services, 21	-30 min.	99443	ONCE	IN 45 DAYS		
Generalized Anxiety Disorder	F41.1	Telephone Services, 21-30 min.		99443		" "		
Insomnia	F51.05	Telephone Services, 21	-30 min.	99443		" "		
Pain Dis. w/Related Psychologi	F45.42	Telephone Services, 21	-30 min.	99443		и и		
Treating Physician Sign	ature:			Da	ate: 2/15/2022			
Claims Administrator		Mod						
Approved Deni		e separate decision le usly denied		Delay (See separ eatment is disputed		f delay)		
Authorization Number (i	f assigned):]	Date:				
Authorized Agent Name	<u>:</u>		9	Signature:				
Phone:	Fax Num	ber:	Ē	E-mail Address:				
Comments:								



Message Sent: 81880264 | 3/3/2022 2:57:06 PM PST

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Fax: 19414446200

Date: 3/3/2022 2:57:06 PM PST

RE: Roquemore, Sandra

Pages: 6

Comments:

11/29/21 PR-2 and RFAs

^{*}Collections*

^{*}Psychological Assessment Services * Ph. 714-972-0040 Fax 714-972-0477

PROOF OF SERVICE BY MAIL (1013a.2015.5. C.C.P.)

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the county aforesaid; I am over the age of eighteen years and not a party to the within entitled action; my business address is 2107 N. Broadway, Suite 207, Santa Ana, CA 92706.

On 2/17/2022, I served the within progress report(s) dated 10/18/21

and bill regarding

Sandra Roquemore

01/31/22

on the appropriate parties in said action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Santa Ana, California, addressed as follows:

Workers Defenders Law Group 8018 E.Santa Ana Cyn #100-215 Anaheim Hills, CA 92808

Ted Tribble PSY.D. 4344 Latham Street Ste. 120 Riverside, CA 92501

> Claim #: Attn.

Accident Fund Ins. Co. of America P.O. Box 40790 Lansing, MI 48901 CL#:UW2000031101 Attn.: Patricia Carruther

Next Level Administrators P.O. Box 1061 Bradenton, FL 34206 Claim#: Attn.

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

Executed on 2/17/2022, at Santa Ana, California.

cc: File

State of California

A 1 1'.' 1		. 1 1	
Additional	nages	attached	

Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or IMC 81556

☐ Periodic Report (required 45 days after last report) ☐ Change in treat☐ Change-in work status ☐ Need for referral or consultation ☐ Info. Re	quested by:
	Other: <u>UR REQUESTED</u>
Patient: Last Roquemore First Sandra M.I. Address 1763 Exposition Blvd City Occupation SS# Los Angeles 564-92-358	Sex Female DOB 02/11/1955 State Zip 90018 Phone () (213)677-8002
Claims Administrator: Name Address Phone Phone Phone Accident Fund Ins. Co. of America P.O. Box 40790 Employer name: American Guard Services (DBA) Claim Nu Claim Nu Claim Nu Employer City Lansing Employer name: American Guard Services (DBA)	mber CI#:UW2000031101 State Zip 48901 yer Phone: ()
The information below must be provided. You may use this form or you may substitute Complaints:	stitute or append a narrative report.
Ms. Roquemore reports pain in her left shoulder, left arm, left hand, local controlling her emotions. She tends to socially isolate and withdraw from nervous, restless, anxious, depressed, and helpless. (Continue on 2 nd pages)	om others. She feels sad, fearful, age).
Objective Findings: (Include significant physical examination, laboratory, imagin	ng, or other diagnostic findings.)
Sad mood.	
Diagnosis:	
1. Major Depressive Dis., Single Episode, Severe w/o	ICD-9 F32.2
2. Generalized Anxiety Disorder	ICD-9 F41.1
3. Insomnia Related to Other Mental Disorder	ICD-9 F51.05
Treatment Plan: (Include treatment rendered to date. List methods, frequency a Specify consultation/referral, surgery, and hospitalization. Identify each physician type, frequency and duration of physical medicine services (e.g., physical therapy codes is encouraged. Have there been any changes in treatment plan? If so, where the property of the pr	n and non-physician provider. Specify
Cognitive Behavioral Group Psychotherapy 1x week for 6 weeks. Relative treatment of patient's anxious symptoms 1x week for 6 weeks. (Continue)	nue on 2 nd page).
Work Status: From the resychological standpoint, this patient is psychiatrically to	emporarily totally disabled until 12/03/2021.
Restriction: To be determined when patient reaches MMI Status.	
Primary Treating Physician: (original signature, do not stamp) I declare under penalty of perjury that this report is true and correct to the best of my knowledge.	e of exam: October 18, 2021 and that I have not violated Labor Code § 139.3.
Signature: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Cal. Lic. # PSY12317/PSB94026051
Executed at: SANTA ANA	Date: 10/18/2021
Name: Nelson J. Flores, Ph.D, QME/Ting V. Chiu, M.A.	Specialty: Psychology
Address: P.O. Box 6299 Laguna Niguel, CA 92607-6299	Phone: (714) 972-0040
Next report due no later than DWC Form PR-2 (Rev. 1/1/99)	(Use additional pages, if necessary)

Primary Treating Physician's Progress Report (PR-2)

RE: Sandra Roquemore Date: October 18, 2021

Page 2 of 2

Subjective Complaints:

She experiences crying episodes and, at times, she feels like crying. She has difficulty communicating and making decisions. She has a decreased appetite and reports she has lost weight. She has lost interest in her usual activities. She fears the worst happening. She endorses sleep difficulties, including nightmares and distressing dreams. She feels tired and has low energy throughout the day. She experiences intrusive recollections and flashbacks. She has a decreased sexual desire. She is bothered by headaches. She reports gastrointestinal disturbances, including heartburn, indigestion, diarrhea, and constipation. She has shown improvement in her motivation to engage in treatment and insight.

