Market Rate Summary Graph

Payments for legal DOS on litigated cases or cases settled in-house at market rate or less than market rate, received between 1/2/20 and 1/31/20

	Invoice	Service Date(s)	Invoice Date	Type of Svc(s) plus additional fees		Amount billed		Check No.	Check Date	Total Paid Amt	Percentage of market rate paid	Percentage of market rate paid, including P&I	Payment Authority
1	74905	4/17/14-9/11/19	1/6/20	**Medical treatment**	F.C.E. ($150), 2 NCV/EMGs ($150 each), 12 f/u acup ($180 each)	$ 2,610.00	PYMTS RCVD	8817437171	12/24/19	$ 3,573.00	Total Amt Paid for legal services ($813) / Total Amt Billed for medical treatment ($813)	N/A	Farmers
				Legal services	**Depo prep (156.50), Board appear. (WCAB LBO) ($156.50), C&R Reading ($250), Depo Review ($250)**	**$ 813.00**		8817440913	12/31/19	$ 2,127.00			
				Additional services billed/ collected	Lien filing fee	$ 150.00							
					P&I for medical services	$ 714.69							
				TOTAL AMT BILLED =>		**$ 4,287.69**		**TOTAL AMT PAID =>**		**$ 5,700.00**	**100%**		
2	74677	2/9/16-3/20/17	1/13/20	**Legal services**	2 Depo preps ($156.50 each), 2 Depo reviews ($250 each), Board Appear. (WCAB LBO) ($156.50)	**$ 969.50**	PYMTS RCVD	1294003038	10/9/18	$ 516.50	Total Amt Paid for legal services ($969.50) / Total Amt Billed for legal services ($969.50)	Total Amt Paid for legal services + Penalties & Interest ($1,133.03 / Principal Amt Billed for legal services ($969.50)	Hartford/Amtrust
								1309097496	11/12/19	$ 483.50			
								04266610	1/2/20	$ 1,516.50			
				Additional items billed	P&I for late paid settlement	$ 163.53		04271838	1/7/20	$ 153.48			
					Additional costs collected	$ 1,547.00							
				TOTAL AMT BILLED =>		**$ 2,680.03**		**TOTAL AMT PAID =>**		**$ 2,669.98**	**100%**	**117%**	
3	60650	1/7/14-5/6/19	1/27/20	**Legal services**	Depo prep ($156.50), Depo review ($250), 2 C&R Readings ($250 each), 5 Board Appear. (WCAB LBO) ($156.50 each)	**$ 1,689.00**	PYMTS RCVD	01612880	8/18/16	$ 703.28	Total Amt Paid for legal services ($1,689) / Total Amt Billed for legal services ($1,689)	Total Amt Paid for legal services + Penalties & Interest ($2,277.43) / Principal Amt Billed for legal services ($1,689)	Liberty Mutual/Marriott Claims
								87479618	6/26/17	$ 156.50			
								03333178	12/4/18	$ 156.50			
								87659993	10/12/18	$ 156.50			
				Additional items billed	Penalties & Interest, including P&I for unpaid settlement	$ 588.43		02281107	6/20/17	$ 156.56			
								03812603	8/6/19	$ 535.86			
					Additional costs collected	$ 3,500.00		0032254392	1/21/20	$ 3,912.23			
				TOTAL AMT BILLED =>		**$ 5,777.43**		**TOTAL AMT PAID =>**		**$ 5,777.43**	**100%**	**135%**	

Market Rate Summary Graph

Payments for legal DOS on litigated cases or cases settled in-house at market rate or less than market rate, received between 1/2/20 and 1/31/20

	Invoice	Service Date(s)	Invoice Date	Type of Svc(s) plus additional fees		Amount billed		Check No.	Check Date	Total Paid Amt	Percentage of market rate paid	Percentage of market rate paid, including P&I	Payment Authority
4	09698	7/14/04-11/25/19	1/17/20	**Medical treatment**	Initial ($230), MRI ($150), 4 Re-evals ($120 each), EMG ($125), NCV ($125)	$ 1,110.00	PYMTS RCVD	9057	1/13/20	$ 1,507.00	Total Amt Paid for medical treatment and legal dates of service ($397) / Total Amt Billed for medical treatment and legal dates of service ($397)	N/A	Nile Corp. (Employer)
				Legal services	**Board appear. (WCAB LBO), C&R Reading ($250)**	**$ 397.00**							
				Additional services billed/ collected	Lien activation fee	$ 100.00							
					Penalties & Interest	$ 310.17							
				TOTAL AMT BILLED =>		**$ 1,917.17**		**TOTAL AMT PAID =>**		**$ 1,507.00**	**100%**		
5	69519	5/26/16-11/28/16	2/3/20	**Legal services**	2 Board Appear. (WCAB LAO) ($156.50 each)	**$ 313.00**	PYMTS RCVD	0070393005	6/29/16	$ 156.50	Total Amt Paid for legal services ($313) / Total Amt Billed for legal services ($313)	Total Amt Paid for legal services + Penalties & Interest ($361.68 / Principal Amt Billed for legal services ($313)	Sedgwick
								89564765	5/9/18	$ 156.50			
								89891221	6/4/18	$ 48.68			
				Additional items billed	Penalties & Interest	$ 48.68		102678523	1/28/20	$ 750.00			
					Additional costs collected	$ 750.00							
				TOTAL AMT BILLED =>		**$ 1,111.68**		**TOTAL AMT PAID =>**		**$ 1,111.68**	**100%**	**116%**	
6	62039	5/13/14-8/5/19	1/27/20	**Legal services**	2 Depo preps ($156.50 each), 2 Depo reviews ($250 each), 6 Board Appear. (WCAB LBO) ($156.50 each)	**$ 1,752.00**	PYMTS RCVD	0051001594	8/15/14	$ 90.00	Total Amt Paid for legal services ($1,752) / Total Amt Billed for legal services ($1,752)	Total Amt Paid for legal services + Penalties & Interest ($2,193.02 / Principal Amt Billed for legal services ($1,752)	Sedgwick
								0073202347	5/3/17	$ 1,192.50			
								0073202651	5/30/17	$ 450.00			
				Additional items billed	Penalties & Interest	$ 441.02		78728357	1/21/20	$ 1,055.00			
					Additional costs collected	$ 594.48							
				TOTAL AMT BILLED =>		**$ 2,787.50**		**TOTAL AMT PAID =>**		**$ 2,787.50**	**100%**	**125%**	

Market Rate Summary Graph

Payments for legal DOS on litigated cases or cases settled in-house at market rate or less than market rate, received between 1/2/20 and 1/31/20

	Invoice	Service Date(s)	Invoice Date	Type of Svc(s) plus additional fees		Amount billed		Check No.	Check Date	Total Paid Amt	Percentage of market rate paid	Percentage of market rate paid, including P&I	Payment Authority
7	72245	7/21/17-1/8/20	1/28/20	**Legal services**	2 Board Appear. (WCAB LBO) ($156.50 & $195), Depo prep ($156.50), Depo review ($250)	**$ 758.00**	PYMTS RCVD	0079275840	10/2/17	$ 180.00	Total Amt Paid for legal services ($758) / Total Amt Billed for legal services ($758)	N/A	Sedgwick
								96380295	3/20/19	$ 226.50			
								103837561	11/20/19	$ 156.50			
				Additional items billed	Additional costs collected	$ 274.06		107939371	1/9/20	$ 156.50			
								108544382	1/28/20	$ 312.56			
				TOTAL AMT BILLED =>		**$ 1,032.06**		**TOTAL AMT PAID =>**		**$ 1,032.06**	**100%**		
8	70144	8/8/16-12/5/16	1/20/20	**Legal services**	2 Board Appear. (WCAB POM) ($156.50 each)	**$ 313.00**	PYMTS RCVD	CP-952331	12/28/16	$ 156.50	Total Amt Paid for legal services ($313) / Total Amt Billed for legal services ($313)	Total Amt Paid for legal services + Penalties & Interest ($368.53) / Principal Amt Billed for legal services ($313)	SCIF
								CP-015745	6/21/18	$ 156.50			
				Additional items billed	Penalties & Interest	$ 55.53		CP-059850	1/16/20	$ 700.00			
					Additional costs collected	$ 644.47							
				TOTAL AMT BILLED =>		**$ 1,013.00**		**TOTAL AMT PAID =>**		**$ 1,013.00**	**100%**	**118%**	
9	72791	10/24/17-10/14/19	1/23/20	**Legal services**	2 Board Appear. (WCAB LBO) ($156.50 each), Depo prep ($156.50), Depo review ($250)	**$ 719.50**	PYMTS RCVD	14655	11/30/17	$ 156.50	Total Amt Paid for legal services ($719.50) / Total Amt Billed for legal services ($719.50)	N/A	York Claims on behalf of Safety First
								18166	8/5/19	$ 250.00			
								18234	8/15/19	$ 156.50			
				Additional items billed	Additional costs collected	$ 843.50		19217	1/20/20	$ 1,000.00			
				TOTAL AMT BILLED =>		**$ 1,563.00**		**TOTAL AMT PAID =>**		**$ 1,563.00**	**100%**		

Average % of Market Rate paid without P&I	**100%**
Average % of Market Rate paid with P&I	**122%**

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/06/20 74905

EAMS#(s):

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
WC 10107641

BILL TO:
FARMERS INS. (OKLAHOMA-108843)
W. C. DEPARTMENT
ATTN: KEVIN CALE
P.O. BOX# 108843
OKLAHOMA CITY, OK 73101

Case: vs CARAVAN FASHION ENTERPRISES
Date Of Injury: 1/6/2001-3/6/2014

DOS	SERVICE	DESCRIPTION	AMOUNT
04/17/14	F.C.E. TEST	FUNCTIONAL CAPACITY EVAL @ ADVANCE CARE*	150.00
/ /	INTERPRETER:	ELIZABETH HERRERA # 301231	0.00
04/21/14	EMG TESTING	& NCV BY DR SCHILLLING: U/E @ ADVANCE CARE*	150.00
/ /	INTERPRETER:	ELIZABETH HERRERA # 301231	0.00
05/05/14	EMG TESTING	& NCV BY DR SCHILLING: L/E @ ADVANCE CARE*	150.00
/ /	INTERPRETER:	JASON RAMIREZ # 500371	0.00
07/09/14	PR2-RE/EVAL	W/ACUPUNCT DARBANDI @ ACS*	180.00
/ /	INTERPRETER:	SEAN CRIST # 500186	0.00
07/17/14	PR2-RE/EVAL	W/ACUPUNCT SUNG HAN @ ACS*	180.00
/ /	INTERPRETER:	SEAN CRIST # 500186	0.00
07/23/14	PR2-RE/EVAL	W/ACUPUNCTURIST G. DARBANDI*	180.00
/ /	INTERPRETER:	JORGE SANDOVAL # 05511585	0.00
08/07/14	PR2-RE/EVAL	W/ACUPUNCT HAN/JANG @ ACS*	180.00
/ /	INTERPRETER:	SEAN CRIST # 500186	0.00
08/14/14	PR2-RE/EVAL	W/ACUPUNCTURIST HAN/JANG @ ADVANCE CARE*	180.00
/ /	INTERPRETER:	MARIA SALINAS # 100942	0.00
08/28/14	PR2-RE/EVAL	W/ACUPUNCTURIST KIM/SUNG*	180.00
/ /	INTERPRETER:	PATRICIA HERNANDEZ 301690	0.00
09/25/14	PR2-RE/EVAL	W/ACUPUNCT HAN/KIM @ ACS* (AMENDED)	180.00
/ /	INTERPRETER:	LILIANA HALPERIN # 100048	0.00
11/13/14	PR2-RE/EVAL	W/ACUPUNCT KIM @ ACS*	180.00
/ /	INTERPRETER:	JENNIFER MINOTTA # 101254	0.00
11/20/14	FOLLOW-UP	W/ ACUPUNCT KIM @ ACS*	180.00
/ /	INTERPRETER:	JORGE MORAN # 500270	0.00
12/11/14	FOLLOW-UP	W/ACUPUNCT HAN/KIM @ ACS*	180.00
/ /	INTERPRETER:	MARIA E. SALINAS # 100942	0.00

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/06/20 74905

EAMS#(s):

SS # : XXX-XX
DOB :
Terms: 60 days
Claim #(s):
WC 10107641

BILL TO:
FARMERS INS. (OKLAHOMA-108843)
W. C. DEPARTMENT
ATTN: KEVIN CALE
P.O. BOX# 108843
OKLAHOMA CITY, OK 73101

Case: vs CARAVAN FASHION ENTERPRISES
Date Of Injury: 1/6/2001-3/6/2014

DOS	SERVICE	DESCRIPTION	AMOUNT
01/15/15	FOLLOW-UP	W/ ACUPUNCT KIM @ ACS*	180.00
/ /	INTERPRETER:	JENNIFER MINOTTA # 101254	0.00
01/22/15	FOLLOW-UP	W/ ACUPUNCT HAN @ ACS*	180.00
/ /	INTERPRETER:	CESAR TERAN # 500150	0.00
10/02/18	LEGAL_PREP	DEPO PREP @ L/O EARLY MASLACH	156.50
/ /	INTERPRETER:	WALTER VASQUEZ # 100770	0.00
02/22/19	LEGAL_REVIEW	DEPO REVIEW @ L/O DENNIS FUSI	250.00
/ /	INTERPRETER:	MARIA PACO CORTEZ # 100533	0.00
08/22/19	LEGAL_WCAB	MSC @ WCAB LONG BEACH	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 100585	0.00
09/11/19	LEGAL_C&R	C&R READING @ L/O FUSI LAKEWOOD, CA	250.00
/ /	INTERPRETER:	CARLOS TORRES # 301694	0.00
10/29/19	LIEN FIL FEE	LIEN FILING FEE	150.00
12/12/19	PENALTIES	FOR DATE OF SERVICE 04/17/14	22.50
12/12/19	INTEREST	FOR DATE OF SERVICE 04/17/14	18.57
12/12/19	PENALTIES	FOR DATE OF SERVICE 04/21/14	22.50
12/12/19	INTEREST	FOR DATE OF SERVICE 04/21/14	18.57
12/12/19	PENALTIES	FOR DATE OF SERVICE 05/05/14	22.50
12/12/19	INTEREST	FOR DATE OF SERVICE 05/05/14	18.57
12/12/19	PENALTIES	FOR DATE OF SERVICE 07/09/14	27.00
12/12/19	INTEREST	FOR DATE OF SERVICE 07/09/14	22.29
12/12/19	PENALTIES	FOR DATE OF SERVICE 07/17/14	27.00
12/12/19	INTEREST	FOR DATE OF SERVICE 07/17/14	22.29
12/12/19	PENALTIES	FOR DATE OF SERVICE 07/23/14	27.00
12/12/19	INTEREST	FOR DATE OF SERVICE 07/23/14	22.29
12/12/19	PENALTIES	FOR DATE OF SERVICE 08/07/14	27.00
12/12/19	INTEREST	FOR DATE OF SERVICE 08/07/14	22.29
12/12/19	PENALTIES	FOR DATE OF SERVICE 08/14/14	27.00
12/12/19	INTEREST	FOR DATE OF SERVICE 08/14/14	22.29
12/12/19	PENALTIES	FOR DATE OF SERVICE 08/28/14	27.00

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/06/20 74905

EAMS#(s):

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
WC 10107641

BILL TO:
FARMERS INS. (OKLAHOMA-108843)
W. C. DEPARTMENT
ATTN: KEVIN CALE
P.O. BOX# 108843
OKLAHOMA CITY, OK 73101

Case: vs CARAVAN FASHION ENTERPRISES
Date Of Injury: 1/6/2001-3/6/2014

DOS	SERVICE	DESCRIPTION	AMOUNT
12/12/19	INTEREST	FOR DATE OF SERVICE 08/28/14	22.29
12/12/19	PENALTIES	FOR DATE OF SERVICE 09/25/14	27.00
12/12/19	INTEREST	FOR DATE OF SERVICE 09/25/14	22.29
12/12/19	PENALTIES	FOR DATE OF SERVICE 11/13/14	27.00
12/12/19	INTEREST	FOR DATE OF SERVICE 11/13/14	22.29
12/12/19	PENALTIES	FOR DATE OF SERVICE 11/20/14	27.00
12/12/19	INTEREST	FOR DATE OF SERVICE 11/20/14	22.29
12/12/19	PENALTIES	FOR DATE OF SERVICE 12/11/14	27.00
12/12/19	INTEREST	FOR DATE OF SERVICE 12/11/14	22.29
12/12/19	PENALTIES	FOR DATE OF SERVICE 01/15/15	27.00
12/12/19	INTEREST	FOR DATE OF SERVICE 01/15/15	22.29
12/12/19	PENALTIES	FOR DATE OF SERVICE 01/22/15	27.00
12/12/19	INTEREST	FOR DATE OF SERVICE 01/22/15	22.29
12/24/19	PMT BY CHECK	DOS 1/21/19* # 8817437171	-3573.00
12/12/19	COSTS	ADD'L COSTS AWARDED	1412.31
12/31/19	PMT BY CHECK	DOS N/A # 8817440913	-2127.00

BALANCE 0.00

* INDICATES BILLED AT A MINIMUM OF 2 HOURS
NOTE: Any and all partial payments received have been acknowledged and clearly reflected in the enclosed statement. However, payments received do not represent full and final satisfaction. In accordance with CCR Section 10770 lien claimant/ or Petitioner is hereby seeking recovery of the balance. Demand is hereby made for Current Print Out of Benefits, MPN Notices, Completed DWC-1, Applic of Adjud, 4600 Election letter, Depo Transcript, Complete Medical Index and any documentary evidence to be utilized in an attempt to defeat this lien/ or Petition. ** THIS SERVES AS DEMAND FOR PAYMENT **

Farmers Auto Claims

Check Number: 8817437171
Date: 12/24/2019

PAY NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE
NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE $3,573.00****

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Claimant/Patient:	
Insured:	Caravan Fashion Enterprises
Date of Loss:	11/30/2012
Claim Number:	WC10107641-1
Check Number:	8817437171
Payment Under Insured's:	Workers Comp Medical
Correspondence Reference:	019S1FPKW
Print Date	12/24/2019 11:01 AM
Requested By	Kevin Cale

PAID
JAN 0 2 2020

PLEASE FOLD AND DETACH CHECK ON RED LINE BELOW

THIS DOCUMENT CONTAINS VOID TEXT THAT WILL APPEAR WHEN PHOTOCOPIED.

