Market Rate Summary Graph

Payments for Exotic legal DOS on litigated cases or cases settled in-house at market rate or less than market rate, received between 8/1/19 and 5/29/20

	Invoice	Service Date(s)	Invoice Date	Language	Type of service	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	64439	4/25/14 - 6/5/19	12/3/19	Korean	**2 Depo Preps ($485 each), Half Day Board Appearance (LBO) ($485), Full Day Board Appearance (LBO) ($970)**	**$ 2,425.00**	**PYMTS RCVD**	103855848	4/14/15	$ 970.00	Total Amt Paid for legal interpreting ($2,425) / Total Amt Billed for legal interpreting ($2,425)	N/A	CNA & Employers
								21201623	9/10/19	$ 1,455.00			
								22755070	11/25/19	$ 1,250.00			
					Additional costs	$ 2,000.00		107293857	12/2/19	$ 750.00			
					TOTAL AMT BILLED =>	**$ 4,425.00**		**TOTAL AMT PAID =>**		**$ 4,425.00**	**100%**		
2	75995	11/19/18 - 2/5/19	8/19/19	Korean	**2 Half Day Board Appearances (AHM) ($485 each)**	**$ 970.00**	**PYMTS RCVD**	DA80917101	1/8/19	$ 90.00	Total Amt Paid for legal interpreting ($970) / Total Amt Billed for legal interpreting ($970)	N/A	Employers & Chubb
								DA81463365	4/25/19	$ 90.00			
								DA81754732	6/21/19	$ 790.00			
					Additional costs	$ 700.00		20700302	8/14/19	$ 700.00			
					TOTAL AMT BILLED =>	**$ 1,670.00**		**TOTAL AMT PAID =>**		**$ 1,670.00**	**100%**		

Market Rate Summary Graph

Payments for Exotic legal DOS on litigated cases or cases settled in-house at market rate or less than market rate, received between 8/1/19 and 5/29/20

	Invoice	Service Date(s)	Invoice Date	Language	Type of service	Amount billed		Check No.	Check Date	Total Paid Amt	Percentage of market rate paid	Percentage of market rate paid, including P&I	Payment Authority
3	60271	11/5/13 - 2/24/15	11/4/19	Vietnamese	MEDICAL TREATMENT 12 PR-2s ($485 each), EMG Testing ($485)	$ 6,305.00	**PYMTS RCVD**	662679	10/25/19	$ 11,300.00	Total Amt Paid for legal interpreting ($1,940) / Total Amt Billed for legal interpreting ($1,940)	Total Amt Paid for legal interpreting + Penalties & Interest ($3,012.61) / Total Amt Billed for legal interpreting ($1,940)	Intercare
					LEGAL SERVICES **2 Board Appearances (ANA) ($485 each), Depo Prep ($485), Depo Review ($485)**	**$ 1,940.00**							
					Lien filing fee	$ 150.00							
					P&I for legal services	$ 1,072.61							
					Additional costs	$ 1,832.39							
					TOTAL AMT BILLED =>	**$ 11,300.00**		**TOTAL AMT PAID =>**		**$ 11,300.00**	**100%**	**155%**	

Average % of Market Rate paid without P&I	**100%**
Average % of Market Rate paid with P&I	**155%**

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

*** INVOICE ***
Date NO#
12/03/19 64439

EAMS#(s):

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
E2B30709

BILL TO:
CNA CLAIM PLUS (CHICAGO)
W. C. DEPARTMENT
ATTN: CYNTHIA SANTOS
P.O. BOX # 8317
CHICAGO, IL 60680

Case: vs UNI CAPS
Date Of Injury: 9/1/10

DOS	SERVICE	DESCRIPTION	AMOUNT
04/25/14	DEPO PREP	@ THE L/O OF TOBIN LUCKS (KOREAN)	485.00
/ /	INTERPRETER:	ANNIE EUNHEE LEE # 301157	0.00
02/13/15	LEGAL_EXOTIC	DEPO PREP @ L/O DENNIS FUSI VOL II	485.00
/ /	INTERPRETER:	CHANSUN NISHIMURA # 301033	0.00
04/14/15	PMT BY CHECK	DOS 4/25/14-2/13/15* # 103855848 CNA	-970.00
03/20/19	LEGAL_EXOTIC	MSC @ WCAB LBO	485.00
/ /	INTERPRETER:	CHANSUN NISHIMURA # 301033	0.00
06/05/19	LEGAL_EXOTIC	MSC @ WCAB LONG BEACH (FULL DAY)	970.00
/ /	INTERPRETER:	HAESOON PARK # 301457	0.00
09/10/19	PMT BY CHECK	DOS 2/13/15-9/30/15* =# 21201623 EMPLOYER	-1455.00
11/14/19	COSTS	ADD'L COSTS AWARDED	2000.00
11/25/19	PMT BY CHECK	DOS 11/13/19* =# 22755070	-1250.00
12/02/19	PMT BY CHECK	DOS 12/4/19* # 107293857 CNA	-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 **