Treatment Plan:

Follow up in 45 days. Continue with current treatment plan. The treatment to be provided by Dr. Flores and Registered Psychological Assistants, Jennifer Lightner-Farrell and Ting F. Chiu.

Psychological Testing:

Burns Depression Checklist score: 87 (extreme depression) Burns Anxiety Inventory score: 87 (extreme anxiety)

Psychological testing administered today: 31 minutes (testing time includes administration, scoring, and interpretation).

Disclosure:

The patient was informed and consented to the use of telehealth services.

Scoring and interpretation of the psychological testing were conducted by Dr. Flores/Psychological Assistants, Jennifer Lightner-Farrell/Ting F. Chiu.

Time spent for this service: 20 minutes face to face time with the patient via telemedicine.

Time spent preparing this report: 1.15 hours preparing, testing score, interpretation, transcribing, and editing this report.

I have reviewed the medical records and collateral records. X 15 mins.

State of California Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

		First Report of Occupa Form PR-2, or narrative			Form DLSR 5021, a Treating e requested treatment.
Expedited Review: Ch	neck box if employe	<u>nge in Material Facts</u> <u>ee faces an imminent and</u> ation of a prior oral reque	d serio	us threat to his or he	er health
Employee Information					
Employee Name (Last, F	First, Middle): Ro	quemore, Sandra	R	OQSA000	
Date of Injury (MM/DD/Y		•	Date	of Birth (MM/DD/YY	<u>YY):</u> 02/11/1955
Claim Number: CL#:UV	V2000031101		Empl	oyer: American G	uard Services (DBA)
Provider Information					
Provider Name: Nelson	J. Flores, PH.D.				
Practice Name: Psycho	ological Assessme	nt Serv.	Conta	act Name: Ted Tr	ibble PSY.D.
Address: 2107 N Broady			<u>City:</u>	Santa Ana	State: CA
Zip Code: 92706	Phone: 71	4-972-0040	Fax N	Number: 714-972	2-0477
Provider Specialty: Psy	chology		NPI	Number: 183123	7981
E-mail Address:					
Claims Administrator I	nformation				
Claims Administrator Na	me: Accident	Fund Ins. Co. of America	caCont	act Name:	
Address: P.O. Box 407			City:	Lansing	State: MI
Zip Code: 48901	Phone: (87	77)563-4636	Fax	Number: (qu	1)444 6200
E-mail Address:					
Requested Treatment	see instructions	for guidance; attached	additi	onal pages if neces	ssary)
Either state the requeste	ed treatment in the	below space or indicate	the spe	ecitic page number(s) of the accompanying medical
	iested treatment ca	an be found. Op to live (5) proce	edures may be enter	red; attach additional requests
on a separate sheet. Diagnosis	ICD-Code	Procedure Requeste	<u>:d</u>	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Major Depressive Dis., Single	F32.2	Group Medical Psychothera	apv	90853	1X WK X 6 WKS, TOTAL 6 SESSIONS
Generalized Anxiety Disorder	F41.1	Group Medical Psychothera		90853	и п
Insomnia	F51.05	Group Medical Psychothers		90853	н н
Pain Dis. w/Related Psychologi	F45.42	Group Medical Psychother		90853	и и
Pain Dis. W/Related Psychologi	140.42				
			1		te: 1/31/2022
Treating Physician Sign	ature:	May		<u>Da</u>	te: 1/31/2022
Claims Administrator Approved Deni Requested treatment	ed or Modified (Se	e separate decision lette	r) for tre	Delay (See separa	ite notification of delay)
Authorization Number (Date:	
Authorized Agent Name			3	Signature:	
Phone:	Fax Nun	nber:	E	E-mail Address:	
Comments:					

State of California Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA - California Code of Regulations, title 8, section 9785.