FARMERS INSURANCE

62-20/311

MID-CENTURY INSURANCE COMPANY
CLAIMS SERVICE CENTER
NATIONAL DOCUMENT CENTER PO BOX 268994
OKLAHOMA CITY OK 73126

Claim Number
WC10107641

Check No. 8817437171
Date: 12/24/2019

PAY Three Thousand Five Hundred Seventy Three Dollars And No Cents $3,573.00****

NOT GOOD AFTER SIX MONTHS

FARMERS INSURANCE

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Thomas S. Noh

Citibank N.A. - One Penns Way - New Castle, DE 19720

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK — HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

⑈8817437171⑈ ⑆031100209⑆ 3872438⑈

Explanation of Review

FARMERS INSURANCE

03 02 000559 01 9S1FPKW1 CE1224P1 04 [ ] 000559

Carrier

FARMERS - WC-CA -
Carrier No:
Carrier: Mid-Century Insurance Company
6301 Owensmouth Ave
Woodland Hills, CA 91367

Bill: FRM-FWCA-36113

Provider

JOYCE ALTMAN INTERPRETERS,INC
PO BOX # 4165
TUSTIN, CA 92781

Claimant

NPI: **Rendering NPI:**
Tax ID: 330956713 **Type:** OT **Specialty (1):** AO
License: 99999999
Rendering Provider: JOYCE ALTMAN INTERPRETERS

Claim Number: WC10107641
DOI/DOL: 11-30-2012
CR Date / BR Date: 12-20-2019 / 12-20-2019
External Claim Number: WC10107641
Social Security Number:
Policy Number: 0A09318012
Employer/Insured: CARAVAN FASHION ENTERPRISES

Invoice Date: 12-12-2019
Patient Account: 74905

Region: 26 **Payment Status Code:** 1

Policy Admin Information: 0A09318012

Bill Details

Dates of Service: 01-21-2019
Post Date: 12-24-2019

Reviewer: H8/
Pay Auth: L
Client Type of Bill: 370
Adjuster: KEVIN.T.CALE

Bill ICD Version: 10
Dx A: T14.90 INJURY, UNSPECIFIED

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description				Explanation Code(s)	
				Charges	BRV	CBR	PPO	ONR	OTH	ADJ	Allow.
1	01-21-2019	11	MDO10	A	1	PAYMENT BY ORDER				G67, B14, G1, B92, 961	
				5,700.00	2,127.00						3,573.00

Totals

Total Charges:	5,700.00
Bill Review Reductions:	2,127.00
Recommended Allowance:	**3,573.00**

Messages

961 ALLOWANCE REFLECTS THE LUMP SUM SETTLEMENT AMOUNT.
B14 THIS PAYMENT SETTLES ALL DATES OF SERVICE AND ANY/ALL P & I (PENALTIES AND INTEREST).
B92 OVERRIDE DENIED/CONTROVERTED CLAIM FOR THIS PROCEDURE/DATE ONLY.
G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G67 PAYMENT BASED ON INDIVIDUAL PRE- NEGOTIATED AGREEMENT FOR THIS SPECIFIC SERVICE.

"All date of service from 04/17/2014 to 09/11/2019."

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL MITCHELL INTERNATIONAL, INC. AT (800) 732-0153 OR SEND YOUR BILL AND ANALYSIS TO:

FARMERS, PO BOX 108843, OKLAHOMA CITY, OK 73101-8843

Explanation of Review

FARMERS INSURANCE

Carrier	FARMERS - WC-CA - Carrier No: Carrier: Mid-Century Insurance Company 6301 Owensmouth Ave Woodland Hills, CA 91367

Bill: FRM-FWCA-36113

Provider	JOYCE ALTMAN INTERPRETERS,INC PO BOX # 4165 TUSTIN, CA 92781

Claimant	

NPI: **Rendering NPI:**
Tax ID: 330956713 **Type:** OT **Specialty (1):** AO
License: 99999999
Rendering Provider: JOYCE ALTMAN INTERPRETERS

Invoice Date: 12-12-2019
Patient Account: 74905

Region: 26 **Payment Status Code:** 1

Claim Number: WC10107641
DOI/DOL: 11-30-2012
CR Date / BR Date: 12-20-2019 / 12-20-2019
External Claim Number: WC10107641
Social Security Number:
Policy Number: 0A09318012
Employer/Insured: CARAVAN FASHION ENTERPRISES

Policy Admin Information: 0A09318012

Bill Details

Dates of Service: 01-21-2019
Post Date: 12-24-2019

Reviewer: H8/
Pay Auth: L
Client Type of Bill: 370
Adjuster: KEVIN.T.CALE

Bill ICD Version: 10
Dx A: T14.90 INJURY, UNSPECIFIED

Notes

Unless otherwise noted, all reductions are in accordance with the medical or med-legal fee schedule as per the rules and regulations authorized by California Labor Code Section 4603.5 and 5307.1.

TIME LIMITS TO DISPUTE PAYMENT AMOUNT

Request for Second Review (SBR): After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee that disputes the amount paid may submit an appeal/reconsideration/Request for SBR to the claims administrator within 90 days of service of the explanation of review. The Request for SBR must conform to the requirements of the Division of Workers' Compensation Medical Billing and Payment Guide, and regulations at CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the health care provider, health care facility, or billing agent/assignee does not request a SBR within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

Request for Independent Bill Review (IBR): After a health care provider, health care facility, or billing agent/assignee submits a Request for SBR, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, for dates of service January 1, 2013 or after, a health care provider, health care facility, or billing agent/assignee that still disputes the amount paid may submit a request for IBR within 30 days of service of the EOR. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. If the health care provider, health care facility, or billing agent/assignee fails to request an IBR within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL MITCHELL INTERNATIONAL, INC. AT (800) 732-0153 OR SEND YOUR BILL AND ANALYSIS TO:

FARMERS, PO BOX 108843, OKLAHOMA CITY, OK 73101-8843

03 03 000559 019S1FPKW1 CE1224P1 04 [1] 000559

MID-CENTURY INSURANCE COMPANY

Check Number: 8817440913
Date: 12/31/2019

Amount: $2,127.00****

PAY NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Claimant/Patient:		Primary Adjuster:	Kevin Cale
Insured:	Caravan Fashion Enterprises	Toll Free Number:	8884861451
Date of Loss:	11/30/2012	Applicable Coverage:	Workers Compensation
Claim Number:	WC10107641		
Correspondence Reference:	TFZDTZXKW		

Additional Information:
If there are questions regarding the cashing of this check, please contact the Primary Adjuster at their toll free telephone number or claims office at the address on the check.

Service From/To	Payment For	Paid Amount
	Other Treatment	$2127.00

PLEASE FOLD AND DETACH CHECK ON RED LINE BELOW

FARMERS INSURANCE

THIS DOCUMENT CONTAINS VOID TEXT THAT WILL APPEAR WHEN PHOTOCOPIED.

62-20/311

CLAIMS SERVICE CENTER
NATIONAL DOCUMENT CENTER PO BOX 268994
OKLAHOMA CITY OK 73126

Claim #: WC10107641 Check No. 8817440913

Date: 12/31/2019

Payable, if desired, at any Citibank

PAY Two Thousand One Hundred Twenty Seven Dollars And No Cents $2,127.00****

NOT GOOD AFTER SIX MONTHS

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

FARMERS INSURANCE

Thomas S. Toth

Citibank N.A. - One Penns Way - New Castle, DE 19720

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

⑈8817440913⑈ ⑆031100209⑆ 3872438⑈

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/13/20 74677

EAMS#(s):

SS # : XXX-X
DOB :
Terms: 60 days
Claim #(s):
2235520

BILL TO:
AMTRUST NORTH AMERICA (89404)
W. C. DEPARTMENT
ATTN: MICHELLE ERLECH
PO BOX 89404
CLEVELAND, OH 44101

Case: vs DAE WON FOOD USA
Date Of Injury: 5/9/14

DOS	SERVICE	DESCRIPTION	AMOUNT
02/09/16	LEGAL_PREP	DEPO PREP @ L/O LAUGHLIN, FALBO, LEVY & MORES	156.50
/ /	INTERPRETER:	GLADYS PINEDA REYNA # 301721	0.00
02/29/16	LEGAL_REVIEW	DEPO REVIEW @ L/O DENNIS FUSI	250.00
/ /	INTERPRETER:	GLADYS REYNA # 301721	0.00
09/08/16	LEGAL_PREP	DEPO PREP @ L/O LOUIE STETTLER VOL II	156.50
/ /	INTERPRETER:	CARLOS TORRES # 301694	0.00
10/04/16	LEGAL_REVIEW	DEPO REVIEW @ L/O DENNIS FUSI VOL II	250.00
/ /	INTERPRETER:	JOHANNA JORDAN # 301566	0.00
03/20/17	LEGAL_WCAB	MSC @ WCAB LONG BEACH	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 100585	0.00
10/09/18	PMT BY CHECK	DOS 2/9/16-3/20/18* # 129400303 8 HARTFO	-516.50
/ /	COSTS	ADD'L COSTS AWARDED	1547.00
11/12/19	PMT BY CHECK	DOS 11/7/19* # 130909749 6 THE HARTFORD	-483.50
12/11/19	PENALTIES_U	FOR UNPAID STLM'T 11/07/19	151.65
12/11/19	INTEREST_U	FOR UNPAID STLM'T 11/07/19	1.83
01/02/20	PMT BY CHECK	DOS 11/7/19* =# 4266610 AMTRUST	-1516.50
01/06/20	BLCE OFF SET	BALANCE OFF SET	-153.48
01/02/20	PENALTIES_L	FOR LATE PD STLM'T	151.65
01/02/20	INTEREST_L	FOR LATE PD STLM'T	11.88
01/07/20	PMT BY CHECK	DOS 12/20/19* =# 04271838 AMTRUST	-153.48
01/13/20	BLCE OFF SET	BALANCE OFF SET	-10.05

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/13/20 74677

EAMS#(s):

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
2235520

BILL TO:
AMTRUST NORTH AMERICA (89404)
W. C. DEPARTMENT
ATTN: MICHELLE ERLECH
PO BOX 89404
CLEVELAND, OH 44101

Case: vs DAE WON FOOD USA
Date Of Injury: 5/9/14

DOS	SERVICE	DESCRIPTION	AMOUNT

BALANCE 0.00

* INDICATES BILLED AT A MINIMUM OF 2 HOURS
NOTE: Any and all partial payments received have been acknowledged and clearly reflected in the enclosed statement. However, payments received do not represent full and final satisfaction. In accordance with CCR Section 10770 lien claimant/ or Petitioner is hereby seeking recovery of the balance. Demand is hereby made for Current Print Out of Benefits, MPN Notices, Completed DWC-1, Applic of Adjud, 4600 Election letter, Depo Transcript, Complete Medical Index and any documentary evidence to be utilized in an attempt to defeat this lien/ or Petition. ** THIS SERVES AS DEMAND FOR PAYMENT **

THE HARTFORD
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
8664019222 x2307971

MB 01 001636 63420 B 6 C

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

PAID
OCT 19 2018
BY:

001636 1/1

74677
74612

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	68624 Insured Name/ Claimant Name		Amount Paid
07/23/2015	72WEC GE8579 YMQC 51542	DAE WON FOOD USA INC		$516.50
Nature of Benefits: Translation Services		Nature of Payment: Payment Reason - Translation Services	Service Dates 02/09/2016 03/20/2018	$516.50

Claim Handler: ANNE FAULKNER
8664019222 x2307971
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

Additional Comments:
FULL AND FINAL PAYMENT

Issue Date	10/09/2018	Check Number	129400303 8	Total Check Amount	$516.50

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

HAR-100-2

119755240

THE HARTFORD

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
8664019222 x2307971

MB 01 003451 13253 B 12 C

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

PAID
NOV 19 2019
BY: .....

003451 1/1

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
07/23/2015	72WEC GE8579 YMQC 51542	DAE WON FOOD USA INC		$483.50
Nature of Benefits: Interpreter Fees at Hearing		Nature of Payment: Payment Reason - Interpreter Fees at Hrng	Service Dates 11/07/2019 11/07/2019	$483.50

Claim Handler: ANNE FAULKNER 8664019222 x2307971 Centralized Workers Compensation Claim Center PO Box 14267 Lexington, KY 40512-4267	Additional Comments:

Issue Date	11/12/2019	Check Number	130909749 6	Total Check Amount	$483.50

Please keep the above information for your records.

118690860

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04266610
2235520-1
WC 046955

DATE	AMOUNT
1/2/2020	$1,516.50

One Thousand Five Hundred Sixteen and 50/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈04266610⑈ ⑆021309379⑆ 601877533⑈

Explanation Of Bill Review

Check Number	04266610
Claim Number:	2235520-1
Regulatory ID:	
Bill Number:	15130747
Invoice Number:	FP1-MJCA-931549
Policy / Insured:	WC 046955/ Dae Won Food USA Inc.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC
Loss Date:	5/9/2014 FP1-MJCA-931549
Location:	400 E Alondra Blvd Gardena CA 90248 - 902
Examiner Code:	32049
Network/PPO Network:	

TECHNOLOGY INSURANCE CO (Claims Funding) 1085 on behalf of PUBLIC SERVICE INSURANCE COMPANY
AmTrust North America
P. O. Box 89404
Cleveland, OH 44101
626-915-1951

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
11/7/2019	MDO10	PAYMENT BY ORDER	1.00	1516.50	0.00	0.00	1516.50	
				1516.50	0.00	0.00	1516.50	

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING WITH OPTUM AT HTTPS://WCC.INGENIX.COM AND CHOOSE REQUEST AN ACCOUNT

Reconsiderations or appeals need to be submitted to the carrier listed above.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS, PLEASE CALL Mitchell International AT 800-732-0153.

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04271838
2235520-1
WC 046955

DATE	AMOUNT
1/7/2020	$153.48

One Hundred Fifty-Three and 48/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈04271838⑈ ⑆021309379⑆ 6018225 33⑈

PAID
JAN 13 2020

Explanation Of Bill Review

Check Number	04271838
Claim Number:	2235520-1
Regulatory ID:	
Bill Number:	15145185
Invoice Number:	FP1-MJCA-944704
Policy / Insured:	WC 046955/ Dae Won Food USA Inc.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC
Loss Date:	5/9/2014 FP1-MJCA-944704
Location:	400 E Alondra Blvd Gardena CA 90248 - 902
Examiner Code:	32049
Network/PPO Network:	

BY TECHNOLOGY INSURANCE CO (Claims Funding) 1085 on behalf of PUBLIC SERVICE INSURANCE COMPANY
AmTrust North America
P. O. Box 89404
Cleveland, OH 44101
626-915-1951

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
12/20/2019	MDS10	SETTLEMENT FOR DISPUTE	1.00	1669.98	1516.50	0.00	153.48	G5, 375, G67, 96
				1669.98	1516.50	0.00	153.48	

G5 - THIS CHARGE WAS ADJUSTED FOR THE REASONS SET FORTH IN THE ATTACHED LETTER.; 375 - PLEASE SEE SPECIAL *NOTE* BELOW.; G67 - PAYMENT BASED ON INDIVIDUAL PRE- NEGOTIATED AGREEMENT FOR THIS SPECIFIC SERVICE.; 961 - ALLOWANCE REFLECTS THE LUMP SUM SETTLEMENT AMOUNT.;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING WITH OPTUM AT HTTPS://WCC.INGENIX.COM AND CHOOSE REQUEST AN ACCOUNT

Reconsiderations or appeals need to be submitted to the carrier listed above.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS, PLEASE CALL Mitchell International AT 800-732-0153.