CNA ATTN CLAIM
PO BOX 8317
CHICAGO IL 60680

CNA

002694

JOYCE ALTMAN INTERPRETERS INC

PO BOX 4165
TUSTIN CA 92781

D

PAID APR 20 2015

*** To expedite handling of your claim, please include our claim number on all future correspondence to us.**

Claim Number * E2 B30709FL

Insured/Client	Claimant	ATT
UNI CAPS LLC		04/14/15

Date of Loss	Total WC Ind to Date	From - thru Dates	Suff/DT	TRAN Code#	EXP	Pay Code#	Amount
09/01/10		04/25/14-02/13/15	IND	26	TR		$970.00
							$970.00

61786

Reason
INV 64439 INTER/DEPO PREP/LEGAL EXOTIC

To ensure timely delivery of your check, please verify that the address on this check is complete and correct. If not, please notify your claims representative with the correct information. Thank you.

ACCIWF 02.28.13

PLEASE DETACH BEFORE CASHING

CNA
Continental Casualty Company
Chicago, IL 60604

UNDERWRITTEN BY:
VALLEY FORGE INSURANCE COMPANY

103855848
Date Issued
04/14/15

66-156
531
Bank Acct.
4759628092

VOID IF PURPLE BACKGROUND IS ABSENT — THIS DOCUMENT CONTAINS A WATERMARK - HOLD UP TO LIGHT TO VIEW

Claim Number	Desk Code	Insured/Client	Issuing Off. No.
E2 B30709	FL	UNI CAPS LLC	81
Prefix & Contract No. WC -4023009414		Claimant	Date of Loss 09/01/10
From-thru (Dates) 04/25/14	In Payment of 02/13/15	INV 64439 INTER/DEPO PREP/LEGAL EXOTIC	

PAY NINE HUNDRED SEVENTY AND NO/100THS ---------- Dollars

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

********$970.00

Wells Fargo Bank, N.A

VOID IF NOT CASHED IN SIX MONTHS FROM MONTH OF ISSUE

⑈0103855848⑈ ⑆053101561⑆ 4759628092⑈

EMPLOYERS
PO BOX 32036
Lakeland FL, 33802-2036

0000057-0000281 D0106 001 823853 EIG

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

EMPLOYERS®

America's small business insurance specialist®

The attached check and Explanation of Payment(s) have been sent to you for benefits or services rendered on behalf of EMPLOYERS® who is working with VPay® to process its payments. **If you have general questions regarding the payment or cashing this check, please email VPay at support@vpayusa.com or call 1-855-523-9634.** Injured Employees: If you have questions regarding the payment amount or benefit calculation, please contact EMPLOYERS at 1-888-682-6671. Medical Providers: If you have questions regarding the payment amount, please contact CONDUENT at 1-863-669-0861, option 6. For all other payment inquiries, please contact EMPLOYERS at 1-888-682-6671.

Claim ID:	2014224879
Client Reference ID:	270277806
VP Trans ID:	642646361
	EIG0001003
Date:	09/10/2019
Amount:	$1,455.00
Check Number:	21201623

PAID
SEP 12 2019
BY: .....

Get Paid Faster

When you sign up for **VCard or ACH**

Email support@vpayusa.com today to find out how.

EMPLOYERS provides workers compensation insurance through Employers Preferred Insurance Company, Employers Assurance Company, Employers Compensation Insurance Company and Employers Insurance Company of Nevada. EIG Services, Inc. (in California, dba EIG Insurance Services) is an affiliated agency and adjuster.
Form #: CL_VEN_0033_US Rev. 3/2017

EIG.OT

EMPLOYERS
PO BOX 32036
Lakeland FL, 33802-2036

0000024-0000131 D0106 001 844103 EIG

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

EMPLOYERS®
America's small business insurance specialist®

The attached check and Explanation of Payment(s) have been sent to you for benefits or services rendered on behalf of EMPLOYERS® who is working with VPay® to process its payments. **If you have general questions regarding the payment or cashing this check, please email VPay at support@vpayusa.com or call 1-855-523-9634.** Injured Employees: If you have questions regarding the payment amount or benefit calculation, please contact EMPLOYERS at 1-888-682-6671. Medical Providers: If you have questions regarding the payment amount, please contact CONDUENT at 1-863-669-0861, option 6. For all other payment inquiries, please contact EMPLOYERS at 1-888-682-6671.

Claim ID:	2014224879
Client Reference ID:	270288501
VP Trans ID:	690879970
	EIG0001003
Date:	11/25/2019
Amount:	$1,250.00
Check Number:	22755070

PAID
DEC 03 2019
BY: .....