This form must accompany 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. X 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** Employee Name (Last, First, Middle): Roquemore, Sandra ROOSA000 02/11/1955 Date of Injury (MM/DD/YYYY): 11/03/2020 Date of Birth (MM/DD/YYYY): American Guard Services (DBA) Claim Number: CL#:UW2000031101 Employer: **Provider Information** Provider Name: Nelson J. Flores, PH.D. Contact Name: Ted Tribble PSY.D. Practice Name: Psychological Assessment Serv. State: CA City: Santa Ana Address: 2107 N Broadway Ste 207 Fax Number: 714-972-0477 714-972-0040 Zip Code: 92706 Phone: NPI Number: Provider Specialty: Psychology 1831237981 E-mail Address: Claims Administrator Information Accident Fund Ins. Co. of Americ Contact Name: Claims Administrator Name: MI State: City: Lansing Address: P.O. Box 40790 Fax Number: Phone: (877)563-4636 Zip Code: 48901 E-mail Address: Requested Treatment (see instructions for guidance; attached additional pages if necessary) Either state the requested treatment in the below space or indicate the specific page number(s) of the accompanying medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; attach additional requests on a separate sheet. Other Information: CPT/HCPCS (Frequency, Duration Procedure Requested ICD-Code Diagnosis Code Quantity, Facility, etc.) 1X WK X 6 WKS, TOTAL 6 SESSIONS 90880 Medical Hypnotherapy/Relaxation Tra F32.2 Major Depressive Dis., Single 90880 F41.1 Medical Hypnotherapy/Relaxation Tra Generalized Anxiety Disorder . .. Medical Hypnotherapy/Relaxation Tra 90880 F51.05 Insomnia 90880 F45.42 Medical Hypnotherapy/Relaxation Tra Pain Dis. w/Related Psychologi My 1/31/2022 Date: Treating Physician Signature: Claims Administrator 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 Authorization Number (if assigned): Signature: Authorized Agent Name: E-mail Address: Fax Number: Phone: Comments:

<u>State of California</u> <u>Division of Workers' Compensation</u>

REQUEST FOR AUTHORIZATION

This form must accomp	oany the Doctor's ss Report, DWC	First Report of Occupa Form PR-2, or narrative	tional repor	Injury or Illness, For t substantiating the	orm DLSR 50 requested t	21, a Treating reatment.
Expedited Review: Ch	eck box if employe	<u>nge in Material Facts</u> <u>ee faces an imminent and</u> ation of a prior oral reque	l serio	us threat to his or he	r health	
Employee Information						
Employee Name (Last, F	irst, Middle): Roo	nuemore, Sandra	RC	QSA000		
Date of Injury (MM/DD/Y		1	Date	of Birth (MM/DD/YY)	<u>(Y):</u> 02/	11/1955
Claim Number: CL#:UW	2000031101		Emplo	oyer: American Gu	ard Services	(DBA)
Provider Information						
Provider Name: Nelson	J. Flores, PH.D.					
Practice Name: Psychol	logical Assessmen	nt Serv.	Conta	act Name: Ted Trib	ble PSY.D.	
Address: 2107 N Broady	vay Ste 207		City:	Santa Ana		State: CA
Zip Code: 92706	Phone: 71	4-972-0040	Fax N	Number: 714-972-	0477	
Provider Specialty: Psyc	chology		NPIN	Number: 18312379	981	
E-mail Address:						
Claims Administrator I						!
Claims Administrator Na	me: Accident	Fund Ins. Co. of Americ	aConta	act Name:		200
Address: P.O. Box 407			City:	City: Lansing State. M1		
Zip Code: 48901	Phone: (87	7)563-4636	Fax N	Number:		
E-mail Address:	ì					
Requested Treatment (see instructions	for guidance; attached a	additio	onal pages if neces	sary)	ananying medical
Either state the requeste	d treatment in the	below space or indicate to the below space or indicate to the space of	ne spe	edures may be entere	ed: attach add	litional requests
on a separate sheet.	ested treatment ca	an be lound. Op to live (o)	proce	daroo may so omer	,	
<u>Diagnosis</u>	ICD-Code	Procedure Requester	ested CPT/HCPCS Other Information (Frequency, Du Quantity, Facility		ency, Duration	
Major Depressive Dis., Single	F32.2	Phone call, intermediate		99442	ONC	E IN 45 DAYS
Generalized Anxiety Disorder	F41.1	Phone call, intermediate		99442		и и
Insomnia	F51.05	Phone call, intermediate		99442		и и
Pain Dis. w/Related Psychologi	F45.42	Phone call, intermediate		99442		" "
an Bio. Wittenson Co., San						
Treating Physician Sign	ature:	Ma		Date	e: 1/31/2022	2
Claims Administrator	Response		1			
Approved Deni		e separate decision letter usly denied Liability	for tre	Delay (See separat atment is disputed	e notification	of delay)
Authorization Number (i				Date:		
Authorized Agent Name			5	Signature:		
Phone:	Fax Nun	nber:	E	-mail Address:		
Comments:						



Message Sent: 81258266 | 2/3/2022 12:41:56 PM PST

1 message

FAXAGENT <noreply@mitelcloud.com>
To: Fax 3 <collections@drnelsonflores.com>

Thu, Feb 3, 2022 at 12:49 PM

Delivery Information:

Message #:

81258266

Status:

Success

Sender Name:

Fax 3

Sender Company: Sender Phone:

Remote CSID:

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2/3/2022 4:49:31 AM PST

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Fax Transmission

To: 19414446200

From: Fax 3

Fax: 19414446200

Date: 2/3/2022 12:41:56 PM PST

RE: Roquemore, Sandra

Pages: 6

Comments:

10/18/21 PR-2 and RFAs

^{*}Collections*

^{*}Psychological Assessment Services * Ph. 714-972-0040 Fax 714972-0477

PROOF OF SERVICE BY MAIL (1013a.2015.5. C.C.P.)

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the county aforesaid; I am over the age of eighteen years and not a party to the within entitled action; my business address is 2107 N. Broadway, Suite 207, Santa Ana, CA 92706.

