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
Division of Workers' Compensation

Additional pages attached ☐

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 plan ☐ Discharged
☐ Change-in work status ☐ Need for referral or consultation ☐ Info. Requested by:
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Other: UR REQUESTED

Patient:
Last Roquemore First Sandra M.I. Sex Female DOB 02/11/1955
Address 1763 Exposition Blvd City Los Angeles State Zip 90018
Occupation SS # 564-92-3586 Phone ( ) (213)677-8002

Claims Administrator:
Name Accident Fund Ins. Co. of America Claim Number CL#:UW2000031101
Address P.O. Box 40790 City Lansing State Zip 48901
Phone ( ) (877)563-4636 FAX ( )
Employer name: American Guard Services (DBA) Employer Phone: ( )

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective Complaints:

Ms. Roquemore reports pain in her lower back, legs, and feet, and numbness 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 emotions. (Continue on 2nd page)

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Anxious mood and nervous.

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 and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture. Use CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

Cognitive Behavioral Group Psychotherapy 1x week for 6 weeks. Relaxation Training/Hypnotherapy 1x week for 6 weeks. Follow up in 45 days. Continue with current treatment plan. (Continue on 2nd page)

Work Status: From the psychological standpoint, this patient is psychiatrically temporarily 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.

Signature:
Executed at: SANTA ANA Cal. Lic. # PSY12317/PSY31773
Name: Nelson J. Flores, Ph.D, QME/Nelson L. Flores, Psy.D. Date: 11/29/2021
Address: P.O. Box 6299 Laguna Niguel, CA 92607-6299 Specialty: Psychology
Next report due no later than Phone: (714) 972-0040

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

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.

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 ROQSA000	
Date of Injury (MM/DD/YYYY): 11/03/2020	Date of Birth (MM/DD/YYYY): 02/11/1955
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~~	
E-mail Address:			

Claims Administrator Information

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) 444-1120	
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.

Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Major Depressive Dis., Single	F32.2	Group Medical Psychotherapy	90853	1X WK X 16 WKS, TOTAL 16 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: [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:		

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 ROQSA000	
Date of Injury (MM/DD/YYYY): 11/03/2020	Date of Birth (MM/DD/YYYY): 02/11/1955
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	
E-mail Address:			

Claims Administrator Information

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:	
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.

Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Major Depressive Dis., Single	F32.2	Medical Hypnotherapy/Relaxation Tra	90880	1X WK X 4 WKS, TOTAL 4 SESSIONS
Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxation Tra	90880	" "
Insomnia	F51.05	Medical Hypnotherapy/Relaxation Tra	90880	" "
Pain Dis. w/Related Psychologi	F45.42	Medical Hypnotherapy/Relaxation Tra	90880	" "

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:		

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	ROQSA000
Date of Injury (MM/DD/YYYY): 11/03/2020	Date of Birth (MM/DD/YYYY): 02/11/1955
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	
E-mail Address:			

Claims Administrator Information

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:	
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.

Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, 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	" "

Treating Physician Signature: [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:		

Gmail

Collections Department <collections@drnelsonflores.com>

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

1 message

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

Thu, Mar 3, 2022 at 4:00 PM

Delivery Information:

Message #:	81880274
Status:	Success
Sender Name:	Fax 3
Sender Company:	
Sender Phone:	
Remote CSID:	FF240-IP.Rx
Total Pages:	6
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End Time:	3/3/2022 8:00:03 AM PST
Duration:	0.447 sec
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Fax Transmission

To: 19414446200

Fax: 19414446200

RE: Roquemore, Sandra

From: Fax 3

Date: 3/3/2022 2:57:49 PM PST

Pages: 6

Comments:

11/29/21 PR-2 and RFAs

Collections
*Psychological Assessment Services *
Ph. 714-972-0040
Fax 714-972-0477

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 ROQSA000	
Date of Injury (MM/DD/YYYY): 11/03/2020	Date of Birth (MM/DD/YYYY): 02/11/1955
Claim Number:	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	
E-mail Address:			

Claims Administrator Information

Claims Administrator Name: Next Level Administrators		Contact Name:	
Address: P.O. Box 1061		City: Bradenton	State: FL
Zip Code: 34206	Phone: (941)281-3494	Fax Number: (941)444-6200	
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.

Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Major Depressive Dis., Single	F32.2	Group Medical Psychotherapy	90853	1X WK X 12 WKS, TOTAL 12 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:		

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 ROQSA000	
Date of Injury (MM/DD/YYYY): 11/03/2020	Date of Birth (MM/DD/YYYY): 02/11/1955
Claim Number:	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	
E-mail Address:			

Claims Administrator Information

Claims Administrator Name: Next Level Administrators		Contact Name:	
Address: P.O. Box 1061		City: Bradenton	State: FL
Zip Code: 34206	Phone: (941)281-3494	Fax Number: (941)444-6200	
E-mail Address:			

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Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Major Depressive Dis., Single	F32.2	Medical Hypnotherapy/Relaxation Tra	90880	1X WK X 6 WKS, TOTAL 6 SESSIONS
Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxation Tra	90880	" "
Insomnia	F51.05	Medical Hypnotherapy/Relaxation Tra	90880	" "
Pain Dis. w/Related Psychologi	F45.42	Medical Hypnotherapy/Relaxation Tra	90880	" "

Treating Physician Signature: Date: 2/15/2022

Claims Administrator Response

[ ] Approved [ ] Denied or Modified (See separate decision letter) [ ] Delay (See separate notification of delay)
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Authorized Agent Name:		Signature:
Phone:	Fax Number:	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 ROQSA000	
Date of Injury (MM/DD/YYYY): 11/03/2020	Date of Birth (MM/DD/YYYY): 02/11/1955
Claim Number:	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	
E-mail Address:			

Claims Administrator Information

Claims Administrator Name: Next Level Administrators		Contact Name:	
Address: P.O. Box 1061		City: Bradenton	State: FL
Zip Code: 34206	Phone: (941)281-3494	Fax Number: (941)444-6200	
E-mail Address:			

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

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Insomnia	F51.05	Telephone Services, 21-30 min.	99443	" "
Pain Dis. w/Related Psychologi	F45.42	Telephone Services, 21-30 min.	99443	" "

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:		

Gmail

Collections Department <collections@drnelsonflores.com>

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

1 message

FAXAGENT <noreply@mitelcloud.com> Thu, Mar 3, 2022 at 3:54 PM
To: Fax 3 <collections@drnelsonflores.com>

Delivery Information:

Message #:	81880264
Status:	Success
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Duration:	0.432 sec
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To: 19414446200

From: Fax 3

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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 & 01/31/22 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 2/17/2022 , at Santa Ana, California.

By: _____
Jose Elpa

cc: File

State of California
Division of Workers' Compensation

Additional pages attached ☐

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 plan ☐ Discharged
☐ Change-in work status ☐ Need for referral or consultation ☐ Info. Requested by:
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Other: UR REQUESTED

Patient:

Last Roquemore First Sandra M.I. Sex Female DOB 02/11/1955
Address 1763 Exposition Blvd City Los Angeles State Zip 90018
Occupation SS # 564-92-3586 Phone ( ) (213)677-8002

Claims Administrator:

Name Accident Fund Ins. Co. of America Claim Number CL#:UW2000031101
Address P.O. Box 40790 City Lansing State Zip 48901
Phone ( ) (877)563-4636 FAX ( )
Employer name: American Guard Services (DBA) Employer Phone: ( )

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective Complaints:

Ms. Roquemore reports pain in her left shoulder, left arm, left hand, lower back, and feet. She has difficulty controlling her emotions. She tends to socially isolate and withdraw from others. She feels sad, fearful, nervous, restless, anxious, depressed, and helpless. (Continue on 2nd page).

Objective Findings: (Include significant physical examination, laboratory, imaging, 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 and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture. Use CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

Cognitive Behavioral Group Psychotherapy 1x week for 6 weeks. Relaxation Training/Hypnotherapy for the treatment of patient's anxious symptoms 1x week for 6 weeks. (Continue on 2nd page).

Work Status: From the psychological standpoint, this patient is psychiatrically temporarily totally disabled until 12/03/2021.

Restriction: To be determined when patient reaches MMI Status.

Primary Treating Physician: (original signature, do not stamp) Date of exam: October 18, 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.

Signature:
Executed at: SANTA ANA Cal. Lic. # PSY12317/PSB94026051
Name: Nelson J. Flores, Ph.D, QME/Ting F. Chiu, M.A. Date: 10/18/2021
Address: P.O. Box 6299 Laguna Niguel, CA 92607-6299 Specialty: Psychology
Next report due no later than Phone: (714) 972-0040

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

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

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.

☒ 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 ROQSA000	
Date of Injury (MM/DD/YYYY): 11/03/2020	Date of Birth (MM/DD/YYYY): 02/11/1955
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	
E-mail Address:			

Claims Administrator Information

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)444-0200	
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.

Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Major Depressive Dis., Single	F32.2	Group Medical Psychotherapy	90853	1X WK X 6 WKS, TOTAL 6 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: 1/31/2022

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:		

State of California
Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

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Provider Specialty: Psychology		NPI Number: 1831237981	
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Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxation Tra	90880	" "
Insomnia	F51.05	Medical Hypnotherapy/Relaxation Tra	90880	" "
Pain Dis. w/Related Psychologi	F45.42	Medical Hypnotherapy/Relaxation Tra	90880	" "

Treating Physician Signature: Date: 1/31/2022

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:		

State of California
Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

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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	
E-mail Address:			

Claims Administrator Information

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:	
E-mail Address:			

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Major Depressive Dis., Single	F32.2	Phone call, intermediate	99442	ONCE IN 45 DAYS
Generalized Anxiety Disorder	F41.1	Phone call, intermediate	99442	" "
Insomnia	F51.05	Phone call, intermediate	99442	" "
Pain Dis. w/Related Psychologi	F45.42	Phone call, intermediate	99442	" "

Treating Physician Signature: Date: 1/31/2022

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:		

Gmail

Collections Department <collections@drnelsonflores.com>

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

1 message

FAXAGENT <noreply@mitelcloud.com> Thu, Feb 3, 2022 at 12:49 PM
To: Fax 3 <collections@drnelsonflores.com>

Delivery Information:

Message #:	81258266
Status:	Success
Sender Name:	Fax 3
Sender Company:	
Sender Phone:	
Remote CSID:	FF240-IP.Rx
Total Pages:	6
Start Time:	2/3/2022 12:41:56 PM PST
End Time:	2/3/2022 4:49:31 AM PST
Duration:	0.423 sec
Delivery Count:	1

Recipient List:
19414446200 - 19414446200

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81258266.pdf
598K

Fax Transmission

To: 19414446200

Fax: 19414446200

RE: Roquemore, Sandra

From: Fax 3

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

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 & 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.

By: _____
Alina Flores

cc: File

State of California
Division of Workers' Compensation

Additional pages attached ☐

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 plan ☐ Discharged
☐ Change-in work status ☐ Need for referral or consultation ☐ Info. Requested by:
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Other: UR REQUESTED

Patient:

Last Roquemore First Sandra M.I. Sex Female DOB 02/11/1955
Address 1763 Exposition Blvd City Los Angeles State Zip 90018
Occupation SS # 564-92-3586 Phone ( ) (323)643-4539

Claims Administrator:

Name Accident Fund Ins. Co. of America Claim Number CL#:UW2000031101
Address P.O. Box 40790 City Lansing State Zip 48901
Phone ( ) (877)563-4636 FAX ( )
Employer name: American Guard Services (DBA) Employer Phone: ( )

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective Complaints:

Ms. Roquemore reports pain in her lower back, arms, feet, and legs. She has difficulty controlling her emotions and impulses. She tends to socially isolate and withdraw from others. She feels sad, irritable, fearful, nervous, restless, anxious, depressed, and helpless. (Continue on 2nd page).

Objective Findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Sad and anxious mood and difficulties concentrating.

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 and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture. Use CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

Cognitive Behavioral Group Psychotherapy 1x week for 6 weeks. Relaxation Training/Hypnotherapy 1x week for 6 weeks. Follow up in 45 days. Continue with current treatment plan. (Continue on 2nd page).

Work Status: From the psychological standpoint, this patient is psychiatrically temporarily totally disabled until 09/10/2021.

Restriction: To be determined when patient reaches MMI Status.

Primary Treating Physician: (original signature, do not stamp) Date of exam: July 26, 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.

Signature:
Executed at: SANTA ANA Cal. Lic. # PSY12317/PSY31773
Name: Nelson J. Flores, Ph.D, QME/Nelson L. Flores, Psy.D. Date: 07/26/2021
Address: P.O. Box 6299 Laguna Niguel, CA 92607-6299 Specialty: Psychology
Next report due no later than Phone: (714) 972-0040

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

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

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[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 ROQSA000	
Date of Injury (MM/DD/YYYY): 11/03/2020	Date of Birth (MM/DD/YYYY): 02/11/1955
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	
E-mail Address:			

Claims Administrator Information

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:	
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.