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/27/20 60650

EAMS#(s):

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
608A75629

BILL TO:
LIBERTY MUTUAL(PORTLAND-4555)

ATTN: ROGER HATHAWAY
P.O. BOX 4555
PORTLAND, OR 97208

Case: vs MARRIOTT/LOEWS HOLLYWOOD HOTEL
Date Of Injury: 1/22/13

DOS	SERVICE	DESCRIPTION	AMOUNT
01/07/14	DEPO PREP	@ THE L/O OF HUTCHINGS COURT REPORTERS	156.50
/ /	INTERPRETER:	SANDRA MONTALTO # 100754	0.00
05/08/14	DEPO REVIEW	BEFORE SIGNING-DEPO TRANSCRIP	250.00
/ /	INTERPRETER:	PATRICIA HAYES # 100761	0.00
12/14/15	PENALTIES	FOR DATE OF SERVICE 1/7/14	23.48
08/18/16	INTEREST	FOR DATE OF SERVICE 1/7/14	48.03
12/14/15	PENALTIES	FOR DATE OF SERVICE 5/8/14	37.50
08/18/16	INTEREST	FOR DATE OF SERVICE 5/8/14	67.19
07/21/16	LEGAL_WCAB	STATUS CONFERENCE @ WCAB LB (BOTH CLAIMS)	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 100585	0.00
08/18/16	PMT BY CHECK	DOS 1/7/14-7/21/16* LIB MTL # 01612880	-703.28
05/09/17	LEGAL_WCAB	STATUS CONFERENCE @ WCAB LB (BOTH CLAIMS)	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 100585	0.00
06/26/17	PMT BY CHECK	DOS 5/9/17* #87479618 MARRIOT	-156.56
09/20/18	LEGAL_WCAB	MSC @ WCAB LBO (BOTH CLAIMS)	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 100585	0.00
11/13/18	LEGAL_WCAB	MSC @ WCAB LBO (BOTH CLAIMS)	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 101585	0.00
12/04/18	PMT BY CHECK	DOS 11/13/18* =# 03333178 LIBERTY MUTUAL	-156.50
10/12/18	PMT BY CHECK	DOS 9/20/18* # 87659993 MARRIOTT	-156.50
06/20/17	COSTS	MONIES CREDITED TOWARDS COSTS #02281107 LIBTY MUTL	156.50
06/20/17	PMT BY CHECK	DOS 5/9/17* #02281107 LIBERTY	-156.50

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/27/20 60650

EAMS#(s):

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
608A75629

BILL TO:
LIBERTY MUTUAL(PORTLAND-4555)

ATTN: ROGER HATHAWAY
P.O. BOX 4555
PORTLAND, OR 97208

Case: [redacted] vs MARRIOTT/LOEWS HOLLYWOOD HOTEL
Date Of Injury: 1/22/13

DOS	SERVICE	DESCRIPTION	AMOUNT
01/22/19	LEGAL_WCAB	TRIAL @ WCAB LONG BEACH	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 100585	0.00
06/20/17	CREDIT_MCTC	APPLIED TO DOS 1/22/19 #02281107 LIBTY MUTL	-156.50
02/21/19	LEGAL_C&R	C&R READING @ L/O DENNIS FUSI	250.00
/ /	INTERPRETER:	ARACELI RUBIO # 100358	0.00
05/06/19	LEGAL_C&R	C&R READING @ L/O DENNIS FUSI (ADDENDUM)	250.00
/ /	INTERPRETER:	MARIA PACO-CORTEZ # 100533	0.00
08/06/19	PMT BY CHECK	DOS 1/22/19-5/6/19* # 03812603	-535.86
12/12/19	PENALTIES_U	FOR UNPAID STLM'T 10/21/19	350.00
01/08/20	INTEREST_U	FOR UNPAID STLM'T 10/21/19	62.23
01/21/20	COSTS	ADD'L COSTS AWARDED	3500.00
01/21/20	PMT BY CHECK	DOS 1/16/20* # 0032254392 LIBERTY MUTUAL	-3912.23

BALANCE 0.00

* INDICATES BILLED AT A MINIMUM OF 2 HOURS
NOTE: Any and all partial payments received have been acknowledged and clearly reflected in the enclosed statement. However, payments received do not represent full and final satisfaction. In accordance with CCR Section 10770 lien claimant/ or Petitioner is hereby seeking recovery of the balance. Demand is hereby made for Current Print Out of Benefits, MPN Notices, Completed DWC-1, Applic of Adjud, 4600 Election letter, Depo Transcript, Complete Medical Index and any documentary evidence to be utilized in an attempt to defeat this lien/ or Petition. ** THIS SERVES AS DEMAND FOR PAYMENT **

BRANCH OFFICE ADDRESS:
P O BOX 4555
PORTLAND, OR 97208
916-564-1792

Liberty Mutual. INSURANCE

B. CODE	CHECK NUMBER	CHECK DATE
189	01612880	08/18/16
	CHECK AMOUNT ****$703.28	BLOCK NUMBER 002402

CLAIM #: WC 608-A75629
CONTRACT #: WC1-621-004009-572-94

OSN: EE2801081803-002084

CONTROL #: 000002617 ID: CRNWB97
PROVIDER #: 33095671383466

PAYEE: JOYCE ALTMAN INTERPRETING

TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781

PROVIDER:

DATE OF INJURY: 01/22/13
EMPLOYEE:

EMPLOYER: LOEWS CORPORATION
DATES OF SERVICE 01/07/14-07/21/16
LOCATION CODE: 303127

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	UNITS	CHARGE	PAYABLE	EXPL CODE
01/07/14	07/21/16	MISC		703.28	703.28	

NOTE: INV#60650

TOTAL CHARGES	703.28
TOTAL PAYABLE:	703.28
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	703.28

MR

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

MCS - on behalf of Marriott

PO Box 261866 Plano, TX 75026-1866

WC (Employee Work Injury)

Payee: Joyce Altman Interpreting, Inc.
Employer: HOLLYWOOD RENAISSANCE,ROOMS
Claim Number: 417942
Claimant Name
Injury Date. 05/15/2012
Description: Translation/Investigative
Body Part: Multiple Body Parts
Instruction: No Attachment or Special Instruction Required
Comment:
Document Number:
Jurisdiction:

IRS/SSN: 330956713
Check Number: 87479618
Claimant SSN: NNN-NN
Invoice Number: 60605
Account Number:
Payee NPI:

Examiner: LLORD
Check Total: 156.50
Check Date: 06/26/2017
From Date: 05/09/2017
Through Date: 05/09/2017
Status: Open

Delivery Type: Regular Mail

Rendering Physician:

Rendering Physician NPI:

FILED
JUL 05 2017
BY: .....

[redacted]

BRANCH OFFICE ADDRESS:
PO BOX 8016
WAUSAU, WI 54402
916-564-1792

Liberty Mutual. INSURANCE

B. CODE	CHECK NUMBER	CHECK DATE
189	03333178	12/04/18
	CHECK AMOUNT ****$156.50	BLOCK NUMBER 003100

OSN: EE2801120403-003077

CLAIM #: WC 608-A75629
CONTRACT #: WC1-621-004009-572

CONTROL #: 000004916 ID: CRWE063

PAYEE: JOYCE ALTMAN INTERPRETERS INC

DATE OF INJURY: 01/22/13
EMPLOYEE:

EMPLOYER: LOEWS CORPORATION
DATES OF SERVICE 11/13/18-11/13/18
LOCATION CODE: 303127

-1
60650 —

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	PERIOD	WEEKLY RATE	GROSS	PAYABLE	EXPL CODE
11/13/18	11/13/18	EXPENSE		.00	156.50	156.50	

NOTE: PAYS INVOICE #60605 DTD 11/28/2018

TOTAL GROSS	156.50
TOTAL PAYABLE:	156.50
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	156.50

DEC 10 2018

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

[redacted]

MCS - on behalf of Marriott

WC (Employee Work Injury)

PO Box 261866 Plano, TX 75026-1866

Payee: Joyce Altman Interpreting, Inc.
Employer: HOLLYWOOD RENAISSANCE,ROOMS
Claim Number: 417942
Claimant Name
Injury Date: 06/15/2012
Description: Translation/Medical
Body Part: Multiple Body Parts
Instruction: No Attachment or Special Instruction Required
Comment:
Document Number:
Jurisdiction:

IRS/SSN: 330956713
Check Number: 87659993
Claimant SSN: NNN-NN
Invoice Number: 60605
Account Number:
Payee NPI:

Rendering Physician:

Examiner: LLORD
Check Total: 156.50
Check Date: 10/12/2018
From Date: 09/20/2018
Through Date: 09/20/2018
Status: Open

Delivery Type: Regular Mail

Rendering Physician NPI:

PAID
OCT 19 2018
BY: .....

[redacted]

BRANCH OFFICE ADDRESS:
P O BOX 4555
PORTLAND, OR 97208
916-564-1792

Liberty Mutual. INSURANCE

B. CODE	CHECK NUMBER	CHECK DATE
189	02281107	06/20/17
	CHECK AMOUNT ****$156.56	BLOCK NUMBER 002869

OSN: EE2801062003-002849

CLAIM #: WC 608-A75629
CONTRACT #: WC1-621-004009-572-94

CONTROL #: 000002662 ID: CRNWB97
PROVIDER #: 33095671310961

PAYEE: JOYCE ALTMAN INTERPRETING

DATE OF INJURY: 01/22/13
EMPLOYEE:

TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781

PROVIDER:

EMPLOYER: LOEWS CORPORATION
DATES OF SERVICE 01/03/14-05/09/17
LOCATION CODE: 303127

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	UNITS	CHARGE	PAYABLE	EXPL CODE
01/03/14	05/09/17	MISC		156.56	156.56	

NOTE: INV#60605

TOTAL CHARGES	156.56
TOTAL PAYABLE:	156.56
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	156.56

PAID
JUN 26 2017

BY: .....

VOID

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

[redacted]

BRANCH OFFICE ADDRESS:
PO BOX 8016
WAUSAU, WI 54402
916-564-1792

Liberty Mutual. INSURANCE

B. CODE	CHECK NUMBER	CHECK DATE
189	03812603	08/06/19
	CHECK AMOUNT ****$535.86	BLOCK NUMBER 003118

CLAIM #: WC 608-A75629
CONTRACT #: WC1-621-004009-572

OSN: EE2801080603-003301

CONTROL #: 000000354 ID: CRWE165

PAYEE: JOYCE ALTMAN INTERPRETERS INC

DATE OF INJURY: 01/22/13
EMPLOYEE:

EMPLOYER: LOEWS CORPORATION
DATES OF SERVICE 01/22/19-05/06/19
LOCATION CODE: 303127

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	PERIOD	WEEKLY RATE	GROSS	PAYABLE	EXPL CODE
01/22/19	05/06/19	EXPENSE		.00	535.86	535.86	

NOTE: INTERP FEES; INV#60650; DOS: 01/22/19; 02/21/19; 05/06/19

TOTAL GROSS	535.86
TOTAL PAYABLE:	535.86
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	535.86

PAID
AUG 12 2019
BY.

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

[redacted]

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

Liberty Mutual. INSURANCE

B. CODE	CHECK REFERENCE	CHECK DATE
288	0032254392	01/21/20
	CHECK AMOUNT ***$3912.23	BLOCK NUMBER 002417

OSN: MM0801012102-002417
BANK: 288
CHECK REF: 0032254392 DATE: 01/21/20 AMT: 3,912.23
INTERNAL BILL NO: 126154436 MSR: N0077377
CUST/EXTERNAL BILL NO: 1105380028
BR PROVIDER #: 330956713-0024

CLAIM NO. WC 608-A75629 HOD
CONTRACT NO: WC1-621-004009-572
DOCUMENT NO: 11053800280

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781

PATIENT ACCT. #: NA
SSN: XXX-XX
DOI: 01/22/[illegible]
PATIENT:

PROVIDER: CHRIS ALCALA
CHRIS ALCALA JOYCE ALTMAN INTERP

EMPLOYER: LOEWS CORPORATION
ADDRESS: 1755 HIGHLAND AVE
LOS ANGELES, CA 90028

LOCATION CODE: 303127

AGENCY CLAIM #(BOARD COMM #): 201310111609468604O134
DIAG CODES: R68.89

DATES OF SERVICE: 01/16/20-01/16/20
AUDIT DATE: 01/17/20

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
01/16/20	MDS10		LUMP SUM SETTLEMENT WHERE	1.00	3912.23	3912.23	N/A	0.00	3912.23 G1	876

TOTAL CHARGES:	3912.23
TOTAL PREVIOUSLY PAID:	0.00
TOTAL CURRENT PAYABLE:	3912.23
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	3912.23

EXPLANATION CODE DESCRIPTIONS:

G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

876 FEE SCHEDULE AMOUNT IS EQUAL TO THE CHARGE

ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 8011, WAUSAU, WI 54402. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER OF THIS EOB. (ZC72)

Z849 GO PAPERLESS. LIBERTY MUTUAL INSURANCE CAN ACCEPT ELECTRONIC BILL SUBMISSIONS AND ISSUE PAYMENTS

CAREFULLY DETACH CHECK BEFORE DEPOSITING. RETAIN STATEMENT FOR YOUR RECORDS

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

Liberty Mutual. INSURANCE

BLOCK NUMBER
002418

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

OSN: MM0801012102-002418
BANK: 288
CHECK REF: 0032254392 DATE: 01/21/20 AMT: 3,912.23
INTERNAL BILL NO: 126154436 MSR: N0077377
CUST/EXTERNAL BILL NO: 1105380028
BR PROVIDER #: 330956713-0024

CLAIM NO. WC 608-A75629 HOD
CONTRACT NO: WC1-621-004009-572
DOCUMENT NO: 11053800280

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781

PATIENT ACCT. #: NA
SSN: XXX-XX-
DOI: 01/22/13
PATIENT:

PROVIDER: CHRIS ALCALA
CHRIS ALCALA JOYCE ALTMAN INTERP

EMPLOYER: LOEWS CORPORATION
ADDRESS: 1755 HIGHLAND AVE
LOS ANGELES, CA 90028

LOCATION CODE: 303127

AGENCY CLAIM #(BOARD COMM #): 201310111609468604O134
DIAG CODES: R68.89

DATES OF SERVICE: 01/16/20-01/16/20
AUDIT DATE: 01/17/20

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES

ELECTRONICALLY. SIGN-UP TODAY TO TAKE ADVANTAGE OF THE BENEFITS OF PAPERLESS BILLING AND PAYMENTS BY VISITING WWW.JOPARI.COM OR BY CALLING 1-800-630-3060. (Z849)

Z850 MEDICAL BILLS FOR THIS CLAIM SHOULD BE SUBMITTED TO THE 'SEND BILLS TO' ADDRESS REFERENCED IN THE UPPER LEFT CORNER OF THE EOP. (Z850)

5688 TIME LIMITS TO DISPUTE PAYMENT AMOUNT REQUEST FOR SECOND REVIEW FORM: HTTP://WWW.DIR.CA.GOV/DWC/DWCPROPREGS/IBR/FORMSBR_1.PDF AFTER AN EOR IS RECEIVED ON AN ORIGINAL BILL SUBMISSION, A HEALTH CARE PROVIDER, HEALTH CARE FACILITY, OR BILLING AGENT/ASSIGNEE (HEREIN REFERRED TO AS 'PROVIDER') THAT DISPUTES THE AMOUNT PAID MAY SUBMIT AN APPEAL/RECONSIDERATION/REQUEST FOR SECOND REVIEW TO THE CLAIMS ADMINISTRATOR WITHIN 90 DAYS OF SERVICE OF THE EOR. THE REQUEST FOR SECOND REVIEW MUST CONFORM TO THE REQUIREMENTS OF THE DWC'S MEDICAL BILLING AND PAYMENT GUIDE, AND REGULATIONS AT TITLE 8, CA CODE OF REGULATIONS, SECTION 9792.5.4 ET SEQ. IF THE DISPUTE IS THE AMOUNT OF PAYMENT AND THE PROVIDER DOES NOT REQUEST A SECOND REVIEW WITHIN 90 DAYS OF THE SERVICE OF THE EOR, THE BILL SHALL BE DEEMED SATISFIED AND NEITHER THE EMPLOYER NOR THE EMPLOYEE SHALL BE LIABLE FOR ANY FURTHER PAYMENT. REQUEST FOR INDEPENDENT BILL REVIEW FORM: HTTP://WWW.DIR.CA.GOV/DWC/DWCPROPREGS/IBR/FORMIBR_1.PDF AFTER THE PROVIDER SUBMITS A REQUEST FOR SECOND REVIEW, THE CLAIMS ADMINISTRATOR WILL REVIEW THE BILL AND ISSUE AN EOR WHICH IS THE FINAL WRITTEN DETERMINATION BY THE CLAIMS ADMINISTRATOR ON THE BILL. AFTER THE EOR IS RECEIVED ON THE SECOND BILL REVIEW SUBMISSION, THE PROVIDER THAT STILL DISPUTES THE AMOUNT PAID MAY SUBMIT A REQUEST FOR INDEPENDENT BILL REVIEW (IBR) WITHIN 30 DAYS OF SERVICE OF THE EOR. THE REQUEST FOR IBR MUST CONFORM TO THE REQUIREMENTS OF TITLE 8, CA CODE OF REGULATIONS, SECTION 9792.5.4 ET SEQ. IF THE PROVIDER FAILS TO REQUEST AN IBR WITHIN 30 DAYS, THE BILL SHALL BE DEEMED SATISFIED, AND NEITHER THE EMPLOYER NOR THE EMPLOYEE SHALL BE LIABLE FOR ANY FURTHER PAYMENT. IF THE EMPLOYER HAS CONTESTED LIABILITY FOR ANY ISSUE OTHER THAN THE REASONABLE AMOUNT PAYABLE FOR SERVICES, THAT ISSUE SHALL BE RESOLVED PRIOR TO FILING A REQUEST FOR IBR, AND THE TIME LIMIT FOR REQUESTING IBR SHALL NOT BEGIN TO RUN UNTIL THE RESOLUTION OF THAT ISSUE BECOMES FINAL.