EIG OT

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

EMPLOYERS
America's small business insurance specialist®

Employers Compensation Insurance Company
PO BOX 32036
Lakeland FL, 33802-2036

VPay
1-855-523-9634

METABANK
Sioux Falls, SD
72-7011/2739

22755070

11/25/2019

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC **$1,250.00**

ONE THOUSAND TWO HUNDRED FIFTY DOLLARS AND 00/100 DOLLARS

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

VOID AFTER 180 DAYS

MEMO

690879970

⑈22755070⑈ ⑆273970116⑆ 17000129941⑈

Employers Compensation Insurance Company 501

Process Date: 11/21/2019
Control Number: 306015795
EOR Page 1 of 2
Rev/Aud: SS/JS

Payment Number: 270288501 **Payment Date: 11/25/2019**

Claim Number:	2014224879		PPO/OSR ID:		
Claimant:			NPI Number:		
Provider Tax ID:	[illegible]	Vendor: 5628181#5628181	Claimant SSN:		
Provider Ref:		Geo Zip: 92781	Date Of Injury:	01/01/2013	
Provider License:	CA99999		Claims Received Date:	11/20/2019	

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

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/13/19	11	MDO10		FINAL ORDR/AWAI	1.000	1,250.00	0.00	0.00	0.00	1,250.00	197,6483, G67,G67
			TOTALS:			**1,250.00**	**0.00**	**0.00**	**0.00**	**1,250.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**1,250.00**	

Rendering Provider Name: JOYCE ALTMAN INTERPRETERS INC.
Rendering Provider NPI:

DWC CODE DESCRIPTION

G67 -PAYMENT BASED ON INDIVIDUAL PRE-NEGOTIATED AGREEMENT FOR THIS SPECIFIC SERVICE. ( )

CARRIER EXPLANATION REASON CODE

197 -RECOMMENDED ALLOWANCE BASED ON NEGOTIATED DISCOUNT/RATE.
6483 -FULL AND FINAL SETTLEMENT

2444-H-817479-0 47097664

699879970

Payment Number: 270288501 **Payment Date: 11/25/2019**

Claim Number:	2014224879		PPO/OSR ID:		
Claimant:			NPI Number:		
Provider Tax ID:	330956713	Vendor: 5628181#5628181	Claimant SSN:		
Provider Ref:		Geo Zip: 92781	Date Of Injury:	01/01/2013	
Provider License:	CA99999		Claims Received Date:	11/20/2019	

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

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

Carrier/Insurer: EMPLOYERS COMPENSATION INSURANCE COMPANY

Employer Name: UNI CAPS, LLC (EIG 150451200), Employer ID: EIG 150451200, Employer Address: 540 W. LAMBERT ROAD, BREA, CA 92821

Payer Name: EMPLOYERS COMPENSATION INSURANCE COMPANY, Payer Address: 10375 PROFESSIONAL CIR RENO, NV 895214802, Payer ID Number: 030443592

Claimant Address

Payment Information: Payment Status Code:

TIME LIMITS TO DISPUTE PAYMENT AMOUNT
REQUEST FOR SECOND REVIEW
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
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.

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.

Note to Provider regarding appeals process: Please send appeal requests to Conduent, along with this EOR, the medical bill and all supporting documentation.

47097664

Conduent
PO Box 32045
Lakeland, FL 33802
(866) 851-7739
billinginquiries@conduent.com

Conduent is neither the employer nor the insurance carrier, nor is it responsible for payment of the medical services contained in this explanation of benefits.

2444-H-817479-0

*** Workers Compensation ***

690879970

CNA ATTN CLAIM
PO BOX 8317
CHICAGO IL 60680

CNA

001241
JOYCE ALTMAN INTERPRETERS INC
JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781

PAID
DEC 10 2019
BY.

001241 - 0001 of 0001 - NNNNNNN - 01241 JOBID 03819634344

*** To expedite handling of your claim, please include our claim number on all future correspondence to us.**

Claim Number *
E2 B30702VJ

Insured/Client	Claimant	ATT
UNI CAPS LLC		12/02/19

Date of Loss	Total WC Ind to Date	From - thru Dates	Suff/DT	TRAN Code#	EXP	Pay Code#	Amount
06/30/12		12/04/19-12/04/19	IND	26	TR		$750.00
							$750.00

Reason
CASE NO # 9338640 12/04/2019

To ensure timely delivery of your check, please verify that the address on this check is complete and correct. If not, please notify your claims representative with the correct information. Thank you.