On12/13/2021, I served the within progress report(s) dated 7/26/21 3 7/28/21 and bill regarding Sandra Roquemore

on the appropriate parties in said action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Santa Ana, California, addressed as follows:

Workers Defenders Law Group 8018 E.Santa Ana Cyn #100-215 Anaheim Hills, CA 92808

Ted Tribble PSY.D. 4344 Latham Street Ste. 120 Riverside, CA 92501

Claim #:

Attn.

Accident Fund Ins. Co. of America P.O. Box 40790 Lansing, MI 48901 CL#:UW2000031101 Attn.: Patricia Carruther

Next Level Administrators P.O. Box 1061 Bradenton, FL 34206 Claim #: Attn.

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

Executed on 12/13/2021, at Santa Ana, California.

Alina Flore

cc: File

State of California

Additional pages attached □

Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or IMC 81556

☐ Periodic Report (required 45 days after last report) ☐ Change in treati	ment plan	☐ Disc	harged
☐ Change-in work status ☐ Need for referral or consultation ☐ Info. Rec	uested by:		
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐	Other:	UR REQUE	STED
Patient:			
Last Roquemore First Sandra M.I.	Sex	Female	DOB 02/11/195
Address 1763 Exposition Blvd City Los Angeles		State	Zip90018
Occupation SS # 564-92-35	86 Phone	() (323)643-4539
Claims Administrator: Name Accident Fund Ins. Co. of America. Claim Nun	07		
Address City	uper C	<u>L#:UW2000</u> State	Zin
Dhana Laising		State	- ^{Zip} -48901-
() (8//)303-4030	er Phone:		
The information below must be provided. You may use this form or you may subst		and a narrati	us report
Subjective Complaints:	litute of app	benu a namati	ve report.
Ms. Roquemore reports pain in her lower back, arms, feet, and legs. She	has diffic	ulty controll	ling her
emotions and impulses. She tends to socially isolate and withdraw from	others Sh	ne feels sad	irritable
fearful, nervous, restless, anxious, depressed, and helpless. (Continue or	1 2 nd page)		iiiitaoic,
, , , , , , , , , , , , , , , , , , , ,	P-8-)		
Objective Findings: (Include significant physical examination, laboratory, imaging	g, or other of	diagnostic find	lings.)
Sad and anxious mood and difficulties concentrating.			
Diagnosis:			
1. Major Depressive Dis., Single Episode, Severe w/o	ICD-9	F32.2	
Generalized Anxiety Disorder	ICD-9	F41.1	
Insomnia Related to Other Mental Disorder	ICD-9	F51.05	
Treatment Plan: (Include treatment rendered to date. List methods, frequency an	d duration o	of planned tre	atment(s).
Specify consultation/referral, surgery, and hospitalization. Identify each physician a type frequency and duration of physical modicine convices (a.g., physical thorags)	and non-phy	ysician provid	er. Specify
type, frequency and duration of physical medicine services (e.g., physical therapy, codes is encouraged. Have there been any changes in treatment plan? If so, why	manipulatio ?	on, acupunctu	re. Use CP1
Cognitive Behavioral Group Psychotherapy 1x week for 6 weeks. Relax		ning/Hypnot	harany 1v
week for 6 weeks. Follow up in 45 days. Continue with current treatment			
Work Status: From the psychological standpoint, this patient is psychiatrically ten	1		1 0 /
	iporarily to	tally disabled	until 03/10/2021.
Restriction: To be determined when patient reaches MMI Status.			
Primary Treating Physician: (original signature, do not stamp) Date of	of exam:	July 2	26, 2021
I declare under penalty of perjuly that this report is true and correct to the best of my knowledge an	d that I have	not violated Lab	or Code § 139.3.
Signature:	Cal. Lic. #	PSV12	317/PSY31773
Executed at: SANTA ANA	Date:		7/26/2021
Name: Nelson J. Flores, Ph.D, QME/Nelson L. Flores, Psy.D.	Specialty:		sychology
Address: P.O. Box 6299 Laguna Niguel, CA 92607-6299	Phone:		4) 972-0040
Next report due no later than	_		
DWC Form PR-2 (Rev. 1/1/99)		(Use additiona	l pages, if necessary)

Primary Treating Physician's Progress Report (PR-2)

RE: Sandra Roquemore Date: July 26, 2021

Page 2 of 2

Subjective Complaints:

She experiences crying episodes and, at times, she feels like crying. She has difficulty communicating and making decisions. She has a decreased appetite and reports she has lost weight. She has lost interest in her usual activities. She fears the worst happening. She endorses sleep difficulties, including nightmares and distressing dreams. She feels tired and has low energy throughout the day. She experiences intrusive recollections and flashbacks. She has a decreased sexual desire. She is bothered by headaches. She reports gastrointestinal disturbances, including heartburn, indigestion, diarrhea, constipation, and nausea. She has shown improvement in her motivation.

Treatment Plan:

The treatment to be provided by Dr. Flores, and Registered Psychological Assistants, Stephanie T. Imp, Jennifer Lightner, and Ting F. Chiu.

Psychological Testing:

Burns Depression Checklist score: 79 (extreme depression) Burns Anxiety Inventory score: 84 (extreme anxiety)

Psychological testing administered today: 31 minutes (testing time includes administration, scoring, and interpretation).