5792 TO OBTAIN INFORMATION ABOUT THE STATUS OF YOUR MEDICAL BILL SUBMISSIONS AND TO LEARN ABOUT THE RECONSIDERATION PROCESS, OR THE BENEFITS OF PAPERLESS BILLING & ELECTRONIC PAYMENTS (EFT), VISIT OUR PROVIDER SUPPORT WEBSITE AT WWW.LIBERTYMUTUALPROVIDERSUPPORT.COM.

NOTES
- FOR APPEALS, CORRECTED BILLS OR QUESTIONS PERTAINING TO THE AMOUNT IN THE REVIEW ALLOW COLUMN ON THIS EOB, INCLUDE
- A COPY OF THE EOB, YOUR REASON FOR DISPUTE, AND ANY DOCUMENTATION YOU WOULD LIKE US TO REVIEW FOR RECONSIDERATION.
- SEND THIS INFORMATION TO THE APPEALS ONLY ADDRESS LOCATED ON THE LEFT CORNER OF THE EOB. (Z212)
- DATE BILL RECEIVED: 01/16/2020 PAY STATUS CD: 1 BILL FREQ. TYPE: DRG CD: PAY METHOD: PAPER PATIENT
- DOB: 09/03/1954
- PPO/MPN NAME: PPO/MPN ID #: PAY-TO PROVIDER STATE LIC #:
-
- LINE # 1 BILLED UNIT: 1.00 RX #: RENDRG PROV NPI:

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/17/20 09698

EAMS#(s):

SS # : XXX-XX
DOB :
Terms: 60 days
Claim #(s):
N/A

BILL TO:
UEF/NILE CORPORATION

ATTN: MANAGER/ OWNER
15457 PROCTOR AVENUE
CITY OF INDUSTRY, CA 91745-1025

Case: rs NILE CORPORATION/SUPER MAX
Date Of Injury: 5/19/04

DOS	SERVICE	DESCRIPTION	AMOUNT
07/14/04	MRI	REF BY DR WANG: L/S*	150.00
07/06/04	RE-EVAL	DR ANDALIB*	120.00
07/09/04	EMG TESTING	DR WANG: U/E*	125.00
07/09/04	NCV	DIAGNOSTIC STUDY INTERP: U/E*	125.00
08/05/04	RE-EVAL	DR ANDALIB*	120.00
08/06/04	RE-EVAL	DR WANG*	120.00
09/24/04	RE-EVAL	DR WANG*	120.00
04/13/05	WCAB LB	MSC	147.00
01/26/06	PENALTIES	FOR DATE OF SERVICE 7/14/04	22.50
04/05/07	INTEREST	FOR DATE OF SERVICE 7/14/04	47.97
01/26/06	PENALTIES	FOR DATE OF SERVICE 7/9/04	37.50
04/05/07	INTEREST	FOR DATE OF SERVICE 7/9/04	80.34
01/26/06	PENALTIES	FOR DATE OF SERVICE 4/13/05	22.05
04/05/07	INTEREST	FOR DATE OF SERVICE 4/13/05	34.37
02/22/06	INITIAL EXAM	DR GROMIS*	230.00
05/02/06	PENALTIES	FOR DATE OF SERVICE 2/22/06	34.50
04/05/07	INTEREST	FOR DATE OF SERVICE 2/22/06	30.94
12/16/15	LIENACTIVFEE	LIEN ACTIVATION FEE	100.00
11/25/19	LEGAL_C&R	C&R READING @ L/O DENNIS FUSI	250.00
/ /	INTERPRETER:	MARIA PACO CORTEZ # 100533	0.00
01/13/20	PMT BY CHECK	DOS 1/13/20 # 9057 GUERRERO & CHAN, LLP	-1507.00
01/17/20	BLCE OFF SET	BALANCE OFF SET	-410.17

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/17/20 09698

EAMS#(s):

SS # : XXX-XX
DOB :
Terms: 60 days
Claim #(s):
N/A

BILL TO:
UEF/NILE CORPORATION

ATTN: MANAGER/ OWNER
15457 PROCTOR AVENUE
CITY OF INDUSTRY, CA 91745-1025

Case: vs NILE CORPORATION/SUPER MAX
Date Of Injury: 5/19/04

DOS	SERVICE	DESCRIPTION	AMOUNT

BALANCE 0.00

* INDICATES BILLED AT A MINIMUM OF 2 HOURS
NOTE: Any and all partial payments received have been acknowledged and clearly reflected in the enclosed statement. However, payments received do not represent full and final satisfaction. In accordance with CCR Section 10770 lien claimant/ or Petitioner is hereby seeking recovery of the balance. Demand is hereby made for Current Print Out of Benefits, MPN Notices, Completed DWC-1, Applic of Adjud, 4600 Election letter, Depo Transcript, Complete Medical Index and any documentary evidence to be utilized in an attempt to defeat this lien/ or Petition. ** THIS SERVES AS DEMAND FOR PAYMENT **

NILE
16685 E. Johnson Drive
City of Industry, CA 91745

CATHAY BANK
1250 S. FULLERTON ROAD
CITY OF INDUSTRY, CA 91748
16-395/1222

9057

FRAUDARMOR

01/13/2020

PAY TO THE ORDER OF

Joyce Altman Interpreters Inc

$ **1,507.00

DOLLAR

One thousand five hundred seven and 00/100**********

Joyce Altman Interpreters Inc
P. O. BOX #4165
Tustin, CA 92781-4165
United States

MEMO

AUTHORIZED SIGNATURE

⑈009057⑈ ⑆122203950⑆ 04 028 953⑈

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
02/03/20 69519

EAMS#(s):

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
30153842142-0001

BILL TO:
SEDGWICK CLAIMS (LEXINGT14442)
W. C. DEPARTMENT
ATTN: DEBBIE HENSON
P.O. BOX # 14442
LEXINGTON, KY 40512

Case: vs RSI PROFESSIONAL CABINET SOL.
Date Of Injury: 10/15/13-4/8/14

DOS	SERVICE	DESCRIPTION	AMOUNT
05/26/16	LEGAL_WCAB	STATUS CONFERENCE @ WCAB POM	156.50
/ /	INTERPRETER:	LORRAINE MORELL # 300628	0.00
06/29/16	PMT BY CHECK	DOS 5/26/16* # 0070393005	-156.50
11/28/16	LEGAL_WCAB	EXPEDITED HEARING @ WCAB POM	156.50
/ /	INTERPRETER:	LORRAINE MORELL # 300628	0.00
05/14/01	PENALTIES	FOR DATE OF SERVICE 11/28/16	23.48
05/09/18	INTEREST	FOR DATE OF SERVICE 11/28/16	25.20
05/09/18	PMT BY CHECK	DOS 11/28/16* # 89564765 SEDGWICK	-156.50
06/04/18	PMT BY CHECK	DOS 5/26/16-5/9/18* # 89891221 SEDGWICK	-48.68
01/28/20	COSTS	ADD'L COSTS AWARDED	750.00
01/28/20	PMT BY CHECK	DOS 11/28/16* =# 102678523 SEDGWICK	-750.00

BALANCE 0.00

* INDICATES BILLED AT A MINIMUM OF 2 HOURS
NOTE: Any and all partial payments received have been acknowledged and clearly reflected in the enclosed statement. However, payments received do not represent full and final satisfaction. In accordance with CCR Section 10770 lien claimant/ or Petitioner is hereby seeking recovery of the balance. Demand is hereby made for Current Print Out of Benefits, MPN Notices, Completed DWC-1, Applic of Adjud, 4600 Election letter, Depo Transcript, Complete Medical Index and any documentary evidence to be utilized in an attempt to defeat this lien/ or Petition. ** THIS SERVES AS DEMAND FOR PAYMENT **

P690502R000

20160629162O

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

Electronic Service Requested

SINGLE PIECE

2606 0.5738 SP 0.465

JOYCE ALTMAN INTERPRETERS
P.O. BOX 4165
TUSTIN, CA 92781-4165

2 OF 2

ENV 2606

DATE	CHECK AMT	CHECK NO.
06/29/2016	156.50	0070393005

PAYEE	TAX ID
JOYCE ALTMAN INTERPRETERS	*****6713

SCMS UNIT	PAGE
600 Sedgwick Claims Management Services, Inc	1 of 1

Claimant Name		Loss Date	Claim Number
		04/08/2014	30153842142-0001
Amt Paid:	156.50	Description:	
Amt Billed:	156.50	Invoice: 69519	ICN: 129264347.6
Dates:	05/26/2016-05/26/2016	Comment:	

0 5

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

DATE	CHECK AMOUNT	CHECK NUMBER
05/09/2018	156.50	89564765
PAYEE		TAX ID
JOYCE ALTMAN INTERPRETERS		*****6713
SCMS UNIT		PAGE
600 Sedgwick Claims Management Services, Inc		01 of 01

0004874-0014387 0106 001 705391

JOYCE ALTMAN INTERPRETERS
P.O. BOX 4165
TUSTIN CA 92781

Claimant Name	Loss Date	Claim Number
	04/08/2014	30153842142-0001
Amt Paid: 156.50 Amt Billed: 156.50 Dates: 11/28/2016 - 11/28/2016	Description: Invoice: 69519 ~1 Comment:	ICN:301538421420001

73916 - 1
73917 - 1

MAY 15 2018

SWK.RM.STD.00.NP

For additional information about this payment or other bills, visit us at https://vianeselfservice.sedgwickcms.net/User/Login

THE FACE OF THIS CHECK IS PRINTED BLUE - THE BACK CONTAINS A SIMULATED WATERMARK - SEE BACK FOR DETAILS

Sedgwick as Agent for Everest National Insurance Co - CA1
Everest National Insurance

ORIGIN 6005201 Wells Fargo Bank, N.A.

VOID AFTER 60 DAYS

DATE: 05/09/2018

89564765

62-22
311

PAY: ******ONE HUNDRED FIFTY SIX AND 50/100 DOLLARS

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

$156.50

3631365S1

Bob Blankenship

MEMO: MP

Everest National Insurance Co, Principal
Sedgwick Claims Management Services, Inc., Agent By:

⑈89564765⑈ ⑆031100225⑆ 207995005970 3⑈

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

0006812-0029177 0106 001 710793 SWK

JOYCE ALTMAN INTERPRETERS
P.O. BOX 4165
TUSTIN CA 92781

DATE	CHECK AMOUNT	CHECK NUMBER
06/04/2018	48.68	89891221
PAYEE		TAX ID
JOYCE ALTMAN INTERPRETERS		*****6713
SCMS UNIT		PAGE
600 Sedgwick Claims Management Services, Inc		01 of 01

Claimant Name		Loss Date	Claim Number
		04/08/2014	30153842142-0001
Amt Paid: 48.68	Description:		
Amt Billed: 48.68	Invoice:	69519	ICN:163597950.6
Dates: 05/26/2016 - 05/09/2018	Comment:		

JUN 07 2018

SWK.RM.STD.00.NP

For additional information about this payment or other bills, visit us at https://visaoneselfservice.sedgwickcms.net/User/Login

THE FACE OF THIS CHECK IS PRINTED BLUE - THE BACK CONTAINS A SIMULATED WATERMARK - SEE BACK FOR DETAILS

Sedgwick as Agent for Everest National Insurance Co - CA1
Everest National Insurance

ORIGIN 6005201
Wells Fargo Bank, N.A.

VOID AFTER 60 DAYS

DATE: 06/04/2018

89891221
62-22
311

PAY: ******FORTY EIGHT AND 68/100 DOLLARS

$48.68

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

Bob Blankenship

MEMO: MP

Everest National Insurance Co, Principal
Sedgwick Claims Management Services, Inc., Agent By:

376381079

⑈89891221⑈ ⑆031100225⑆ 207995005970 3⑈

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

DATE	CHECK AMOUNT	CHECK NUMBER
01/28/2020	750.00	102678523

PAYEE	TAX ID
JOYCE ALTMAN INTERPR	*****6713

SCMS UNIT	PAGE
600 Sedgwick Claims Management Services, Inc	01 of 01

0006095-0016691 0106 001 860495

JOYCE ALTMAN INTERPR
PO BOX 4165
TUSTIN CA 92781-4165

Claimant Name		Loss Date	Claim Number
		04/08/2014	30153842142-0001
Amt Paid: 750.00	Description:	Interpreter	
Amt Billed: 977.00	Invoice:	5312020012418137	ICN:5201-13462443
Dates: 11/28/2016 - 11/28/2016	Comment:		

SWK.RM.STD.00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

EXPLANATION OF BILL REVIEW

PAYOR **Sedgwick**	RECEIVED BY VENDOR **01/27/2020**	DATE OF INJURY **04/08/2014**	
BILL ID(ICN) **5201-13462443**	PROCESSED BY VENDOR **01/27/2020**	SOCIAL SECURITY NUMBER	
INJURED NAME (LAST FIRST MI)	TPA CLAIM NUMBER **30153842142-0001**		
INJURED ADDRESS	PATIENT ACCOUNT NUMBER	PROVIDER NAME AND ADDRESS **JOYCE ALTMAN INTERPR PO BOX 4165 TUSTIN, CA 92781**	
	EMPLOYER CONTRACT NUMBER **5201**		
IMAGE NUMBER (DCN) **6020200123021233**	TPA TRANSACTION# (MBDCN) **5312020012418137**		
EMPLOYER NAME **RSI HOME PRODUCTS INC.**	CARRIER NAME **Everest National Insurance**		
EMPLOYER ADDRESS **11350 RIVERSIDE DRIVE MIRA LOMA, CA 91752 Everest National Insurance**	CARRIER ADDRESS **P.O. Box 830 Liberty Corner Liberty Corner, NJ 079380830**	TREATING PROVIDER **JOYCE ALTMAN INTERPR ETERS INC**	
		PROVIDER TAX ID **330956713**	
PROVIDER NPI	ICD CODES **T14.90**	DATES OF SERVICE **11/28/2016 - 11/28/2016**	

Date of Service	Submitted Code	Mod(s)	Units	Reimbursed Code	Billed Amount	FS/UCR Reduction	Negotiated/ Discount	Network Reduction	Recommended Allowance
11/28/2016	MDO10		1	MDO10	977.00	227.00	0.00	0.00	750.00
	FINAL ORDR/AWARD WC APPL REQ LUM SUM/MUL BILL-DISP				REASON CODES	G4,5385			

Explanation of Reason Codes For Detail Lines

G4 THIS CHARGE WAS ADJUSTED TO COMPLY WITH THE RATE AND RULES OF THE CONTRACT INDICATED.

5385 This payment is being made in full and final satisfaction of the lien per the settlement agreement.

Explanation of Bill Review:

TIME LIMITS TO DISPUTE PAYMENT AMOUNT REQUEST FOR SECOND REVIEW Form: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/FormSBR_1.pdf After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee (herein referred to as 'Provider') that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the EOR. The Request for Second Review must conform to the requirements of the DWC's Medical Billing and Payment Guide, and regulations at Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the dispute is the amount of payment and the Provider does not request a second review within 90 days of the service of the EOR, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. REQUEST FOR INDEPENDENT BILL REVIEW Form: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/FormIBR_1.pdf After the Provider submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, the Provider that still disputes the amount paid may submit a request for independent bill review (IBR) within 30 days of service of the EOR. The Request for IBR must conform to the requirements of Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the Provider fails to request an IBR within 30 days, the bill shall be deemed satisfied, and neither the employer nor

QUESTIONS ABOUT OTHER SEDGWICK PAYMENTS?