ACCIWF 02.28.13

PLEASE DETACH BEFORE CASHING

CNA
Continental Casualty Company
Chicago, IL 60604

UNDERWRITTEN BY:
AMERICAN CASUALTY COMPANY OF READING, PENNSYLVAN

107293857
Date Issued
12/02/19

66-156
531
Bank Acct.
4759628092

VOID IF PURPLE BACKGROUND IS ABSENT **THIS DOCUMENT CONTAINS A WATERMARK - HOLD UP TO LIGHT TO VIEW**

Claim Number	Desk Code	Insured/Client	Issuing Off. No.
E2 B30702	VJ	UNI CAPS LLC	81
Prefix & Contract No.		Claimant	Date of Loss
WC -402300941 4			06/30/12
From-thru (Dates)	In Payment of		
12/04/19	12/04/19	CASE NO # 9338640 12/04/2019	

PAY SEVEN HUNDRED FIFTY AND NO/100THS ---------- Dollars

TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781

********$750.00

Wells Fargo Bank, N.A

VOID IF NOT CASHED IN SIX MONTHS FROM MONTH OF ISSUE

⑈0107293857⑈ ⑆053101561⑆ 4759628092⑈

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950 FAX: 714 832-1979
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
08/19/19 75995

EAMS#(s):

SS # : XXX-XX
DOB :
Terms: 60 days
Claim #(s):
2008178290

BILL TO:
EMPLOYERS INS (FL - 32036)
W. C. DEPARTMENT
ATTN: RYAN SAMSTAG
P.O. BOX 32036
LAKELAND, FL 33802

Case: vs WIN SOON,INC.
Date Of Injury: 3/1/08

DOS	SERVICE	DESCRIPTION	AMOUNT
11/19/18	LEGAL_EXOTIC	MSC @ WCAB ANAHEIM LANG: KOREAN	485.00
/ /	INTERPRETER:	CHANGSUN NISHIMURA # 301033	0.00
01/08/19	PMT BY CHECK	DOS 11/19/18* # DA80917101	-90.00
02/05/19	LEGAL_EXOTIC	TRIAL @ WCAB ANAHEIM	485.00
/ /	INTERPRETER:	AERYOUNG KIM # 300769	0.00
04/25/19	PMT BY CHECK	DOS 11/19/18-2/5/19* # DA81463365	-90.00
06/21/19	PMT BY CHECK	DOS 11/19/18-2/5/19* # DA81754732	-790.00
08/12/19	COSTS	ADD'L COSTS AWARDED	700.00
08/14/19	PMT BY CHECK	DOS 8/6/19* # 20700302 EMPLOYERS	-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 **

P7092028004

ACE PROPERTY AND CASUALTY INSURANCE COMPANY
PO BOX 6569
SCRANTON, PA 18505-6569

201901070148

Electronic Service Requested

MIXED AADC 926
485 1.1458 MB 0.421
JOYCE ALTMAN INTERPRETERS INC 112
PO BOX 4165
TUSTIN, CA 92781-4165

DATE: 01/08/19
CHECK NO: **DA80917101**

STATEMENT

CHUBB

CHUBB
ACE Property and Casualty Insurance Company

FILE ID	DOLLARS
494C2573945	$ 90.00

* **NOT NEGOTIABLE** *
INVOICE # 74975
AGENCY CLAIM # 201112231552769526577

FOR
SERVICES FROM 11/19/18 THRU 11/19/18 PAT.#74975

CLAIMANT

DATE OF EVENT
12/17/11

Question with regard to this payment should be referred to your agent or the Customer Service Unit of the Claim Office whose address appears above.

JAN 14 2019

ENV 485 1 OF 5 F

EM-BOA18B

DETACH THIS PORTION BEFORE CASHING

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

CHUBB
CHUBB
ACE Property and Casualty Insurance Company

64-1278/611 GA

DATE: 01/08/19

DA80917101

PLEASE DEPOSIT or CASH WITHIN 90 DAYS

FILE ID
494C2573945

Bank of America

1973302

Pay Ninety Dollars

$ *****$90.00*

PAY TO THE ORDER OF: JOYCE ALTMAN INTERPRETERS INC
P.O. BOX #4165
TUSTIN CA 92781

FOR
SERVICES FROM 11/19/18 THRU 11/19/18
POLICY HOLDER
WIN SOON, INC

CLAIM OFFICE
FREMONT WC
CLAIMANT

SPECIAL HANDLING
00

CHUBB

AUTHORIZED SIGNATURE

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

⑈618091710⑈ ⑆061112788⑆ 00329978640 2⑈

ESIS MedBill Impact
P.O. Box 6561; Scranton, PA
18505-6561

Review Analysis oo
Control Number: 506393169
Bill Index Number: X506393169
Date Reviewed: 01/02/2019
Reviewed By: 9040
Rep/Sup: 713/750