Disclosure:

The patient was informed and consented to the use of telehealth services.

Scoring and interpretation of the psychological testing were conducted by Dr. Flores/Psychological Assistants, Stephanie T. Imp/Jennifer Lightner/Ting F. Chiu.

Time spent for this service: 20 minutes face to face time with the patient via telemedicine.

Time spent preparing this report: 1.15 hours preparing, testing score, interpretation, transcribing, and editing this report.

I have reviewed the medical records and collateral records. X 15 mins.

State of California Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA - California Code of Regulations, title 8, section 9785.

		's First Report of Occupa Form PR-2, or narrative					iting
Expedited Review: C	heck box if employ	ange in Material Facts yee faces an imminent and mation of a prior oral reque		ous threat to his or h	er health		
Employee Information							
Employee Name (Last,	First, Middle):	Roquemore, Sandra		ROQSA000			
Date of Injury (MM/DD/)	YYY): 11/03/2020)	<u>Date of Birth (MM/DD/YYYY):</u> 02/11/1955				
Claim Number: CL#	:UW2000031101		Emp	loyer: American	Guard Service	s (DBA)	
Provider Information							
	son J. Flores, PH.I						
Practice Name: Psychological Assessment Serv.			Cont	act Name: Ted	Tribble PSY.D.		
Address: 2107 N Broads	way Ste 207		City:	Santa Ana		State: CA	`
<u>Zip Code:</u> 92706	Phone:	714-972-0040	Fax I	<u>Number:</u> 714-9	72-0477		
Provider Specialty:	Psychology		NPI I	Number: 18312	237981		
E-mail Address:							
Claims Administrator I	nformation						
Claims Administrator Na		lent Fund Ins. Co. of Ame	reant				MI
Address: P.O. Box	40790	(077) 7 (2)	City:	Lansing		State:	1411
Zip Code: 48901	Phone:	(877)563-4636	Fax I	Number:			
E-mail Address:			No Carrent				
		for guidance; attached a				nanyina m	edical
report on which the requeste	ed treatment in the rested treatment c	below space or indicate the below space or indicate the below space or indicate the below space of the below space of the below space of the below space or indicate the b	proce	edures mav be ente	red: attach add	itional requ	iests
on a separate sheet.	iodioa troatmoni o	an so roanar op to me (e)	-	,,		1	
<u>Diagnosis</u>	ICD-Code	Procedure Requested	<u>i</u>	CPT/HCPCS Code	(Freque	nformation ncy, Durati , Facility, et	<u>on</u>
Major Depressive Dis., Single	F32.2	Group Medical Psychothera	ру	90853	1X WK X WKS	S, TOTAL	SESSIONS
Generalized Anxiety Disorder	F41.1	Group Medical Psychothera	ру	90853	2	" "	
Insomnia	F51.05	Group Medical Psychothera	ру	90853			
Pain Dis. w/Related Psychologi	F45.42	Group Medical Psychothera	ру	90853		""	
					7/28/202	1	
Treating Physician Sign	ature:	My		Dat	e:		
Claims Administrator				Chia e a aparamente			
Approved Denic		ee separate decision letter) usly denied	or tre	Delay (See separa atment is disputed	te notification of	of delay)	
Authorization Number (i	f assigned):			Date:			
Authorized Agent Name	<u>:</u>		Signature:				
Phone:	Fax Nun	nber:	E-mail Address:				
Comments:							

<u>State of California</u> <u>Division of Workers' Compensation</u>

REQUEST FOR AUTHORIZATION

DWC Form RFA - California Code of Regulations, title 8, section 9785.

		's First Report of Occup Form PR-2, or narrativ					
Expedited Review: C	heck box if emplo	nange in Material Facts yee faces an imminent ar mation of a prior oral requ		ous threat to his or h	er health		
Employee Information							
Employee Name (Last, I	First, Middle):	Roquemore, Sandra		ROQSA000			
Date of Injury (MM/DD/Y	YYY): 11/03/2020	<u>0</u>	Date	of Birth (MM/DD/Y)	<u>(YY):</u>	02/11/1955	
Claim Number: CL#	:UW2000031101		Emp	loyer: American	Guard Service	es (DBA)	
Provider Information						***************************************	
	son J. Flores, PH.						
Practice Name: Psychological Assessment Serv.				tact Name: Ted	Tribble PSY.D	•	
Address: 2107 N Broady	way Ste 207		City:	Santa Ana		State: CA	
Zip Code: 92706	Phone:	714-972-0040	Fax	Number: 714-9	72-0477		
Provider Specialty:	Psychology	×	NPL	<u>Number:</u> 1831:	237981		
E-mail Address:							
Claims Administrator I	nformation					1000	
Claims Administrator Na		dent Fund Ins. Co. of An	ericont			I a MI	
Address: P.O. Box		(077) 7 (2) 4 (2) (City:			State:	
Zip Code: 48901	Phone:	(877)563-4636	Fax	Number:			
E-mail Address:							
		for guidance; attached below space or indicate				ananying modical	
		an be found. Up to five (5					
on a separate sheet.							
<u>Diagnosis</u>	ICD-Code	Procedure Requests	<u>ed</u>	CPT/HCPCS Code	(Freque	Information: ency, Duration y, Facility, etc.)	
					,		
Major Depressive Dis., Single	F32.2	Medical Hypnotherapy/Relaxa	tion Tra	90880	1X WK X WWK	S, TOTAL $ ot\!$	
Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxa	tion Tra	90880		H H	
Insomnia	F51.05	Medical Hypnotherapy/Relaxa	tion Tra	90880	-	и и	
Pain Dis. w/Related Psychologi	F45.42	Medical Hypnotherapy/Relaxa	tion Tra	90880		н и	
					7/28/20	21	
Treating Physician Signa	ature:	Mad		Dat	e:		
Claims Administrator I							
Approved Denie Requested treatmen		ee separate decision lette usly denied		Delay (See separa atment is disputed	te notification of	of delay)	
Authorization Number (i	f assigned):		<u></u>	Date:			
Authorized Agent Name	<u>:</u>		Signature:				
Phone:	Fax Nur	nber:	E	-mail Address:			
Comments:						The state of the s	