Visit Sedgwick.com. Point to Technology and click viaOne. Under the left-hand viaOne menu, click for providers. Click the Click here link.

QUESTIONS ABOUT THIS EXPLANATION OF REVIEW?

Bill Review Vendor: Sedgwick CMS - National Bill Review
P.O. Box 14447
Lexington, KY 40512-4447

Customer Service Phone: (866) 495-7844
Customer Service

PPO Network:

PPO Sub Network:

FOR RECONSIDERATIONS

Address: Sedgwick Claims Management Services
P O Box 14442
Lexington, KY 40512-4442

Fax: 833-875-6679
Phone: 800-854-6188

EXPLANATION OF BILL REVIEW

PAYOR	DATE OF INJURY	CARRIER NAME
Sedgwick	**04/08/2014**	**Everest National Insurance**
INJURED NAME (LAST FIRST MI)		TPA CLAIM NUMBER **30153842142-0001**

Date of Service	Submitted Code	Mod(s)	Units	Reimbursed Code	Billed Amount	FS/UCR Reduction	Negotiated/ Discount	Network Reduction	Recommended Allowance

the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final. Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual provider's agreement with the preferred provider organization.

Totals:	977.00	227.00	0.00	0.00	750.00

* Date Received by Sedgwick: 01/23/2020
* Date of Review: 01/27/2020
* Payment Date: 01/28/2020
* Diagnostic Group Code: N/A
* Payment Method: Paper Check
* Check Number: 102678523
* Payment Status Code: 1

728690248

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/27/20 62039

EAMS#(s):

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
30131488273

BILL TO:
SEDGWICK CLAIMS (LEXINGT14442)
W. C. DEPARTMENT
ATTN: JESSICA MARX
P.O. BOX # 14442
LEXINGTON, KY 40512

Case: vs DECO LIGHTING
Date Of Injury: 5/4/13

DOS	SERVICE	DESCRIPTION	AMOUNT
05/13/14	WCAB LB	MSC - JOHANNA JORDAN # 300566	156.50
08/15/14	PMT BY CHECK	DOS 5/13/14* # 0051001594	-90.00
02/25/15	LEGAL_PREP	DEPO PREP @ L/O STOCKWELL, HARRIS	156.50
/ /	INTERPRETER:	HUGO WEINSTEIN # 21981879	0.00
03/30/15	LEGAL_REVIEW	DEPO REVIEW @ L/O DENNIS FUSI	250.00
/ /	INTERPRETER:	PATRICIA HAYES # 100761	0.00
07/14/15	LEGAL_WCAB	MSC @ WCAB LBO	156.50
/ /	INTERPRETER:	JOHANNA JORDAN # 301566	0.00
08/31/15	LEGAL_PREP	DEPO PREP @ L/O STOCKWELL, HARRIS (VOL. II)	156.50
/ /	INTERPRETER:	PATRICIA HAYES # 100761	0.00
09/10/15	LEGAL_WCAB	MSC @ WCAB LONG BEACH	156.50
/ /	INTERPRETER:	JOHANNA JORDAN # 301566	0.00
10/06/15	LEGAL_REVIEW	DEPO REVIEW @ L/O DENNIS FUSI VOL II	250.00
/ /	INTERPRETER:	GLADYS REYNA # 301721	0.00
05/03/17	PMT BY CHECK	DOS 5/13/14-10/6/15* # 0073202347	-1192.50
05/03/17	PENALTIES	FOR DATE OF SERVICE 5/13/14	9.90
05/03/17	INTEREST	FOR DATE OF SERVICE 5/13/14	21.27
05/03/17	PENALTIES	FOR DATE OF SERVICE 2/25/15	23.48
05/03/17	INTEREST	FOR DATE OF SERVICE 2/25/15	39.55
05/03/17	PENALTIES	FOR DATE OF SERVICE 3/30/15	37.50
05/03/17	INTEREST	FOR DATE OF SERVICE 3/30/15	60.18
05/03/17	PENALTIES	FOR DATE OF SERVICE 7/14/15	23.48
05/03/17	INTEREST	FOR DATE OF SERVICE 7/14/15	33.04
05/03/17	PENALTIES	FOR DATE OF SERVICE 8/31/15	23.48
05/03/17	INTEREST	FOR DATE OF SERVICE 8/31/15	30.92
05/03/17	PENALTIES	FOR DATE OF SERVICE 9/10/15	23.48
05/03/17	INTEREST	FOR DATE OF SERVICE 9/10/15	30.37

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/27/20 62039

EAMS#(s):

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
30131488273

BILL TO:
SEDGWICK CLAIMS (LEXINGT14442)
W. C. DEPARTMENT
ATTN: JESSICA MARX
P.O. BOX # 14442
LEXINGTON, KY 40512

Case: vs DECO LIGHTING
Date Of Injury: 5/4/13

DOS	SERVICE	DESCRIPTION	AMOUNT
05/03/17	PENALTIES	FOR DATE OF SERVICE 10/6/15	37.50
05/03/17	INTEREST	FOR DATE OF SERVICE 10/6/15	46.87
05/30/17	PMT BY CHECK	DOS 5/13/14-8/13/15* =# 0073202651	-441.02
10/01/18	LEGAL_WCAB	STATUS CONFERENCE @ WCAB LBO	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 100585	0.00
11/01/18	LEGAL_WCAB	STATUS CONFERENCE @ WCAB LBO	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 100585	0.00
05/30/17	PMT BY CHECK	DOS 5/13/14-8/13/15* # 0073202651	-8.98
08/05/19	LEGAL_WCAB	MSC @ WCAB LBO	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 100585	0.00
01/21/20	COSTS	ADD'L COSTS AWARDED	594.48
01/21/20	PMT BY CHECK	DOS 8/5/19* =# 78728357	-1055.00

BALANCE 0.00

* INDICATES BILLED AT A MINIMUM OF 2 HOURS
NOTE: Any and all partial payments received have been acknowledged and clearly reflected in the enclosed statement. However, payments received do not represent full and final satisfaction. In accordance with CCR Section 10770 lien claimant/ or Petitioner is hereby seeking recovery of the balance. Demand is hereby made for Current Print Out of Benefits, MPN Notices, Completed DWC-1, Applic of Adjud, 4600 Election letter, Depo Transcript, Complete Medical Index and any documentary evidence to be utilized in an attempt to defeat this lien/ or Petition. ** THIS SERVES AS DEMAND FOR PAYMENT **

P6905028006

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

201408151612

PAID AUG 19 2014

Electronic Service Requested

1 OF 2

ENV 2384

SINGLE PIECE
2384 0.5738 SP 0.480

JOYCE ALTMAN INTERPRETERS 4
P.O. BOX 4165
TUSTIN, CA 92781-4165

DATE	CHECK AMT	CHECK NO.
08/15/2014	90.00	0051001594

PAYEE	TAX ID
JOYCE ALTMAN INTERPRETERS	*****6713

SCMS UNIT	PAGE
600 Sedgwick Claims Management Services, Inc	1 of 1

Claimant Name	Loss Date	Claim Number
	12/04/2013	30131488273-0001

Amt Paid: 90.00 Description: Miscellaneous Medical
Amt Billed: 156.50 Invoice: 62039 ICN: 118777285.6
Dates: 05/13/2014-05/13/2014 Comment:

Questions about other Sedgwick CMS payments? Visit sedgwickcms.com. Click on Provider Resources, then choose viaOne Express(R) for Providers

P6905028006

20170503161

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

Electronic Service Requested

3 OF 3 F

ENV 935

SINGLE PIECE

935 0.7389 SP 0.460

JOYCE ALTMAN INTERPRETERS
P.O. BOX 4165
TUSTIN, CA 92781-4165

3

DATE	CHECK AMT	CHECK NO.
05/03/2017	1,192.50	0073202347

PAYEE	TAX ID
JOYCE ALTMAN INTERPRETERS	*****6713

SCMS UNIT	PAGE
600 Sedgwick Claims Management Services, Inc	1 of 1

Claimant Name	Loss Date	Claim Number
	12/04/2013	30131488273-0001

Amt Paid: 1,192.50 Description:
Amt Billed: 1,192.50 Invoice: ICN: 301314882730001
Dates: 05/13/2014-10/06/2015 Comment: per WCJ order dated 04/05/17

MAY 09 2017

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

P6905028006

20170530161I

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

Electronic Service Requested

9

JUN 02 2017

35 0.7389 SP 0.460 SINGLE PIECE

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781-4165

2 OF 3 F

ENV 35

DATE	CHECK AMT	CHECK NO.
05/30/2017	450.00 - 441.02 = 8.98	0073202651

PAYEE	TAX ID
JOYCE ALTMAN INTERPRETERS INC	*****6713

SCMS UNIT	PAGE
600 Sedgwick Claims Management Services, Inc	1 of 3

Claimant Name	Loss Date	Claim Number
	12/04/2013	30131488273-0001

Amt Paid:
Amt Billed: 90.00
Dates: 165.50 05/13/2014-05/13/2014
Description: Miscellaneous Medical
Invoice:
Comment:
ICN: 5201-13058132

Amt Paid:
Amt Billed: 90.00
Dates: 156.50 02/25/2015-02/25/2015
Description: Miscellaneous Medical
Invoice:
Comment:
ICN: 5201-13058132

Amt Paid:
Amt Billed: 90.00
Dates: 250.00 03/30/2015-03/30/2015
Description: Miscellaneous Medical
Invoice:
Comment:
ICN: 5201-13058132

Amt Paid:
Amt Billed: 90.00
Dates: 156.50 07/14/2015-07/14/2015
Description: Miscellaneous Medical
Invoice:
Comment:
ICN: 5201-13058132

Amt Paid:
Amt Billed: 90.00
Dates: 156.50 08/13/2015-08/13/2015
Description: Miscellaneous Medical
Invoice:
Comment:
ICN: 5201-13058132

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

P6905028006

20170530161l

EXPLANATION OF BILL REVIEW

PAYOR: **Sedgwick**	RECEIVED BY VENDOR: 05/24/2017	DATE OF INJURY: 12/04/2013
BILL ID(ICN): 5201-13058132	PROCESSED BY VENDOR: 05/25/2017	SOCIAL SECURITY NUMBER:
INJURED NAME (LAST,FIRST, MI):	TPA CLAIM NUMBER: 30131488273-0001	
INJURED ADDRESS:	PATIENT ACCOUNT NUMBER:	PROVIDER NAME AND ADDRESS: JOYCE ALTMAN INTERPRETERS INC PO BOX 4165 TUSTIN, CA 92781
	EMPLOYER CONTRACT NUMBER: 5201	
IMAGE NUMBER (DCN): 5120170516160853	TPA TRANSACTION # (MBDCN): 5312017051721424	
EMPLOYER NAME: DECO ENTERPRISES INC	CARRIER NAME: Everest National Insurance	
EMPLOYER ADDRESS: 2915 & 2917 SOUTH VAIL AVENUE 2915 & 2917 SOUTH VAIL AVENUE COMMERCE, CA 90040	CARRIER ADDRESS: 477 Martinsville Road Liberty Corner New Jersey, NJ 079380830	TREATING PROVIDER: JOYCE ALTMAN INTERPR JOYCE ALT
PROVIDER NPI:	ICD CODES: 959.9	PROVIDER TAX ID: 330956713
		DATES OF SERVICE: 05/13/2014-08/13/2015

sedgwick.

3 OF 3 F

ENV 35

Date of Service	Submitted Code	Mod(s)	Units	Reimbursed Code	Billed Amount	FS/UCR Reduction	Negotiated/ Discount	Network Reduction	Recommended Allowance
05/13/2014	T1013 SIGN LANGUAGE/ORAL INTEPR SERV		1	T1013	165.50	75.50 REASON CODES	0.00 G1,601	0.00	90.00
02/25/2015	T1013 SIGN LANGUAGE/ORAL INTEPR SERV		1	T1013	156.50	66.50 REASON CODES	0.00 G1,601	0.00	90.00
03/30/2015	T1013 SIGN LANGUAGE/ORAL INTEPR SERV		1	T1013	250.00	160.00 REASON CODES	0.00 G1,601	0.00	90.00
07/14/2015	T1013 SIGN LANGUAGE/ORAL INTEPR SERV		1	T1013	156.50	66.50 REASON CODES	0.00 G1,601	0.00	90.00
08/13/2015	T1013 SIGN LANGUAGE/ORAL INTEPR SERV		1	T1013	156.50	66.50 REASON CODES	0.00 G1,601	0.00	90.00

Explanation of Reason Codes For Detail Lines
G1 THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

Explanation of Bill Review:
TIME LIMITS TO DISPUTE PAYMENT AMOUNT REQUEST FOR SECOND REVIEW Form: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/FormSBR_1.pdf After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee (herein referred to as 'Provider') that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the EOR. The Request for Second Review must conform to the requirements of the DWC's Medical Billing and Payment Guide, and regulations at Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the dispute is the amount of payment and the Provider does not request a second review within 90 days of the service of the EOR, the bill shall be deemed

satisfied and neither the employer nor the employee shall be liable for any further payment. REQUEST FOR INDEPENDENT BILL REVIEW Form: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/FormIBR_1.pdf After the Provider submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, the Provider that still disputes the amount paid may submit a request for independent bill review (IBR) within 30 days of service of the EOR. The Request for IBR must conform to the requirements of Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the Provider fails to request an IBR within 30 days, the bill shall be deeme d satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final. Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount

QUESTIONS ABOUT OTHER SEDGWICK PAYMENTS?

Visit Sedgwick.com. Point to Technology and click viaOne. Under the left-hand viaOne menu, click for providers. Click the Click here link.

QUESTIONS ABOUT THIS EXPLANATION OF REVIEW?

Bill Review Vendor: Sedgwick CMS - National Bill R
P.O. Box 14447
Lexington, KY 40512-4447

Customer Service Phone: (866) 495-7844
Customer Service

PPO Network:

PPO Sub Network:

FOR RECONSIDERATIONS

Address Sedgwick Claims Management Services
P O Box 14442
Lexington, KY 40512-4442

800-854-8188

Fax: 714-258-5001

P6905028006

20170530161

EXPLANATION OF BILL REVIEW

PAYOR **Sedgwick**	RECEIVED BY VENDOR 05/24/2017	DATE OF INJURY 12/04/2013	
BILL ID(ICN) 5201-13058132	PROCESSED BY VENDOR 05/25/2017	SOCIAL SECURITY NUMBER	
INJURED NAME (LAST,FIRST, MI)	TPA CLAIM NUMBER 30131488273-0001		
INJURED ADDRESS	PATIENT ACCOUNT NUMBER	PROVIDER NAME AND ADDRESS JOYCE ALTMAN INTERPRETERS INC PO BOX 4165 TUSTIN, CA 92781	
	EMPLOYER CONTRACT NUMBER 5201		
IMAGE NUMBER (DCN) 5120170516160853	TPA TRANSACTION # (MBDCN) 5312017051721424		
EMPLOYER NAME DECO ENTERPRISES INC	CARRIER NAME Everest National Insurance		
EMPLOYER ADDRESS 2915 & 2917 SOUTH VAIL AVENUE 2915 & 2917 SOUTH VAIL AVENUE COMMERCE, CA 90040	CARRIER ADDRESS 477 Martinsville Road Liberty Corner New Jersey, NJ 079380830	TREATING PROVIDER JOYCE ALTMAN INTERPR JOYCE ALT	
		PROVIDER TAX ID 330956713	
PROVIDER NPI	ICD CODES 959.9	DATES OF SERVICE 05/13/2014-08/13/2015	

sedgwick.

3 OF 3 B

ENV 35

Date of Service	Submitted Code	Mod(s)	Units	Reimbursed Code	Billed Amount	FS/UCR Reduction	Negotiated/ Discount	Network Reduction	Recommended Allowance

recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual provider's agreement wit h the preferred provider organization.

Totals:	885.00	435.00	0.00	0.00	450.00

* Date Received by Sedgwick: 05/16/2017
* Date of Review: 05/25/2017
* Payment Date: 05/30/2017
* Diagnostic Group Code: N/A
* Payment Method: Paper Check
* Check Number: 73202651
* Payment Status Code: 1

QUESTIONS ABOUT OTHER SEDGWICK PAYMENTS?

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QUESTIONS ABOUT THIS EXPLANATION OF REVIEW?