Claim Number: C494C2573945
Patient Name:
Provider Tax ID:330956713
Provider NPI: 0

Date Of Injury: 12/17/2011
Patient ID:
Patient Account: 74975
Payor Receipt Date: 12/27/2018

State Jurisdiction:CA
MPN Name:
PPO Name:
PPO ID: (PPOID: 0)

Impact Receipt Date: 12/27/2018
MPN ID
Provider Invoice:

Branch Name: 635
Employer Name:WIN SOON, INC

Provider	Rendering Provider	Insurer
St Lic No 999999999	NPI:	TIN:060237820
JOYCE ALTMAN	Company:	ACE Property &
INTERPRETERS INC	First Name:	436 WALNUT ST nce
P.O. BOX #4165	Last Name:	Philadelphia, PA
TUSTIN, CA 92781		19106

ICD Codes: T14.90 Injury, unspecified

Date of Service	Billed Procedure	Reviewed Procedure	Qty	Provider Charges	Bill Review	REDUCTION PPO	REDUCTION OON	Recommend Allowance
11/19/18	T1013 00		2	$485.00	$395.00	$0.00	$0.00	$90.00
SIGN LANGUAGE/ORAL INTEPR SERVICES PER 15 MIN						Notes 1,2,3		
				$485.00	$395.00	$0.00	$0.00	$90.00

Notes/Messages:
1 Charge exceeds Fee Schedule allowance (222)
2 P12 - Workers compensation jurisdictional fee schedule adjustment. (ANSIP12)
3 G1: The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance. (G1)

Date of Service	Procedure	Reviewed Procedure	Qty	Provider Charges	Bill Review	REDUCTION PPO	OON	Recommend Allowance	Notes

Amounts billed above the recommended allowance are hereby objected to as being in excess of the amounts authorized under section 5307.1 and 5307.3 of the California Labor Code.

Please be notified that per Labor Code 139.3, it is unlawful for a physician to refer a patient to a person or entity if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral. Without proper documentation or proof, your bill may be rejected.

TIME LIMITS TO DISPUTE PAYMENT AMOUNT

Request for Second Review
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 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.

Please submit all new bills by fax to 855-496-5410. For reconsideration of denied or reduced payment, please respond in writing to ESIS WC Claims P.O. Box 6561 Scranton PA 18505-6561. Please include 1) What specifically you wish reconsidered, 2) a copy of this Review Analysis, 3) supporting documentation and 4) a copy of the original bill. Should you have further questions, please contact ESIS MedBill Provider Services at 855-219-1964

Date of Service	Billed Procedure	Reviewed Procedure	Qty	Provider Charges	Bill Review	REDUCTION PPO	OON	Recommend Allowance	Notes

Amounts billed above the recommended allowance are hereby objected to as being in excess of the amounts authorized under section 5307.1 and 5307.3 of the California Labor Code.

Please be notified that per Labor Code 139.3, it is unlawful for a physician to refer a patient to a person or entity if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral. Without proper documentation or proof, your bill may be rejected.

TIME LIMITS TO DISPUTE PAYMENT AMOUNT

Request for Second Review
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 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.

Please submit all new bills by fax to 855-496-5410. For reconsideration of denied or reduced payment, please respond in writing to ESIS WC Claims P.O. Box 6561 Scranton PA 18505-6561. Please include 1) What specifically you wish reconsidered, 2) a copy of this Review Analysis, 3) supporting documentation and 4) a copy of the original bill. Should you have further questions, please contact ESIS MedBill Provider Services at 855-219-1964

ACE PROPERTY AND CASUALTY INSURANCE COMPANY
PO BOX 6569
SCRANTON, PA 18505-6569

201904243926

Electronic Service Requested

SINGLE PIECE

201 1.6405 SP 0.650

JOYCE ALTMAN INTERPRETERS, INC. 2
PO BOX 4165
TUSTIN, CA 92781-4165

DATE: 04/25/19
CHECK NO: **DA81463365**

STATEMENT

CHUBB

CHUBB
ACE Property and Casualty Insurance Company

FILE ID	DOLLARS
494C2573945	$ 90.00

* **NOT NEGOTIABLE** *
INVOICE # 74975
AGENCY CLAIM # 201112231155276952657 7

FOR
11/19/18 THRU 02/05/19 PT74975

CLAIMANT

DATE OF EVENT
12/17/11

Question with regard to this payment should be referred to your agent or the Customer Service Unit of the Claim Office whose address appears above.

PAID
APR 29 2019
BY.....