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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: 7/28/2021

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:		

State of California
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REQUEST FOR AUTHORIZATION

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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
E-mail Address:			

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Claims Administrator Name:	Accident Fund Ins. Co. of America	Contact Name:	
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Zip Code:	48901 Phone: (877)563-4636	Fax Number:	
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State of California
Division of Workers' Compensation

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Provider Information

Provider Name: Nelson J. Flores, PH.D.			
Practice Name: Psychological Assessment Serv.		Contact Name: Ted Tribble PSY.D.	
Address: 4344 Latham St. Suite 120		City: Riverside	State: CA
Zip Code: 92501	Phone: 714-972-0040	Fax Number: 714-972-0477	
Provider Specialty: Psychology		NPI Number: 1831237981	
E-mail Address:			

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

Gmail

Collections Department <collections@drnelsonflores.com>

Message Sent: 79901644 | 11/26/2021 11:54:06 AM PST

1 message

FAXAGENT <noreply@mitelcloud.com> Fri, Nov 26, 2021 at 12:26 PM
To: Fax 3 <collections@drnelsonflores.com>

Delivery Information:

Message #:	79901644
Status:	Success
Sender Name:	Fax 3
Sender Company:	
Sender Phone:	
Remote CSID:	FF240-IP.Rx
Total Pages:	6
Start Time:	11/26/2021 11:54:06 AM PST
End Time:	11/26/2021 4:26:06 AM PST
Duration:	0.437 sec
Delivery Count:	1

Recipient List:
19414446200 - 19414446200

Delivered by **FAXAGENT**... "When Every Fax is Mission Critical"

79901644.pdf
623K

Fax Transmission

To: 19414446200

Fax: 19414446200

RE: Roquemore, Sandra

From: Fax 3

Date: 11/26/2021 11:54:06 AM PST

Pages: 6

Comments:

07/26/21 PR-2 and RFAs

Collections
*Psychological Assessment Services *
Ph. 714-972-0040
Fax 714-972-0477

State of California
Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

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Zip Code: 92706	Phone: 714-972-0040	Fax Number: 714-972-0477	
Provider Specialty: Psychology		NPI Number: 1831237981	
E-mail Address:			

Claims Administrator Information

Claims Administrator Name: Next Level Administrators		Contact Name:	
Address: P.O. Box 1061		City: Bradenton	State: FL
Zip Code: 34206	Phone: (941)281-3494	Fax Number: (941)444-6200	
E-mail Address:			

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Treating Physician Signature: Date: 7/28/2021

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:		

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 ROQSA000	
Date of Injury (MM/DD/YYYY): 11/03/2020	Date of Birth (MM/DD/YYYY): 02/11/1955
Claim Number:	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
E-mail Address:	

Claims Administrator Information

Claims Administrator Name: Next Level Administrators	Contact Name:
Address: P.O. Box 1061	City: Bradenton State: FL
Zip Code: 34206 Phone: (941)281-3494	Fax Number: (941)444-6200
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.

Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Major Depressive Dis., Single	F32.2	Medical Hypnotherapy/Relaxation Tra	90880	1X WK X 6 WKS, TOTAL 6 SESSIONS
Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxation Tra	90880	" "
Insomnia	F51.05	Medical Hypnotherapy/Relaxation Tra	90880	" "
Pain Dis. w/Related Psychologi	F45.42	Medical Hypnotherapy/Relaxation Tra	90880	" "

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Provider Name: Nelson J. Flores, Ph.D	
Practice Name: Psychological Assessment Serv.	Contact Name: Ted Tribble PSY.D.
Address: 4344 Latham St. Suite 120	City: Riverside State: CA
Zip Code: 92501 Phone: 714-972-0040	Fax Number: 714-972-0477
Provider Specialty: Psychology	NPI Number: 1831237981
E-mail Address:	

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Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Major Depressive Dis., Single	F32.2	Phone call, intermediate	99442	ONCE IN 45 DAYS
Generalized Anxiety Disorder	F41.1	Phone call, intermediate	99442	" "
Insomnia	F51.05	Phone call, intermediate	99442	" "
Pain Dis. w/Related Psychologi	F45.42	Phone call, intermediate	99442	" "

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

Gmail

Collections Department <collections@drnelsonflores.com>

Message Sent: 79901640 | 11/26/2021 11:53:37 AM PST

1 message

FAXAGENT <noreply@mitelcloud.com> Fri, Nov 26, 2021 at 12:23 PM
To: Fax 3 <collections@drnelsonflores.com>

Delivery Information:

Message #:	79901640
Status:	Success
Sender Name:	Fax 3
Sender Company:	
Sender Phone:	
Remote CSID:	FF240-IP.Rx
Total Pages:	6
Start Time:	11/26/2021 11:53:37 AM PST
End Time:	11/26/2021 4:22:50 AM PST
Duration:	0.436 sec
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RE: Roquemore, Sandra

Pages: 6

Comments:

07/26/21 PR-2 and RFAs

Collections
*Psychological Assessment Services *
Ph. 714-972-0040
Fax 714-972-0477