Bill Review Vendor: Sedgwick CMS - National Bill R
P.O. Box 14447
Lexington, KY 40512-4447

Customer Service Phone: (866) 495-7844
Customer Service

PPO Network:

PPO Sub Network:

FOR RECONSIDERATIONS

Address Sedgwick Claims Management Services
P O Box 14442
Lexington, KY 40512-4442

800-854-6188

Fax: 714-258-5001

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

0008371-0022725 0106 001 858737 SWK

JOYCE ALTMAN INTERPR
PO BOX 4165
TUSTIN CA 92781-4165

DATE	CHECK AMOUNT	CHECK NUMBER
01/21/2020	1,055.00	78728357
PAYEE		TAX ID
JOYCE ALTMAN INTERPR		*****6713
SCMS UNIT		PAGE
600 Sedgwick Claims Management Services, Inc		01 of 01

Claimant Name			Loss Date	Claim Number
			12/04/2013	30131488273-0001
Amt Paid:	1,055.00	Description:	Interpreter	
Amt Billed:	1,055.00	Invoice:	5312020012004662	ICN:5201-13459433
Dates:	08/05/2019 - 08/05/2019	Comment:		

SWK RM STD 00 NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

THE FACE OF THIS CHECK IS PRINTED BLUE - THE BACK CONTAINS A SIMULATED WATERMARK - SEE BACK FOR DETAILS

Sedgwick as Agent for Everest National Insurance Co - CA2
Everest National Insurance

ORIGIN 6005201 Wells Fargo Bank, N.A.

VOID AFTER 60 DAYS

DATE: 01/21/2020

78728357

62-22
311

PAY: ******ONE THOUSAND FIFTY FIVE AND 00/100 DOLLARS

$1,055.00

PAY TO THE ORDER OF JOYCE ALTMAN INTERPR

Bob Blankenship

MEMO: MP

Everest National Insurance Co, Principal
Sedgwick Claims Management Services, Inc., Agent By:

⑈78728357⑈ ⑆031100225⑆ 207995005970 3⑈

EXPLANATION OF BILL REVIEW

PAYOR **Sedgwick**	RECEIVED BY VENDOR **01/20/2020**	DATE OF INJURY **12/04/2013**	
BILL ID(ICN) **5201-13459433**	PROCESSED BY VENDOR **01/20/2020**	SOCIAL SECURITY NUMBER	
INJURED NAME (LAST FIRST MI)	TPA CLAIM NUMBER **30131488273-0001**		
INJURED ADDRESS	PATIENT ACCOUNT NUMBER		PROVIDER NAME AND ADDRESS **JOYCE ALTMAN INTERPR PO BOX 4165 TUSTIN, CA 92781**
	EMPLOYER CONTRACT NUMBER **5201**		
IMAGE NUMBER (DCN) **6020200115036107**	TPA TRANSACTION# (MBDCN) **5312020012004662**		
EMPLOYER NAME **DECO ENTERPRISES INC**	CARRIER NAME **Everest National Insurance**		
EMPLOYER ADDRESS **2915 2917 SOUTH VAIL AVENUE 2915 2917 SOUTH VAIL AVENUE COMMERCE, CA 90040 Everest National Insurance**	CARRIER ADDRESS **P.O. Box 830 Liberty Corner Liberty Corner, NJ 079380830**		TREATING PROVIDER **JOYCE ALTMAN INTERPR ETERS INC**
			PROVIDER TAX ID **330956713**
PROVIDER NPI	ICD CODES **T14.90**		DATES OF SERVICE **08/05/2019 - 08/05/2019**

Date of Service	Submitted Code	Mod(s)	Units	Reimbursed Code	Billed Amount	FS/UCR Reduction	Negotiated/ Discount	Network Reduction	Recommended Allowance
08/05/2019	MDS10		1	MDS10	1,055.00	0.00	0.00	0.00	1,055.00
	LUM SUM/MUL BILL-THE AMNT OF REIM IN DISPUTE CLAIM				REASON CODES G4,5385				

Explanation of Reason Codes For Detail Lines

G4 THIS CHARGE WAS ADJUSTED TO COMPLY WITH THE RATE AND RULES OF THE CONTRACT INDICATED.

5385 This payment is being made in full and final satisfaction of the lien per the settlement agreement.

Explanation of Bill Review:

TIME LIMITS TO DISPUTE PAYMENT AMOUNT REQUEST FOR SECOND REVIEW Form: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/FormSBR_1.pdf After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee (herein referred to as 'Provider') that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the EOR. The Request for Second Review must conform to the requirements of the DWC's Medical Billing and Payment Guide, and regulations at Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the dispute is the amount of payment and the Provider does not request a second review within 90 days of the service of the EOR, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. REQUEST FOR INDEPENDENT BILL REVIEW Form: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/FormIBR_1.pdf After the Provider submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, the Provider that still disputes the amount paid may submit a request for independent bill review (IBR) within 30 days of service of the EOR. The Request for IBR must conform to the requirements of Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the Provider fails to request an IBR within 30 days, the bill shall be deemed satisfied, and neither the employer nor

QUESTIONS ABOUT OTHER SEDGWICK PAYMENTS?

Visit Sedgwick.com. Point to Technology and click viaOne. Under the left-hand viaOne menu, click for providers. Click the Click here link.

QUESTIONS ABOUT THIS EXPLANATION OF REVIEW?

Bill Review Vendor: Sedgwick CMS - National Bill Review
P.O. Box 14447
Lexington, KY 40512-4447

Customer Service Phone: (866) 495-7844
Customer Service

PPO Network:

PPO Sub Network:

FOR RECONSIDERATIONS

Address: Sedgwick Claims Management Services
P O Box 14442
Lexington, KY 40512-4442

Fax: 833-875-6679
Phone: 800-854-6188

EXPLANATION OF BILL REVIEW

PAYOR **Sedgwick**	RECEIVED BY VENDOR **01/20/2020**	DATE OF INJURY **12/04/2013**	
BILL ID(ICN) **5201-13459433**	PROCESSED BY VENDOR **01/20/2020**	SOCIAL SECURITY NUMBER	
INJURED NAME (LAST FIRST MI)	TPA CLAIM NUMBER **30131488273-0001**		
INJURED ADDRESS	PATIENT ACCOUNT NUMBER		PROVIDER NAME AND ADDRESS **JOYCE ALTMAN INTERPR PO BOX 4165 TUSTIN, CA 92781**
	EMPLOYER CONTRACT NUMBER **5201**		
IMAGE NUMBER (DCN) **6020200115036107**	TPA TRANSACTION# (MBDCN) **5312020012004662**		
EMPLOYER NAME **DECO ENTERPRISES INC**	CARRIER NAME **Everest National Insurance**		
EMPLOYER ADDRESS **2915 2917 SOUTH VAIL AVENUE 2915 2917 SOUTH VAIL AVENUE COMMERCE, CA 90040 Everest National Insurance**	CARRIER ADDRESS **P.O. Box 830 Liberty Corner Liberty Corner, NJ 079380830**		TREATING PROVIDER **JOYCE ALTMAN INTERPR ETERS INC**
			PROVIDER TAX ID **330956713**
PROVIDER NPI	ICD CODES **T14.90**		DATES OF SERVICE **08/05/2019 - 08/05/2019**

Date of Service	Submitted Code	Mod(s)	Units	Reimbursed Code	Billed Amount	FS/UCR Reduction	Negotiated/ Discount	Network Reduction	Recommended Allowance
08/05/2019	MDS10		1	MDS10	1,055.00	0.00	0.00	0.00	1,055.00
	LUM SUM/MUL BILL-THE AMNT OF REIM IN DISPUTE CLAIM				REASON CODES G4,5385				

Explanation of Reason Codes For Detail Lines

G4 THIS CHARGE WAS ADJUSTED TO COMPLY WITH THE RATE AND RULES OF THE CONTRACT INDICATED.

5385 This payment is being made in full and final satisfaction of the lien per the settlement agreement.

Explanation of Bill Review:

TIME LIMITS TO DISPUTE PAYMENT AMOUNT REQUEST FOR SECOND REVIEW Form: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/FormSBR_1.pdf After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee (herein referred to as 'Provider') that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the EOR. The Request for Second Review must conform to the requirements of the DWC's Medical Billing and Payment Guide, and regulations at Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the dispute is the amount of payment and the Provider does not request a second review within 90 days of the service of the EOR, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. REQUEST FOR INDEPENDENT BILL REVIEW Form: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/FormIBR_1.pdf After the Provider submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, the Provider that still disputes the amount paid may submit a request for independent bill review (IBR) within 30 days of service of the EOR. The Request for IBR must conform to the requirements of Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the Provider fails to request an IBR within 30 days, the bill shall be deemed satisfied, and neither the employer nor

QUESTIONS ABOUT OTHER SEDGWICK PAYMENTS?

Visit Sedgwick.com. Point to Technology and click viaOne. Under the left-hand viaOne menu, click for providers. Click the Click here link.

QUESTIONS ABOUT THIS EXPLANATION OF REVIEW?

Bill Review Vendor: Sedgwick CMS - National Bill Review
P.O. Box 14447
Lexington, KY 40512-4447

Customer Service Phone: (866) 495-7844
Customer Service

PPO Network:

PPO Sub Network:

FOR RECONSIDERATIONS

Address: Sedgwick Claims Management Services
P O Box 14442
Lexington, KY 40512-4442

Fax: 833-875-6679
Phone: 800-854-6188

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/28/20 72245

EAMS#(s):

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
30177233523-0001

BILL TO:
SEDGWICK CLAIMS (LEXINGT14442)
W. C. DEPARTMENT
ATTN: ERIK SANCHEZ
P.O. BOX # 14442
LEXINGTON, KY 40512

Case: vs FLAIR CLEANERS
Date Of Injury: 1/23/17

DOS	SERVICE	DESCRIPTION	AMOUNT
07/21/17	LEGAL_PREP	DEPO PREP @ L/O DENNIS FUSI	156.50
/ /	INTERPRETER:	SANDRA MONTALTO # 100754	0.00
08/16/17	LEGAL_REVIEW	DEPO REVIEW @ L/O DENNIS FUSI	250.00
/ /	INTERPRETER:	GLADYS REYNA # 301721	0.00
10/02/17	PMT BY CHECK	DOS 7/21/17-8/16/17* =# 0079275840	-180.00
03/20/19	PMT BY CHECK	DOS 7/21/17-8/16/17* # 96380295	-226.50
10/21/19	LEGAL_WCAB	MSC @ WCAB LONG BEACH	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 100585	0.00
11/20/19	PMT BY CHECK	DOS 10/21/19* # 103837561	-156.50
01/08/20	LEGAL_WCAB	TRIAL @ WCAB LBO	195.00
/ /	INTERPRETER:	JOYCE ALTMAN # 300624	0.00
01/09/20	PMT BY CHECK	DOS 1/8/20* # 107939371	-156.50
01/08/20	COSTS	COSTS	274.06
01/28/20	PMT BY CHECK	DOS 10/21/19-1/8/20* =# 108544382	-312.56

BALANCE 0.00

* INDICATES BILLED AT A MINIMUM OF 2 HOURS
NOTE: Any and all partial payments received have been acknowledged and clearly reflected in the enclosed statement. However, payments received do not represent full and final satisfaction. In accordance with CCR Section 10770 lien claimant/ or Petitioner is hereby seeking recovery of the balance. Demand is hereby made for Current Print Out of Benefits, MPN Notices, Completed DWC-1, Applic of Adjud, 4600 Election letter, Depo Transcript, Complete Medical Index and any documentary evidence to be utilized in an attempt to defeat this lien/ or Petition. ** THIS SERVES AS DEMAND FOR PAYMENT **

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

201710021617

Electronic Service Requested

1 OF 2 F

ENV 176

SINGLE PIECE

176 0.5486 SP 0.460

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781-4165

DATE	CHECK AMT	CHECK NO.
10/02/2017	180.00	0079275840

PAYEE	TAX ID
JOYCE ALTMAN INTERPRETERS INC	*****6713

SCMS UNIT	PAGE
211 Sedgwick Claims Management Services, Inc	1 of 3

Claimant Name		Loss Date	Claim Number 72245-1
		01/23/2017	30177233523-0001
Amt Paid:	90.00	Description: Miscellaneous Medical	
Amt Billed:	156.50	Invoice:	ICN: 2453-210270
Dates:	07/21/2017-07/21/2017	Comment:	
Amt Paid:	90.00	Description: Miscellaneous Medical	
Amt Billed:	250.00	Invoice:	ICN: 2453-210270
Dates:	08/16/2017-08/16/2017	Comment:	

OCT 05 2017

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS ■ A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

On behalf of National Union and its affiliates
INSURANCE CO. OF THE STATE OF PA

ORIGIN 2112453 | DATE: 10/02/2017 | CHECK NO: 0079275840 | 62-22 / 311

PAY EXACTLY ******One Hundred Eighty Dollars **Amount: *****$180.00***

PAY TO: JOYCE ALTMAN INTERPRETERS INC

AIG, Principal
Sedgwick Claims Management Services, Inc, Agent
BY:

Bob Blankenship

Wachovia Bank, N.A.
Wilmington, DE

VOID AFTER 60 DAYS

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

⑈0079275840⑈ ⑆031100225⑆ 2079950059703⑈

9000174

P6905028006

201710021617

EXPLANATION OF BILL REVIEW

PAYOR **Sedgwick**	RECEIVED BY VENDOR 09/26/2017	DATE OF INJURY 01/23/2017	
BILL ID(ICN) 2453-210270	PROCESSED BY VENDOR 09/26/2017	SOCIAL SECURITY NUMBER	
INJURED NAME (LAST,FIRST, MI)	TPA CLAIM NUMBER 30177233523-0001		
INJURED ADDRESS	PATIENT ACCOUNT NUMBER 72245	PROVIDER NAME AND ADDRESS JOYCE ALTMAN INTERPRETERS INC PO BOX 4165 TUSTIN, CA 92781	
	EMPLOYER CONTRACT NUMBER 2453		
IMAGE NUMBER (DCN) 5120170920087212	TPA TRANSACTION # (MBDCN) 5312017092216211		
EMPLOYER NAME Flair Cleaners Redondo Beach, CA	CARRIER NAME INSURANCE CO. OF THE STATE OF PA		
EMPLOYER ADDRESS 1900 Artesia Blvd Redondo Beach, CA 90278	CARRIER ADDRESS 175 Water Street 18th Floor New York, NY 10038 (212)770-8596	TREATING PROVIDER JOYCE ALTMAN INTERPR JOYCE ALT	
		PROVIDER TAX ID 330956713	
PROVIDER NPI	ICD CODES T14.9	DATES OF SERVICE 07/21/2017-08/16/2017	

sedgwick.

2 OF 2 F

ENV 176

Date of Service	Submitted Code	Mod(s)	Units	Reimbursed Code	Billed Amount	FS/UCR Reduction	Negotiated/ Discount	Network Reduction	Recommended Allowance
07/21/2017	T1013 SIGN LANGUAGE/ORAL INTEPR SERV		1	T1013	156.50	66.50 REASON CODES	0.00 G1,601	0.00	90.00
08/16/2017	T1013 SIGN LANGUAGE/ORAL INTEPR SERV		1	T1013	250.00	160.00 REASON CODES	0.00 G1,601	0.00	90.00

Explanation of Reason Codes For Detail Lines
G1 THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

Explanation of Bill Review:
TIME LIMITS TO DISPUTE PAYMENT AMOUNT REQUEST FOR SECOND REVIEW Form: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/FormSBR_1.pdf After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee (herein referred to as 'Provider') that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the EOR. The Request for Second Review must conform to the requirements of the DWC's Medical Billing and Payment Guide, and regulations at Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the dispute is the amount of payment and the Provider does not request a second review within 90 days of the service of the EOR, the bill shall be deemed

satisfied and neither the employer nor the employee shall be liable for any further payment. REQUEST FOR INDEPENDENT BILL REVIEW Form: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/FormIBR_1.pdf After the Provider submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, the Provider that still disputes the amount paid may submit a request for independent bill review (IBR) within 30 days of service of the EOR. The Request for IBR must conform to the requirements of Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the Provider fails to request an IBR within 30 days, the bill shall be deeme d satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final. Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual provider's agreement wit h the preferred provider organization.

Totals:	406.50	226.50	0.00	0.00	180.00

* Date Received by Sedgwick: 09/20/2017 * Payment Method: Paper Check

QUESTIONS ABOUT OTHER SEDGWICK PAYMENTS?

Visit Sedgwick.com. Point to Technology and click viaOne. Under the left-hand viaOne menu, click for providers. Click the Click here link.

QUESTIONS ABOUT THIS EXPLANATION OF REVIEW?

Bill Review Vendor: Sedgwick CMS - National Bill R
P.O. Box 14447
Lexington, KY 40512-4447

Customer Service Phone: (866) 495-7844
Customer Service

PPO Network:

PPO Sub Network:

FOR RECONSIDERATIONS

Address Sedgwick Claims Management Services
P O Box 14442
Lexington, KY 40512-4442

800-854-6188

Fax: 833-875-6679

P6905028006

20171002161?