EM-BOA18B

DETACH THIS PORTION BEFORE CASHING

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

CHUBB
CHUBB
ACE Property and Casualty Insurance Company

64-1278/611 GA

DATE 04/25/19

DA81463365

PLEASE DEPOSIT or CASH WITHIN 90 DAYS

Bank of America

FILE ID
494C2573945

3451028

Pay Ninety Dollars

$ *****$90.00*

PAY TO THE ORDER OF: JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX # 4165
TUSTIN CA 92781

FOR
11/19/18 THRU 02/05/19 PT74975
POLICY HOLDER
WIN SOON, INC

CLAIM OFFICE
FREMONT WC
CLAIMANT

SPECIAL HANDLING
00

CHUBB

AUTHORIZED SIGNATURE

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

⑈614614633651⑈ ⑆061112788⑆ 00329978640 2⑈

1 OF 7 F

ENV 201

P7092028014

ESIS MedBill Impact
P.O. Box 6561; Scranton, PA
18505-6561

Review Analysis oo

Control Number: 506750277
Bill Index Number: X506750277
Date Reviewed: 04/13/2019
Reviewed By: 9062
Rep/Sup: 713/750

Claim Number: C494C2573945
Patient Name:
Provider Tax ID:330956713
Provider NPI: 0

Date Of Injury: 12/17/2011
Patient ID:
Patient Account: 74975
Payor Receipt Date: 04/08/2019

State Jurisdiction:CA
MPN Name:
PPO Name:
PPO ID: (PPOID: 0)

Impact Receipt Date: 04/09/2019
MPN ID
Provider Invoice:

Branch Name: 635
Employer Name:WIN SOON, INC

Provider	Rendering Provider	Insurer
St Lic No 999999999	NPI:	TIN:060237820
JOYCE ALTMAN	Company:	ACE Property &
INTERPRETERS, INC.	First Name:	436 WALNUT ST nce
P.O. BOX # 4165	Last Name:	Philadelphia, PA
TUSTIN, CA 92781		19106

ICD Codes: T14.90 Injury, unspecified

Date of Service	Billed Procedure	Reviewed Procedure	Qty	Provider Charges	Bill Review	REDUCTION PPO	REDUCTION OON	Recommend Allowance	Notes
11/19/18	T1013 00		1	$485.00	$485.00	$0.00	$0.00	$0.00	1,2,4,7
Sign lang/oral interpreter									
2/5/19	T1013 00		1	$485.00	$395.00	$0.00	$0.00	$90.00	3,5,6
Sign lang/oral interpreter									
				$970.00	$880.00	$0.00	$0.00	$90.00	

Notes/Messages:

1 Original DCN 506393169
2 This procedure on this date was previously reviewed (148)
3 Charge exceeds Fee Schedule allowance (222)
4 18 - Duplicate claim/service. (ANSI18)
5 P12 - Workers compensation jurisdictional fee schedule adjustment. (ANSIP12)
6 G1: The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance. (G1)
7 G56: This appears to be a duplicate charge for a bill previously reviewed or this appears to be a balance forward bill containing a duplicate charge and billing for a new service. (G56)

Date of Service	Billed Procedure	Reviewed Procedure	Qty	Provider Charges	Bill Review	REDUCTION PPO	OON	Recommend Allowance
						Notes		

Amounts billed above the recommended allowance are hereby objected to as being in excess of the amounts authorized under section 5307.1 and 5307.3 of the California Labor Code.

Please be notified that per Labor Code 139.3, it is unlawful for a physician to refer a patient to a person or entity if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral. Without proper documentation or proof, your bill may be rejected.

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Request for Second Review
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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.

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ACE PROPERTY AND CASUALTY INSURANCE COMPANY
PO BOX 6569
SCRANTON PA 18505-6569

DATE 06/21/19
CHECK NO. **DA81754732**

STATEMENT

Chubb
ACE Property and Casualty Insurance Company

CHUBB

5900A11DA 00 00464 DA81754732

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

FILE ID: 494C2573945
DOLLARS: $********790.00

*** NOT NEGOTIABLE ***

Invoice #
Agency Claim # 201112231155276952657 7

FOR
11/19/18 THRU 02/05/19 74975
CLAIMANT

DATE OF EVENT
12/17/11

Question with regard to this payment should be referred to your agent or the Customer Service Unit of the Claim Office whose address appears above.

PAID
JUN 24 2019
BY: .....

PDMLDMCD-001694-01-01-00

BOA18B (07/2016)

DETACH THIS PORTION BEFORE CASHING

EMPLOYERS
PO BOX 32036
Lakeland FL, 33802-2036

0000035-0000231 D0106 001 816976 EIG

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

EMPLOYERS®
America's small business insurance specialist®

PAID
AUG 19 2019
BY

The attached check and Explanation of Payment(s) have been sent to you for benefits or services rendered on behalf of EMPLOYERS® who is working with VPay® to process its payments. **If you have general questions regarding the payment or cashing this check, please email VPay at support@vpayusa.com or call 1-855-523-9634.** Injured Employees: If you have questions regarding the payment amount or benefit calculation, please contact EMPLOYERS at 1-888-682-6671. Medical Providers: If you have questions regarding the payment amount, please contact CONDUENT at 1-863-669-0861, option 6. For all other payment inquiries, please contact EMPLOYERS at 1-888-682-6671.