<u>State of California</u> <u>Division of Workers' Compensation</u>

REQUEST FOR AUTHORIZATION

DWC Form RFA - California Code of Regulations, title 8, section 9785.

		's First Report of Occupa Form PR-2, or narrative				
Expedited Review: C	Check box if emplo	lange in Material Facts yee faces an imminent and mation of a prior oral reque		ous threat to his or h	er health	
Employee Information	1					
Employee Name (Last,	First, Middle):	Roquemore, Sandra		ROQSA000		
Date of Injury (MM/DD/	YYYY): 11/03/2020		Date	of Birth (MM/DD/Y)	<u>(YY):</u> 0	2/11/1955
Claim Number: CL#	#:UW2000031101		Empl	oyer: American	Guard Service	es (DBA)
Provider Information						
TTO TIGOT TTGTTTO.	ls on J. Flores, PH.					
Practice Name: Psy	chological Asses	sment Serv.	Conta	act Name: Ted	Tribble PSY.D.	
Address: 4344 Latham	St. Suite 120		City:	Riverside		State: CA
Zip Code: 92501	Phone:	714-972-0040	Fax N	Number: 714-9	72-0477	
Provider Specialty:	Psychology		NPIN	Number: 18312	237981	
E-mail Address:						,
Claims Administrator	Information					
Claims Administrator N		lent Fund Ins. Co. of Ame	r <u>icanta</u>			MI
Address: P.O. Box	40790		City:	Lansing		State:
<u>Zip Code:</u> 48901	Phone:	(877)563-4636	Fax N	Number:		
E-mail Address:						
		for guidance; attached a				
Either state the request	ed treatment in the	below space or indicate to be found. Up to five (5)	ne spe	ecific page number(<u>s) of the accom</u>	litional requests
on a separate sheet.	uested treatment c	an be lound. Op to live (b)	ргосс	dares may be onto	ou, attaon aud	
<u>Diagnosis</u>	ICD-Code	Procedure Requested	<u>i</u>	CPT/HCPCS Code	(Freque	Information: ency, Duration y, Facility, etc.)
Major Depressive Dis., Single	F32.2	Phone call, intermediate		99442	ONCE	E IN 45 DAYS
Generalized Anxiety Disorder	F41.1	Phone call, intermediate		99442		ни
Insomnia	F51.05	Phone call, intermediate		99442		н и
Pain Dis. w/Related Psychologi	F45.42	Phone call, intermediate		99442		и и
					7/28/202	21
Treating Physician Sign	nature:	My		Dat	te:	
Claims Administrator		\				- f - l - l \
Approved Den		ee separate decision letter usly denied	for trea	Delay (See separa atment is disputed	te notification (of delay)
Authorization Number (if assigned):		D	ate:		
Authorized Agent Name	e:		Signature:			
Phone:	Fax Nur	nber:	E	-mail Address:		
Comments:						



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07/26/21 PR-2 and RFAs

Collections

Ph. 714-972-0040 Fax 714-972-0477

^{*}Psychological Assessment Services *

State of California Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA - California Code of Regulations, title 8, section 9785.