EXPLANATION OF BILL REVIEW

PAYOR **Sedgwick**	RECEIVED BY VENDOR 09/26/2017	DATE OF INJURY 01/23/2017	
BILL ID(ICN) 2453-210270	PROCESSED BY VENDOR 09/26/2017	SOCIAL SECURITY NUMBER	
INJURED NAME (LAST FIRST MI)	TPA CLAIM NUMBER 30177233523-0001		
INJURED ADDRESS	PATIENT ACCOUNT NUMBER 72245	PROVIDER NAME AND ADDRESS JOYCE ALTMAN INTERPRETERS INC PO BOX 4165 TUSTIN, CA 92781	
	EMPLOYER CONTRACT NUMBER 2453		
IMAGE NUMBER (DCN) 5120170920087212	TPA TRANSACTION # (MBDCN) 5312017092216211		
EMPLOYER NAME Flair Cleaners Redondo Beach, CA	CARRIER NAME INSURANCE CO. OF THE STATE OF PA		
EMPLOYER ADDRESS 1900 Artesia Blvd Redondo Beach, CA 90278	CARRIER ADDRESS 175 Water Street 18th Floor New York, NY 10038 (212)770-8596	TREATING PROVIDER JOYCE ALTMAN INTERPR JOYCE ALT	
		PROVIDER TAX ID 330956713	
PROVIDER NPI	ICD CODES T14.9	DATES OF SERVICE 07/21/2017-08/16/2017	

Date of Service	Submitted Code	Mod(s)	Units	Reimbursed Code	Billed Amount	FS/UCR Reduction	Negotiated/ Discount	Network Reduction	Recommended Allowance

* Date of Review: 09/26/2017
* Payment Date: 10/02/2017
* Diagnostic Group Code: N/A

* Check Number: 79275840
* Payment Status Code: 1

2 OF 2 B

ENV 176

QUESTIONS ABOUT OTHER SEDGWICK PAYMENTS?

Visit Sedgwick.com. Point to Technology and click viaOne. Under the left-hand viaOne menu, click for providers. Click the Click here link.

QUESTIONS ABOUT THIS EXPLANATION OF REVIEW?

Bill Review Vendor: Sedgwick CMS - National Bill R
P.O. Box 14447
Lexington, KY 40512-4447

Customer Service Phone: (866) 495-7844
Customer Service

PPO Network:

PPO Sub Network:

FOR RECONSIDERATIONS

Address Sedgwick Claims Management Services
P O Box 14442
Lexington, KY 40512-4442

800-854-6188

Fax: 833-875-6679

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

0007586-0023185 0106 001 778324 SWK

JOYCE ALTMAN INTERPRETERS
P.O. BOX 4165
TUSTIN CA 92781

DATE	CHECK AMOUNT	CHECK NUMBER
03/20/2019	226.50	96380295
PAYEE		TAX ID
JOYCE ALTMAN INTERPRETERS		*****6713
SCMS UNIT		PAGE
211 Sedgwick Claims Management Services, Inc		01 of 01

Claimant Name	Loss Date	Claim Number
	01/23/2017	30177233523-0001

Amt Paid: 226.50
Amt Billed: 226.50
Dates: 07/21/2017 - 08/16/2017

Description: Lump Sum Settlement - Medical
Invoice: ICN:301772335230001
Comment:

PAID
MAR 26 2019
BY: .....

SWK.RM.STD.00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

THE FACE OF THIS CHECK IS PRINTED BLUE - THE BACK CONTAINS A SIMULATED WATERMARK - SEE BACK FOR DETAILS

On behalf of National Union and its affiliates
National Union Fire Ins

ORIGIN 2112453
Wells Fargo Bank, N.A.

VOID AFTER 60 DAYS

DATE: 03/20/2019

96380295
62-22
311

PAY: ******TWO HUNDRED TWENTY SIX AND 50/100 DOLLARS

$226.50

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

Bob Blankenship

MEMO: MP

AIG, Principal
Sedgwick Claims Management Services, Inc., Agent By:

536169351

⑈96380295⑈ ⑆031100225⑆ 20799500597 03⑈

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

0000640-0002035 0106 001 842975 SWK

JOYCE ALTMAN INTERPRETERS
P.O. BOX 4165
TUSTIN CA 92781

DATE	CHECK AMOUNT	CHECK NUMBER
11/20/2019	156.50	103837561
PAYEE		TAX ID
JOYCE ALTMAN INTERPRETERS		*****6713
SCMS UNIT		PAGE
211 Sedgwick Claims Management Services, Inc		01 of 01

72245

Claimant Name			Loss Date	Claim Number
			01/23/2017	30177233523-0001
Amt Paid:	156.50	Description:		
Amt Billed:	156.50	Invoice:	100585	ICN:301772335230001
Dates:	10/21/2019 - 10/21/2019	Comment:		

PAID
NOV 23 2019

SWK.RM.STD.00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

THE FACE OF THIS CHECK IS PRINTED BLUE - THE BACK CONTAINS A SIMULATED WATERMARK - SEE BACK FOR DETAILS

On behalf of National Union and its affiliates
National Union Fire Insurance Company of

ORIGIN 2112453
Wells Fargo Bank, N.A.

VOID AFTER 60 DAYS

DATE: 11/20/2019

103837561
62-22
311

PAY: ******ONE HUNDRED FIFTY SIX AND 50/100 DOLLARS

$156.50

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

Bob Blankenship

AIG, Principal
Sedgwick Claims Management Services, Inc., Agent By:

MEMO: MP

687989767

⑈103837561⑈ ⑆031100225⑆ 207995005970 3⑈

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

0001194-0004715 0106 001 856165 SWK

JOYCE ALTMAN INTERPRETERS
P.O. BOX 4165
TUSTIN CA 92781

DATE	CHECK AMOUNT	CHECK NUMBER
01/09/2020	156.50	107939371

PAYEE	TAX ID
JOYCE ALTMAN INTERPRETERS	*****6713

SCMS UNIT	PAGE
211 Sedgwick Claims Management Services, Inc	01 of 01

Claimant Name	Loss Date	Claim Number
	01/23/2017	30177233523-0001

Amt Paid:	156.50	Description:		
Amt Billed:	156.50	Invoice:	ADJ10832236	ICN:301772335230001
Dates:	01/08/2020 - 01/08/2020	Comment:	interpreting WCAB	

SWKRM STD 00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

THE FACE OF THIS CHECK IS PRINTED BLUE - THE BACK CONTAINS A SIMULATED WATERMARK - SEE BACK FOR DETAILS

On behalf of National Union and its affiliates
National Union Fire Insurance Company of

ORIGIN 2112453 Wells Fargo Bank, N.A.

VOID AFTER 60 DAYS

DATE: 01/09/2020

107939371

62-22
311

PAY: ******ONE HUNDRED FIFTY SIX AND 50/100 DOLLARS

$156.50

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

Bob Blankenship

MEMO: MP

AIG, Principal
Sedgwick Claims Management Services, Inc., Agent By:

⑈107939371⑈ ⑆031100225⑆ 2079950059703⑈

7185541

Sedgwick Claims Management Services, Inc
P O Box 14442
Lexington, KY 40512-4442

0006095-0016683 0106 001 860495 SWK

JOYCE ALTMAN INTERPR
PO BOX 4165
TUSTIN CA 92781-4165

DATE	CHECK AMOUNT	CHECK NUMBER
01/28/2020	312.56	108544382

PAYEE	TAX ID
JOYCE ALTMAN INTERPR	*****6713

SCMS UNIT	PAGE
211 Sedgwick Claims Management Services, Inc	01 of 01

Claimant Name			Loss Date	Claim Number
			01/23/2017	30177233523-0001
Amt Paid:	156.00	Description:	Interpreter	
Amt Billed:	156.50	Invoice:	5312020012004678	ICN:2453-338950
Dates:	10/21/2019 - 10/21/2019	Comment:		
			01/23/2017	30177233523-0001
Amt Paid:	156.56	Description:	Interpreter	
Amt Billed:	195.00	Invoice:	5312020012004678	ICN:2453-338950
Dates:	01/08/2020 - 01/08/2020	Comment:		

SWK.RM.STD.00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

EXPLANATION OF BILL REVIEW

PAYOR **Sedgwick**	RECEIVED BY VENDOR **01/24/2020**	DATE OF INJURY **01/23/2017**	
BILL ID(ICN) **2453-338950**	PROCESSED BY VENDOR **01/24/2020**	SOCIAL SECURITY NUMBER	
INJURED NAME (LAST FIRST MI)	TPA CLAIM NUMBER **30177233523-0001**		
INJURED ADDRESS	PATIENT ACCOUNT NUMBER **72245**	PROVIDER NAME AND ADDRESS **JOYCE ALTMAN INTERPR PO BOX 4165 TUSTIN, CA 92781**	
	EMPLOYER CONTRACT NUMBER **2453**		
IMAGE NUMBER (DCN) **5120200116059880**	TPA TRANSACTION# (MBDCN) **5312020012004678**		
EMPLOYER NAME **Flair Cleaners Redondo Beach, CA**	CARRIER NAME **National Union Fire Insurance Company of Pittsburgh, Pa.**		
EMPLOYER ADDRESS **1900 Artesia Blvd Redondo Beach, CA 90278 National Union Fire Insurance Company of**	CARRIER ADDRESS **70 Pine Street 22 FL Nw York, NY 10270 2127707000**	TREATING PROVIDER **JOYCE ALTMAN INTERPR ETERS INC**	
		PROVIDER TAX ID **330956713**	
PROVIDER NPI	ICD CODES **T14.90**	DATES OF SERVICE **10/21/2019 - 01/08/2020**	

Date of Service	Submitted Code	Mod(s)	Units	Reimbursed Code	Billed Amount	FS/UCR Reduction	Negotiated/ Discount	Network Reduction	Recommended Allowance
10/21/2019	T1013		1	T1013	156.50	0.50	0.00	0.00	156.00
	SIGN LANGUAGE/ORAL INTEPR SERVICES PER 15 MIN				REASON CODES	G1,601			
01/08/2020	T1013		1	T1013	195.00	38.44	0.00	0.00	156.56
	SIGN LANGUAGE/ORAL INTEPR SERVICES PER 15 MIN				REASON CODES	G1,601			

Explanation of Reason Codes For Detail Lines
G1 THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

Explanation of Bill Review:
TIME LIMITS TO DISPUTE PAYMENT AMOUNT REQUEST FOR SECOND REVIEW Form: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/FormSBR_1.pdf After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee (herein referred to as 'Provider') that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the EOR. The Request for Second Review must conform to the requirements of the DWC's Medical Billing and Payment Guide, and regulations at Title 8. CA Code of Regulations, section 9792.5.4 et seq. If the dispute is the amount of payment and the Provider does not request a second review within 90 days of the service of the EOR, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. REQUEST FOR INDEPENDENT BILL REVIEW Form: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/FormIBR_1.pdf After the Provider submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, the Provider that still disputes the amount paid may submit a request for independent bill review (IBR) within 30 days of service of the EOR. The Request for IBR must conform to the requirements of Title 8, CA Code of

QUESTIONS ABOUT OTHER SEDGWICK PAYMENTS?

Visit Sedgwick.com. Point to Technology and click viaOne. Under the left-hand viaOne menu, click for providers. Click the Click here link.

QUESTIONS ABOUT THIS EXPLANATION OF REVIEW?

Bill Review Vendor: Sedgwick CMS - National Bill Review
P.O. Box 14447
Lexington, KY 40512-4447

Customer Service Phone: (866) 495-7844
Customer Service

PPO Network:

PPO Sub Network:

FOR RECONSIDERATIONS

Address: Sedgwick Claims Management Services
P O Box 14442
Lexington, KY 40512-4442

Fax: 833-875-6679
Phone: 800-854-6188

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/20/20 70144

EAMS#(s):

SS # : XXX-XX-
DOB
Terms: 60 days
Claim #(s):
06065818

BILL TO:
SCIF (FRESNO)
W. C. DEPARTMENT
ATTN: CHRISTIN CARR
P.O. BOX # 65005
FRESNO, CA 93650

Case: vs LUXURY EMBROIDERY
Date Of Injury: CT 1/1/14 - 5/4/14

DOS	SERVICE	DESCRIPTION	AMOUNT
08/08/16	LEGAL_WCAB	MSC @ WCAB POMONA	156.50
/ /	INTERPRETER:	LORRAINE MORELL # 300628	0.00
12/05/16	LEGAL_WCAB	MSC @ WCAB POMONA	156.50
/ /	INTERPRETER:	LORRAINE MORELL # 300628	0.00
12/28/16	PMT BY CHECK	DOS 12/5/16* # CP-952331	-156.50
06/25/18	PENALTIES	FOR DATE OF SERVICE 8/8/16	23.48
06/21/18	INTEREST	FOR DATE OF SERVICE 8/8/16	32.05
06/21/18	PMT BY CHECK	DOS 8/8/16* # CP-015745	-156.50
01/09/20	COSTS	ADD'L COSTS AWARDED	644.47
01/16/20	PMT BY CHECK	DOS 1/9/20* # CP-059850	-700.00

BALANCE 0.00

* INDICATES BILLED AT A MINIMUM OF 2 HOURS
NOTE: Any and all partial payments received have been acknowledged and clearly reflected in the enclosed statement. However, payments received do not represent full and final satisfaction. In accordance with CCR Section 10770 lien claimant/ or Petitioner is hereby seeking recovery of the balance. Demand is hereby made for Current Print Out of Benefits, MPN Notices, Completed DWC-1, Applic of Adjud, 4600 Election letter, Depo Transcript, Complete Medical Index and any documentary evidence to be utilized in an attempt to defeat this lien/ or Petition. ** THIS SERVES AS DEMAND FOR PAYMENT **

Explanation of Review (EOR)

State Compensation Insurance Fund
PO BOX 65005
Fresno, CA 93650-5005

Questions & Appeals : (888)782-8338

Provider Number: XXXXX6713

JOYCE ALTMAN INTERPRETERS INC
Po Box 4165
Tustin CA 92781

Check #: **CP-059850**

Issue Date: 01/16/20
Doc #: 035086924

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
Patient Name:					**Claim #:** 06065818		**Date of Injury:** 05/04/14		
SSN: XXX-XX	Employer name: LUXURY EMBROIDERY				Employer ID: 0000001860967140				
	ICD-10 Code:T14.90 INJURY, UNSPECIFIED								
1	SF1-SFCA-20539441	01/09/20	MDO21	Payment By Order	1	1,014.00	314.00	G67 961 G5 375	700.00
					Total Allowances:				**$700.00**

Please refer to the last page(s) of EOR for an explanation of reduction codes and reviewer comments.

To ensure prompt payment of your bills, use the claim number shown above and the injured name on all future correspondence.
Please detach and retain the statement page(s) as your record of payment. THANK YOU.

"GO GREEN! Ebilling is an efficient way to submit bills that also expedites payment. Visit: www.statefundca.com/provider/ElectronicMedicalBilling.asp"

THIS IS WATERMARKED PAPER — HOLD TO LIGHT TO VERIFY WATERMARK

State Compensation Insurance Fund

Medical
SP

Santa Ana District Office
PO BOX 65005
Fresno, CA 93650-5005

CP-059850
Union Bank
Los Angeles, California

90-4156
1222

Payee IRS Number: XXXXX6713

VOID After 365 Days

Check Date	Check Amount
January 16, 2020	**$*******700.00**

PAY ****Seven Hundred and 00/100 Dollars****ONLY

To The
Order Of JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

Please negotiate at your local Union Bank Branch.

268930081

⑈521605985O⑈ ⑆122241501⑆ ⑈908100104 3⑈

State Compensation Insurance Fund
PO BOX 65005
Fresno, CA 93650-5005
Questions & Appeals : (888)782-8338

Provider Number: XXXXX6713

JOYCE ALTMAN INTERPRETERS INC
Po Box 4165
Tustin CA 92781

Check #: **CP-059850**

Issue Date: 01/16/20
Doc #: 035086924

Summary

Bill ID.	Claim Number	Invoice / Account Number	Billed Amounts	Reductions	Allowances	Penalty & Interest	Totals
SF1-SFCA-20539441	06065818	LS	1,014.00	314.00	700.00	.00	700.00

Provider NPI: Rendering Provider NPI: Rendering Provider:
Patient Acct #: LS ReviewerID: VE Carrier Receive Date: 01/09/20 Review Date: 01/15/20 Payment Code: 1 UB04:

The listed invoice totals reflect the amount approved for the associated invoice. This listing is to assist you in reconciling your accounts receivables. Charges that are either denied payment or found in excess of the amount allowed are objected to for the reason(s) stated. Should you have any questions or concerns regarding this remittance, you may contact State Fund at the address and phone number listed herein.

TIME LIMITS TO DISPUTE PAYMENT AMOUNT

Request for Second Review

After an Explanation of Review (EOR) is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the explanation of review. The Request for Second Review must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and regulations at title 8, California Code of Regulations section 9792.5.4 et seq. If the dispute is the amount of payment and the health care provider, health care facility, or billing agent/assignee does not request a second review within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

Request for Independent Bill Review

After a health care provider, health care facility, or billing agent/assignee submits a Request for Second Review, the claims administrator will review the bill and issue an EOR, which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, a health care provider, health care facility, or billing agent/assignee that still disputes the amount paid may submit a request for independent bill review within 30 days of service of the EOR. The Request for Independent Bill Review must conform to the requirements of title 8, California Code of Regulations section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent/assignee fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final.