Claim ID:	2008178290
Client Reference ID:	270274044
VP Trans ID:	626195697
	EIG0001003
Date:	08/14/2019
Amount:	$700.00
Check Number:	20700302

EIG.OT

EMPLOYERS provides workers compensation insurance through Employers Preferred Insurance Company, Employers Assurance Company, Employers Compensation Insurance Company and Employers Insurance Company of Nevada. EIG Services, Inc. (in California, dba EIG Insurance Services) is an affiliated agency and adjuster.
Form #: CL_VEN_0033_US Rev. 3/2017

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

EMPLOYERS
America's small business insurance specialist®

Employers Compensation Insurance Company
PO BOX 32036
Lakeland FL, 33802-2036

VPay
1-855-523-9634

METABANK
Sioux Falls, SD
72-7011/2739

20700302

08/14/2019

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

$700.00

SEVEN HUNDRED DOLLARS AND 00/100 DOLLARS

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

VOID AFTER 180 DAYS

MEMO

626195697

Employers Compensation Insurance Company 501

Process Date: 08/09/2019
Control Number: 305833250
EOR Page 1 of 2
Rev/Aud: SS/JS

Payment Number: 270274044 **Payment Date: 08/14/2019**

Claim Number: 2008178290
Claimant:
Provider Tax ID: [illegible]
Provider Ref: PARK
Provider License: CA99999

Vendor: 5628181#5628181
Geo Zip: 92781

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 03/01/2008
Claims Received Date: 08/08/2019

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

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
08/06/19	11	MDS10		LUM SUM/MUL BIL	1.000	1,685.00	985.00	0.00	0.00	700.00	197,G67, 6483,G67
				TOTALS:		1,685.00	985.00	0.00	0.00	700.00	
				TOTAL RECOMMENDED ALLOWANCE:						700.00	

Rendering Provider Name: JOYCE ALTMAN INTERPRETERS INC.
Rendering Provider NPI:

DWC CODE DESCRIPTION

G67 -PAYMENT BASED ON INDIVIDUAL PRE-NEGOTIATED AGREEMENT FOR THIS SPECIFIC SERVICE. ( )

CARRIER EXPLANATION REASON CODE

197 -RECOMMENDED ALLOWANCE BASED ON NEGOTIATED DISCOUNT/RATE.
6483 -FULL AND FINAL SETTLEMENT

2444-H-813641-0 4575840

626195697

Employers Compensation Insurance Company 501

Process Date: 08/09/2019
Control Number: 305833250
EOR Page 2 of 2
Rev/Aud: SS/JS

Payment Number: 270274044 **Payment Date: 08/14/2019**

Claim Number: 2008178290
Claimant:
Provider Tax ID: 330956713 Vendor: 5628181#5628181 PPO/OSR ID:
Provider Ref: PARK Geo Zip: 92781 NPI Number:
Provider License: CA99999 Claimant SSN:
Date Of Injury: 03/01/2008
Claims Received Date: 08/08/2019

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

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	ER/Red	PPO/Red	Other/Red	Allowance	Reasons

Carrier/Insurer: EMPLOYERS COMPENSATION INSURANCE COMPANY

Employer Name: WINSOON, INC. (SA 81060726077), Employer ID: SA 81060726077, Employer Address: 4569 FIRESTONE BLVD, SOUTH GATE, CA 90280

Payer Name: EMPLOYERS COMPENSATION INSURANCE COMPANY, Payer Address: 10375 PROFESSIONAL CIR RENO, NV 895214802, Payer ID Number: 030443592

Claimant Address:

Payment Information: Payment Status Code:

TIME LIMITS TO DISPUTE PAYMENT AMOUNT
REQUEST FOR SECOND REVIEW
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
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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.

Note to Provider regarding appeals process: Please send appeal requests to Conduent, along with this EOR, the medical bill and all supporting documentation.

Conduent
PO Box 32045
Lakeland, FL 33802
(866) 851-7739
billinginquiries@conduent.com

Conduent is neither the employer nor the insurance carrier, nor is it responsible for payment of the medical services contained in this explanation of benefits.