This form must accom	pany the Doctor ess Report, DWC	's First Report of Occup Form PR-2, or narrative	ationa repor	l Injury or Illness, t substantiating th	Form DLSR 5021, a Treating ne requested treatment.	
Expedited Review: C	heck box if employ	<u>ange in Material Facts</u> y <u>ee faces an imminent an</u> mation of a prior oral requ	d serio est.	us threat to his or h	er health	
Employee Information				În l		
Employee Name (Last,		Roquemore, Sandra	R	OQSA000		
Date of Injury (MM/DD/)			Date	of Birth (MM/DD/YY	<u>YY):</u> 02/11/1955	
Claim Number:			Empl	oyer: American	Guard Services (DBA)	
Provider Information						
	son J. Flores, Ph.I)				
	chological Asses		Conta	act Name: Ted	Tribble PSY.D.	
Address: 2107 N Broads			City:	Santa Ana	State: CA	
Zip Code: 92706	Phone:	714-972-0040	_	Number: 714-9	972-0477	
Provider Specialty:	Psychology		NPIN	Number: 1831	237981	
E-mail Address:		* ·				
Claims Administrator	Information					
Claims Administrator Na		Level Administrators	Conta	act Name:	El	
Address: P.O. Box			City:	Bradenton	State:	
Zip Code: 34206	Phone:	(941)281-3494		Number: (941)444-6200	
E-mail Address:						
	(see instructions	for guidance; attached	additio	nal pages if neces	ssary)	
Either state the requeste	ed treatment in the	below space or indicate	the spe	ecific page number(s) of the accompanying medical	
report on which the requ	uested treatment c	an be found. Up to five (5) proce	dures may be enter	red; attach additional requests	
on a separate sheet.						
<u>Diagnosis</u>	ICD-Code	Procedure Requeste	<u>d</u>	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)	
Major Depressive Dis., Single	F32.2	Group Medical Psychothera	anv	90853	1X WK X WKS, TOTA SESSIONS	
Generalized Anxiety Disorder	F41.1	Group Medical Psychothera		90853	11 11	
Insomnia	F51.05	Group Medical Psychother		90853	n u	
Pain Dis. w/Related Psychologi	F45.42	Group Medical Psychother		90853	" "	
Faili Dis. W/Keialed Psychologi	1 45.42	Group Woulder F Sychother				
		Ma.			7/28/2021	
Treating Physician Sign	ature:	May		Dat	te:	
Claims Administrator						
	ed or Modified (Se	ee separate decision lette	for tre	Delay (See separa atment is disputed	te notification of delay)	
Authorization Number (if assigned):		D	ate:		
Authorized Agent Name			Signature:			
Phone:				E-mail Address:		
Comments:	<u>rax ivui</u>	nber.		Titali / taarooo:		

REQUEST FOR AUTHORIZATION

DWC Form RFA - California Code of Regulations, title 8, section 9785.

This form must accom	pany the Doctor' ess Report, DWC	s First Report of Occup Form PR-2, or narrative	ational e repor	<u>Injury or Illness, F</u> t substantiating th	e requested	021, a Treating treatment.	
Expedited Review: Ch	neck box if employ	ange in Material Facts yee faces an imminent an nation of a prior oral requ	nd serion	us threat to his or he	er health		
Employee Information							
Employee Name (Last, F	irst, Middle):	Roquemore, Sandra	R	OQSA000			
Date of Injury (MM/DD/Y	YYY): 11/03/2020	<u>)</u>	Date	of Birth (MM/DD/YY	<u> </u>	02/11/1955	
Claim Number:			Emple	<u>oyer:</u> American	Guard Service	es (DBA)	
Provider Information							
Provider Name: Nel	son J. Flores, Ph.	D					
Practice Name: Psy	chological Asses	ssment Serv.	Conta	act Name: Ted	Tribble PSY.D).	
Address: 2107 N Broady	vay Ste 207		City:	Santa Ana		State: CA	
Zip Code: 92706	Phone:	714-972-0040	Fax N	<u>lumber:</u> 714-9	72-0477		
Provider Specialty:	Psychology		NPIN	<u>lumber:</u> 18312	237981		
E-mail Address:				\			
Claims Administrator I	nformation	¥					
Claims Administrator Na	me: Next	Level Administrators	Conta	act Name:			
Address: P.O. Box	1061		City:	Bradenton		State:	FL
Zip Code: 34206	Phone:	(941)281-3494	Fax N	Number: (941)444-6200		
E-mail Address:	·						
Requested Treatment (see instructions	for guidance; attached	additio	nal pages if neces	sary)		
Either state the requeste	d treatment in the	e below space or indicate	the spe	ecific page number(s	s) of the accor	mpanying medic	<u>cal</u>
	ested treatment o	an be found. Up to five (5	<u>) proce</u>	dures may be enter	eu, allacii au	ultional request	2
on a separate sheet.					Othor	Information:	
Diamasia	ICD Codo	Procedure Requests	he	CPT/HCPCS	Other Information: (Frequency, Duration		
<u>Diagnosis</u>	ICD-Code	Frocedure requeste	<u>50</u>	Code		y, Facility, etc.)	
				00000	1X WK X	KS, TOTAL SESS	SIONS
Major Depressive Dis., Single	F32.2	Medical Hypnotherapy/Relaxa		90880	IX WK XX WK	""	JIOITE
Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxa				н и	
Insomnia	F51.05	Medical Hypnotherapy/Relaxa		90880		пи	
Pain Dis. w/Related Psychologi	F45.42	Medical Hypnotherapy/Relaxa	ation Ira	90880			
						3.2 37	
					7/28/20	021	
Treating Physician Sign	ature:	May		<u>Dat</u>	<u>e:</u>		
Claims Administrator							
	ed or Modified (Se	ee separate decision lette	y for tre	Delay (See separa atment is disputed	te notification	of delay)	
Authorization Number (i			D	ate:			
Authorized Agent Name			Signature:				
Phone:	Fax Nu	mber:	E	-mail Address:			
Comments:							



REQUEST FOR AUTHORIZATION

DWC Form RFA - California Code of Regulations, title 8, section 9785.