The following PO Box should be used for any 2nd review request or IBR determinations only: PO Box 28919, FRESNO, CA 93729.
All other correspondence should be directed to PO Box listed at the top of this form.

State Fund will only accept paper bills served in accordance with 8 CCR 10505(b)(1),(2) or electronic bills compliant with The California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide. State Fund does not agree to and will not accept bills served in any other manner, including, but not limited to facsimile (fax) and e-mail.

EOR Reduction Code Explanation:

375 : PLEASE SEE SPECIAL *NOTE* BELOW.
961 : Allowance reflects the lump sum settlement amount
G5 : This charge was adjusted for the reasons set forth in the attached letter.
G67 : Payment based on individual pre-negotiated agreement for this specific service.

Reviewer's Comments:

SF1-SFCA-20539441 BR msg 375 Settlement covers the following dates of service 05/04/2014 thru 01/09/2020

0137937603508692400 1 2

[redacted]

Provider Number: XXXXX6713

Check #: **CP-015745**

JOYCE ALTMAN INTERPRETERS INC
Po Box 4165
Tustin CA 92781

Issue Date: 06/21/18
Doc #: 033456631

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
	Patient Name:				**Claim #:**	06065818	**Date of Injury:**	05/04/14	
SSN: XXX-X	Employer name: LUXURY EMBROIDERY			Employer ID: 0000001860967140					
1	SF1-SPCA-366837	08/08/16	999Q9	Interpreter Deposit-	1	156.50	.00		156.50
				Sub-Totals:		156.50	.00		156.50
				Adjustment:		-156.50	-156.50		.00
				Adj-Totals:		.00	-156.50		156.50
								Subtotal:	**156.50**

Total Allowances: **$156.50**

PAID
JUN 25 2018

[redacted]

"GO GREEN! Ebilling is an efficient way to submit bills that also expedites payment. Visit: www.statefundca.com/provider/ElectronicMedicalBilling.asp"

[redacted]

State Compensation Insurance Fund
PO BOX 65005
Fresno, CA 93650-5005
Questions & Appeals: 1888STATEFUND

Provider Number: XXXXX6713

Check #: **CP-015745**

JOYCE ALTMAN INTERPRETERS INC
Po Box 4165
Tustin CA 92781

Issue Date: 06/21/18
Doc #: 033456631

Summary

Bill ID.	Claim Number	Invoice / Account Number	Billed Amounts	Reductions	Allowances	Penalty & Interest	Totals
SF1-SPCA-366837	06065818	70144	156.50	.00	156.50	.00	156.50
Provider NPI:	Rendering Provider NPI:		Rendering Provider:				
Patient Acct #:	ReviewerID: þ©	Carrier Receive Date: 06/20/18 Review Date: 06/20/18 Payment Code: 1 UB04:					
			Adjustment:				.00
			Totals:				156.50

The listed invoice totals reflect the amount approved for the associated invoice. This listing is to assist you in reconciling your accounts receivables. Charges that are either denied payment or found in excess of the amount allowed are objected to for the reason(s) stated. Should you have any questions or concerns regarding this remittance, you may contact State Fund at the address and phone number listed herein.

TIME LIMITS TO DISPUTE PAYMENT AMOUNT

Request for Second Review

After an Explanation of Review (EOR) is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the explanation of review. The Request for Second Review must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and regulations at title 8, California Code of Regulations section 9792.5.4 et seq. If the dispute is the amount of payment and the health care provider, health care facility, or billing agent/assignee does not request a second review within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

Request for Independent Bill Review

After a health care provider, health care facility, or billing agent/assignee submits a Request for Second Review, the claims administrator will review the bill and issue an EOR, which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, a health care provider, health care facility, or billing agent/assignee that still disputes the amount paid may submit a request for independent bill review within 30 days of service of the EOR. The Request for Independent Bill Review must conform to the requirements of title 8, California Code of Regulations section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent/assignee fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final.

The following PO Box should be used for any 2nd review request or IBR determinations only: PO Box 28919, FRESNO, CA 93729.
All other correspondence should be directed to PO Box listed at the top of this form.

Adjustment Explanations:

P300: 08/08/2016 999Q9 INTERPRETER DEPOSIT-
New information has been received. Requesting bill be processed for possible payment.

01357084033456631001 2

Explanation of Review (EOR)

State Compensation Insurance Fund
PO BOX 65005
Fresno, CA 93650-5005

Questions & Appeals: 1888STATEFUND

Provider Number: XXXXX6713

Check #: **CP-952331**

JOYCE ALTMAN INTERPRETERS INC
Po Box 4165
Tustin CA 92781

Issue Date: 12/28/16
Doc #: 031839339

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
	Patient Name:			**Claim #:** 06065818			**Date of Injury:** 05/04/14		
SSN: XXX-X	Employer name: LUXURY EMBROIDERY			Employer ID: 0000001860967140					
1	SF1-SPCA-260656	12/05/16	999Q9	Interpreter Deposit-	1	156.50	.00	375 G5	156.50
				Total Allowances:					**$156.50**

Please refer to the last page(s) of EOR for an explanation of reduction codes and reviewer comments.

To ensure prompt payment of your bills, use the claim number shown above and the injured name on all future correspondence.
Please detach and retain the statement page(s) as your record of payment. THANK YOU.

"GO GREEN! Ebilling is an efficient way to submit bills that also expedites payment. Visit: www.statefundca.com/provider/ElectronicMedicalBilling.asp"

0133798503183933900 2

Explanation of Review (EOR)

State Compensation Insurance Fund
PO BOX 65005
Fresno, CA 93650-5005
Questions & Appeals : 1888STATEFUND

Provider Number: XXXXX6713

Check #: **CP-952331**

JOYCE ALTMAN INTERPRETERS INC
Po Box 4165
Tustin CA 92781

Issue Date: 12/28/16
Doc #: 031839339

Summary

Bill ID.	Claim Number	Invoice / Account Number	Billed Amounts	Reductions	Allowances	Penalty & Interest	Totals
SF1-SPCA-260656	06065818	70144	156.50	.00	156.50	.00	156.50

Provider NPI: Rendering Provider NPI: Rendering Provider:
Patient Acct #: ReviewerID: þ© Carrier Receive Date: 12/22/16 Review Date: 12/27/16 Payment Code: 1 UB04:

The listed invoice totals reflect the amount approved for the associated invoice. This listing is to assist you in reconciling your accounts receivables. Charges that are either denied payment or found in excess of the amount allowed are objected to for the reason(s) stated. Should you have any questions or concerns regarding this remittance, you may contact State Fund at the address and phone number listed herein.

TIME LIMITS TO DISPUTE PAYMENT AMOUNT

Request for Second Review

After an Explanation of Review (EOR) is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the explanation of review. The Request for Second Review must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and regulations at title 8, California Code of Regulations section 9792.5.4 et seq. If the dispute is the amount of payment and the health care provider, health care facility, or billing agent/assignee does not request a second review within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

Request for Independent Bill Review

After a health care provider, health care facility, or billing agent/assignee submits a Request for Second Review, the claims administrator will review the bill and issue an EOR, which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, a health care provider, health care facility, or billing agent/assignee that still disputes the amount paid may submit a request for independent bill review within 30 days of service of the EOR. The Request for Independent Bill Review must conform to the requirements of title 8, California Code of Regulations section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent/assignee fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final.

The following PO Box should be used for any 2nd review request or IBR determinations only: PO Box 28919, FRESNO, CA 93729.
All other correspondence should be directed to PO Box listed at the top of this form.

EOR Reduction Code Explanation:

375 : PLEASE SEE SPECIAL *NOTE* BELOW.
G5 : This charge was adjusted for the reasons set forth in the attached letter.

Reviewer's Comments:

SF1-SPCA-260656 375: DOS FOR 08/08/16 HAS BEEN PREVIOUSLY ADDRESSED. THANK YOU.

0133798503183933900l 2

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
01/23/20 72791

EAMS#(s)

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
AMTX-0167

BILL TO:
YORK CLAIMS SVCS.(ROSE-619079)
W. C. DEPARTMENT
ATTN: PAULA BAUMGARTNER
P.O. BOX 619079
ROSEVILLE, CA 95661

Case: vs AMERICAN TEXTILE MAINTENANCE
Date Of Injury: 9/21/15

DOS	SERVICE	DESCRIPTION	AMOUNT
10/24/17	LEGAL_PREP	DEPO PREP @ L/O DIETZ, GILMOR CHAZEN (LONG BEACH)	156.50
/ /	INTERPRETER:	CARLOS TORRES # 301694	0.00
11/30/17	PMT BY CHECK	DOS 10/24/17* # 14655	-156.50
11/29/17	LEGAL_REVIEW	DEPO REVIEW @ L/O DENNIS FUSI	250.00
/ /	INTERPRETER:	GLADYS REYNA # 301721	0.00
07/08/19	LEGAL_WCAB	MSC @ WCAB LBO	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 100585	0.00
08/05/19	PMT BY CHECK	DOS 10/24/17-11/29/17* # 18166	-250.00
08/15/19	PMT BY CHECK	DOS 10/24/17-8/5/19* # 18234	-156.50
10/14/19	LEGAL_WCAB	MSC @ WCAB LONG BEACH	156.50
/ /	INTERPRETER:	CARMEN GUZMAN # 100585	0.00
01/20/20	COSTS	ADD'L COSTS AWARDED	843.50
01/20/20	PMT BY CHECK	DOS 1/17/20* # 19217	-1000.00

BALANCE 0.00

* INDICATES BILLED AT A MINIMUM OF 2 HOURS
NOTE: Any and all partial payments received have been acknowledged and clearly reflected in the enclosed statement. However, payments received do not represent full and final satisfaction. In accordance with CCR Section 10770 lien claimant/ or Petitioner is hereby seeking recovery of the balance. Demand is hereby made for Current Print Out of Benefits, MPN Notices, Completed DWC-1, Applic of Adjud, 4600 Election letter, Depo Transcript, Complete Medical Index and any documentary evidence to be utilized in an attempt to defeat this lien/ or Petition. ** THIS SERVES AS DEMAND FOR PAYMENT **

Mailing Information:

JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX 4165
TUSTIN, CA 92781-4165

DEC 04 2017

Claim Number:	AMTX-0165
Claimant:	
Date of Loss:	02/03/2016
Check Number:	14655
Check Date:	11/30/2017
Check Amount:	$156.50
Type of Payment:	
	EP 61 - MISC. ALL OTHER
Location:	1 1667 W. Washington Bl. Los Angeles, Ca 90007 1667 W. Washington Bl.
For Period:	10/24/2017 to 10/24/2017
InvoiceNo:	72791
IRS #:	33-0956713
Handling Office:	705-Los Angeles, Roseville, CA

THIS CHECK IS PRINTED ON CHEMICAL REACTIVE PAPER WHICH CONTAINS A WATERMARK • HOLD UP TO LIGHT TO VIEW • CHECK CONTAINS VISIBLE AND INVISIBLE FIBERS

York Risk Services Group, Inc. Client Escrow Account
on behalf of Safety First Insurance Company
American Textile Maintenance Company 7235/W
P.O. Box 1700
Rancho Cucamonga, CA 91729

Wells Fargo Bank, N A
190 River Road
Summit, NJ 07901-1444
55-2/212

REF. NUMBER	
AMTX-0165	
DATE	CHECK NO
11/30/2017	14655
AMOUNT	
***$156.50	

PAY ONE HUNDRED FIFTY-SIX AND 50/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC.
Mail to: P.O. BOX 4165
TUSTIN, CA 92781-4165

Not Negotiable After 180 Days

⑈014655⑈ ⑆121000248⑆ 4129015541⑈

Mailing Information:

JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX 4165
TUSTIN, CA 92781-4165

Claim Number:	AMTX-0165
Claimant:	
Date of Loss:	02/03/2016
Check Number:	18166
Check Date:	08/05/2019
Check Amount:	$250.00
Type of Payment:	
	MP 176 - INTERPRETER MED
Location:	1 DIV 3- ATM Corporate 1667 W. Washington Bl.
For Period:	10/24/2017 to 11/29/2017
IRS #:	33-0956713
Handling Office:	705-Los Angeles, Roseville, CA
Detail:	INTERPRETER FOR DEPOSITION

PAID
AUG 07 2019
BY: .....

THIS CHECK IS PRINTED ON CHEMICAL REACTIVE PAPER WHICH CONTAINS A WATERMARK • HOLD UP TO LIGHT TO VIEW • CHECK CONTAINS VISIBLE AND INVISIBLE FIBERS

York Risk Services Group, Inc.

York Risk Services Group, Inc. Client Escrow Account
on behalf of Safety First Insurance Company
American Textile Maintenance Company 7235/W
P.O. Box 1700
Rancho Cucamonga, CA 91729

Wells Fargo Bank, N A
190 River Road
Summit, NJ 07901-1444
62-22/311

REF. NUMBER	
AMTX-0165	
DATE	CHECK NO
8/5/2019	18166
AMOUNT	
***$250.00	

PAY TWO HUNDRED FIFTY AND 0/100

TO THE ORDER OF **JOYCE ALTMAN INTERPRETERS, INC.**
Mail to: P.O. BOX 4165
TUSTIN, CA 92781-4165

Samanta Mukherjee

Not Negotiable After 180 Days

⑈00018166⑈ ⑆121000248⑆ 4129015541⑈

Mailing Information:

JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX 4165
TUSTIN, CA 92781-4165

Claim Number:	AMTX-0165
Claimant:	
Date of Loss:	02/03/2016
Check Number:	18234
Check Date:	08/15/2019
Check Amount:	$156.50
Type of Payment:	
	EP 71 - LEGAL
Location:	1 DIV 3- ATM Corporate 1667 W. Washington Bl.
For Period:	10/24/2017 to 08/05/2019
InvoiceNo:	72791
IRS #:	33-0956713
Handling Office:	705-Los Angeles, Roseville, CA

PAID
AUG 19 2019
BY .....

THIS CHECK IS PRINTED ON CHEMICAL REACTIVE PAPER WHICH CONTAINS A WATERMARK • HOLD UP TO LIGHT TO VIEW • CHECK CONTAINS VISIBLE AND INVISIBLE FIBERS

York Risk Services Group, Inc.

York Risk Services Group, Inc. Client Escrow Account
on behalf of Safety First Insurance Company
American Textile Maintenance Company 7235/W
P.O. Box 1700
Rancho Cucamonga, CA 91729

Wells Fargo Bank, N A
190 River Road
Summit, NJ 07901-1444
62-22/311

REF. NUMBER	
AMTX-0165	
DATE	CHECK NO
8/15/2019	18234
AMOUNT	
***$156.50	

PAY ONE HUNDRED FIFTY-SIX AND 50/100

TO THE ORDER OF **JOYCE ALTMAN INTERPRETERS, INC.**
Mail to: P.O. BOX 4165
TUSTIN, CA 92781-4165

Sanata Mukherjee

Not Negotiable After 180 Days

⑈0018234⑈ ⑆121000248⑆ 4129015541⑈

Mailing Information:

JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX 4165
TUSTIN, CA 92781-4165

Claim Number:	AMTX-0165
Claimant:	
Date of Loss:	02/03/2016
Check Number:	19217
Check Date:	01/20/2020
Check Amount:	$1,000.00
Type of Payment:	
	MP 230 - PAYMENT ODR-PAYMENT IN DISPUTE
Location:	1 DIV 3- ATM Corporate 1667 W. Washington Bl.
For Period:	01/17/2020 to 01/17/2020
IRS #:	33-0956713
Handling Office:	705-Los Angeles, Roseville, CA
Detail:	FULL AND FINAL LIEN NEGOTIATION

THIS CHECK IS PRINTED ON CHEMICAL REACTIVE PAPER WHICH CONTAINS A WATERMARK • HOLD UP TO LIGHT TO VIEW • CHECK CONTAINS VISIBLE AND INVISIBLE FIBERS

York Risk Services Group, Inc. Client Escrow Account
on behalf of Safety First Insurance Company
American Textile Maintenance Company 7235/W
P.O. Box 1700
Rancho Cucamonga, CA 91729

Wells Fargo Bank, N A
190 River Road
Summit, NJ 07901-1444
62-22/311

REF. NUMBER	
AMTX-0165	
DATE	CHECK NO
1/20/2020	**19217**
AMOUNT	
***$1,000.00	

York Risk

PAY ONE THOUSAND AND 0/100

TO THE ORDER OF **JOYCE ALTMAN INTERPRETERS, INC.**
Mail to: P.O. BOX 4165
TUSTIN, CA 92781-4165

Not Negotiable After 180 Days

⑈0019217⑈ ⑆122000248⑆ 4129015541⑈