*** Workers Compensation ***

46575840

2444-H-813641-0

6261956697

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950 FAX: 714 832-1979
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
11/04/19 60271

EAMS#(s):

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
13-071878

BILL TO:
INTERCARE INS (ORANGE-5915)
W. C. DEPARTMENT
ATTN: LISA TRAN
P.O. BOX 5915
ORANGE, CA 92863

Case: vs ORANGE COUNTY TRANSP AUTHORITY
Date Of Injury: 9/9/13

DOS	SERVICE	DESCRIPTION	AMOUNT
11/05/13	PR2/REEVAL	DR ALI @ MEDICAL ARTS LANG: VIETNAMESE	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
10/29/13	EMG TESTING	BY DR ALI: U/E @ MEDICAL ARTS	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
12/14/13	PR2/REEVAL	DR ALI @ MEDICAL ARTS	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
01/31/14	PR2/REEVAL	DR ALI @ MEDICAL ARTS	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
03/14/14	PR2/REEVAL	DR ALI @ MEDICAL ARTS	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
04/25/14	PR2/REEVAL	DR ALI @ MEDICAL ARTS	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
05/29/14	WCAB SA	STATUS CONFERENCE	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
06/06/14	PR2/REEVAL	DR ALI @ MEDICAL ARTS	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
06/10/14	DEPO PREP	@ THE L/O OF NORMAN HOMEN	485.00
/ /	INTERPRETER:	TRANG LE # 301677	0.00
08/11/14	DEPO REVIEW	BEFORE SIGNING-DEPO TRANSCRIP L/O NORMAN HOMEN	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
08/12/14	WCAB SA	TRIAL - LAN TRINH # 100303	485.00
08/19/14	PR2/REEVAL	DR ALI @ MEDICAL ARTS	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
10/03/14	PR2/REEVAL	DR ALI (LANG: VIETNAMESE)	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
11/13/14	MED_EXOTIC	PR-2 W/DR ALI @ MEDICAL ARTS	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
12/13/14	MED_EXOTIC	PR-2 W/DR ALI @ MEDICAL ARTS	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00

Joyce Altman Interpreters, Inc.
P.O. BOX # 4165
Tustin, CA 92781-4165
PH: 714 838-0950 FAX: 714 832-1979
TAX ID# 33-0956713

*** INVOICE ***
Date NO#
11/04/19 60271

EAMS#(s):

SS # : XXX-XX-
DOB :
Terms: 60 days
Claim #(s):
13-071878

BILL TO:
INTERCARE INS (ORANGE-5915)
W. C. DEPARTMENT
ATTN: LISA TRAN
P.O. BOX 5915
ORANGE, CA 92863

Case: vs ORANGE COUNTY TRANSP AUTHORITY
Date Of Injury: 9/9/13

DOS	SERVICE	DESCRIPTION	AMOUNT
01/17/15	MED_EXOTIC	PR-2 W/DR ALI @ MEDICAL ARTS	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
02/24/15	MED_EXOTIC	PR-2 W/DR ALI @ MEDICAL ARTS	485.00
/ /	INTERPRETER:	LAN TRINH # 100303	0.00
08/09/16	LIEN FIL FEE	LIEN FILING FEE	150.00
11/10/17	PENALTIES	FOR DATE OF SERVICE 5/29/14	72.75
01/29/18	INTEREST	FOR DATE OF SERVICE 5/29/14	203.69
11/10/17	PENALTIES	FOR DATE OF SERVICE 6/10/14	72.75
01/29/18	INTEREST	FOR DATE OF SERVICE 6/10/14	198.19
11/10/17	PENALTIES	FOR DATE OF SERVICE 8/11/14	72.75
01/29/18	INTEREST	FOR DATE OF SERVICE 8/11/14	189.94
11/10/17	PENALTIES	FOR DATE OF SERVICE 8/12/14	72.75
01/29/18	INTEREST	FOR DATE OF SERVICE 8/12/14	189.79
10/08/20	COSTS	ADD'L COSTS AWARDED	1832.39
10/25/19	PMT BY CHECK	DOS 9/20/13-10/10/19* # 662679	-11300.00

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 **

P8528028002

HD

20191028020202

Intercare Holdings Insurance Services
P.O. Box 579
Roseville, CA 95661

Electronic Service Requested

16 OF 18

ENV 8

Joyce Altman Interpeters
PO BOX 4165
TUSTIN, CA 92781-4165

Payee:	Joyce Altman Interpeters
Company Name:	Orange County Transportation Authori
Facility:	Orange County Transportation A
Policy ID:	OCTA - 14
IRS/SSN:	
Administrator:	DGARCIA
Claim Number:	13-071878
Check #:	662679
Check Total:	11,300.00
Check Date:	10/25/2019

Explanation of Benefits

Incident Date	Claim Number Invoice Number	Account Number From/Through Date	Claimant Name Document Number	Description Amount
9/9/2013	13-071878 lien full & Final	09/20/13-10/10/19		Interpreter Fees - Medical Rel 11,300.00

Totals: **11,300.00**

RECD
NOV 04 2019
BY: .....

[redacted]