This form must accom Physician's Progre	<u>pany the Doctor'</u> ess Report, DWC	s First Report of Occupa Form PR-2, or narrative	repor	t substantiating the	requested 1	treatment.
Expedited Review: Cl	neck box if employ	ange in Material Facts yee faces an imminent and nation of a prior oral reque	d seriou	us threat to his or he	r health	
Employee Information						
Employee Name (Last, F	irst, Middle):	Roquemore, Sandra	R	OQSA000		
Date of Injury (MM/DD/Y			Date (of Birth (MM/DD/YY)	<u> </u>	02/11/1955
Claim Number:			Emplo	oyer: American	Guard Servic	es (DBA)
Provider Information						
	son J. Flores, Ph.I)				
Practice Name: Psychological Assessment Serv.			Conta	act Name: Ted T	ribble PSY.D	
Address: 4344 Latham S	St. Suite 120		City: I	Riverside		State: CA
Zip Code: 92501	Phone:	714-972-0040	Fax N	<u>Jumber:</u> 714-97	/2-0477	
Provider Specialty:	Psychology		NPI N	<u>lumber:</u> 18312	37981	
E-mail Address:		, 1				
Claims Administrator I	nformation					grand and the second
Claims Administrator Na	Mark	Level Administrators	Conta	act Name:		El .
Address: P.O. Box	1061		City:	Bradenton		State: FL
Zip Code: 34206	Phone:	(941)281-3494	Fax N	Number: (941)	444-6200	
E-mail Address:						
Requested Treatment	see instructions	for guidance; attached a	additic	nal pages if neces	sary)	
Either state the requeste	ed treatment in the	e below space or indicate to	he spe	ecific page number(s	of the accor	npanying medical
	iested treatment c	an be found. Up to five (5	<u>proce</u>	dures may be entere	ed, allach auc	altional requests
on a separate sheet.					Othor	Information:
5: .	ICD-Code Procedure Requeste		CPT/HCPCS			ency, Duration
<u>Diagnosis</u>	ICD-Code	Procedure Requeste	<u>Code</u>		Quantity, Facility, etc.)	
				00440	ONC	y, Facility, etc.)
Major Depressive Dis., Single	F32.2	Phone call, intermediate		99442	ONC	
Major Depressive Dis., Single Generalized Anxiety Disorder	F41.1	Phone call, intermediate		99442	ONC	<u>y, Facility, etc.)</u> E IN 45 DAYS
		Phone call, intermediate		99442 99442	ONC	y, Facility, etc.) E IN 45 DAYS
Generalized Anxiety Disorder	F41.1	Phone call, intermediate		99442	ONC	y, Facility, etc.) E IN 45 DAYS
Generalized Anxiety Disorder Insomnia	F41.1 F51.05	Phone call, intermediate		99442 99442	ONC	y, Facility, etc.) E IN 45 DAYS
Generalized Anxiety Disorder Insomnia	F41.1 F51.05	Phone call, intermediate		99442 99442	7/28/28	y, Facility, etc.) E IN 45 DAYS "" ""
Generalized Anxiety Disorder Insomnia Pain Dis. w/Related Psychologi	F41.1 F51.05 F45.42	Phone call, intermediate		99442 99442	7/28/20	y, Facility, etc.) E IN 45 DAYS "" ""
Generalized Anxiety Disorder Insomnia Pain Dis. w/Related Psychologi Treating Physician Sign	F41.1 F51.05 F45.42	Phone call, intermediate Phone call, intermediate Phone call, intermediate		99442 99442 99442 Date	7/28/20	y, Facility, etc.) E IN 45 DAYS "" "" ""
Generalized Anxiety Disorder Insomnia Pain Dis. w/Related Psychologi Treating Physician Sign Claims Administrator Approved Deni	F41.1 F51.05 F45.42 ature: Response ed or Modified (Se	Phone call, intermediate Phone call, intermediate Phone call, intermediate Phone call, intermediate Phone call, intermediate	7)	99442 99442 99442 Date	7/28/20	y, Facility, etc.) E IN 45 DAYS "" "" ""
Generalized Anxiety Disorder Insomnia Pain Dis. w/Related Psychologi Treating Physician Sign Claims Administrator	F41.1 F51.05 F45.42 ature: Response ed or Modified (Se	Phone call, intermediate Phone call, intermediate Phone call, intermediate Phone call, intermediate Phone call, intermediate	for treating	99442 99442 99442 Date Delay (See separate atment is disputed	7/28/20	y, Facility, etc.) E IN 45 DAYS "" "" ""
Generalized Anxiety Disorder Insomnia Pain Dis. w/Related Psychologi Treating Physician Sign Claims Administrator Approved Deni	F41.1 F51.05 F45.42 ature: Response ed or Modified (Sont has been previous	Phone call, intermediate Phone call, intermediate Phone call, intermediate Phone call, intermediate Phone call, intermediate	r) To for tree	99442 99442 99442 Date Delay (See separate atment is disputed eate:	7/28/20	y, Facility, etc.) E IN 45 DAYS "" "" ""
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Generalized Anxiety Disorder Insomnia Pain Dis. w/Related Psychologi Treating Physician Sign Claims Administrator Approved Deni Requested treatmer Authorization Number (Authorized Agent Name	F41.1 F51.05 F45.42 ature: Response ed or Modified (Sont has been previous fassigned): e:	Phone call, intermediate Phone call, intermediate Phone call, intermediate Phone call, intermediate Phone call, intermediate Phone call, intermediate Liability	for tree	99442 99442 99442 Date Delay (See separate atment is disputed late:	7/28/20	y, Facility, etc.) E IN 45 DAYS "" "" ""



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