Clinic Name: **Your Clinic Name**

Clinic Code: **(Provided to you during training or located on your WebPT Billing access form)**

Clinic Contact: **Your name**

Deposit Date	Insurance Name	Check Date	Check #	Total Payment
6/4/2012	Universal Smart Co	5/25/2012	1234	$300.00
6/4/2012	State Compensation Insurance	5/31/2012	23823639	$212.80
6/4/2012	State Compensation Insurance	6/1/2012	12345678	$159.37
6/4/2012	State Compensation Insurance	5/31/2012	8765432	$125.38
6/4/2012	State of California	5/31/2012	54321	$37.67
6/4/2012	State of California	5/31/2012	2345678	$23.98
6/4/2012	United World Life Ins	5/25/2012	3456789	$11.29
6/4/2012	Napa Vally United School District	5/30/2012	987654321	$74.50

EFTs

Deposit Date:	**Insurance Name**	**Check #**	**Total Payment**
			$0.00

[redacted]

VENDOR NO: CALI0035 NAME: [redacted] CHECK DATE: 5/25/2012

REFERENCE	INVOICE DATE	GROSS AMOUNT	DISCOUNT TAKEN	NET AMOUNT PAID
AP5984919	5/16/2012	75.00	0.00	75.00
AP5985261	5/16/2012	75.00	0.00	75.00
AP5985264	5/16/2012	75.00	0.00	75.00
AP5988032	5/16/2012	75.00	0.00	75.00

If you would prefer to receive your payment via Direct Deposit please send email request to EFTInfo@universalsmartcomp.com

TOTAL >	300.00	0.00	300.00

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND A WATERMARK - HOLD UP TO THE LIGHT TO VERIFY

[redacted]

Universal SmartComp
480 Johnson Road
Suite 200
Washington, PA 15301

Citizens Bank
3907 Washington Road 15B-0068
McMurray, PA 15317
3-7619/360

DATE 5/25/2012
AMOUNT **300.00

PAY Three Hundred and 00/100*****

TO THE ORDER OF [redacted]
USA

CHECK IS PRINTED ON SECURITY PAPER WHICH INCLUDES A MICROPRINT BORDER & FLUORESCENT FIBERS

[redacted]

Universal SmartComp

Explanation of Payment Analysis

Report #: [redacted]
Preparation Date: 05/16/2012
EOS #: [redacted]
Date of Injury: 09/19/2008

P.O. Box 800
Meadowlands, PA 15347
Telephone 724-206-1500
Facsimile 724-206-1555

Provider: [redacted]
Provider ID: CALI0035
Provider Tax ID: [redacted]
Insurer: Gallagher Bassett
PO Box 23812
Tucson AZ 85734
Insurer ID: [redacted]

Employer:

Patient: [redacted]

Claim: [redacted]
Service ZIP: 94558
ICD9 Code: 724.5 Backache

Date of Service	Procedure Code	Units	Provider Charge	FS/UC/BR/ Reductions	SmartComp Reductions	Allow Amount	Reason Code
03/27/12	97018	1	$ 25.00	$ 20.39	$ 1.50	$ 3.11	USC,G1
	APPLIC MODAL 1/> AREAS; PARAFN BATH						
03/27/12	97014	1	$ 35.00	$ 25.77	$ 2.99	$ 6.24	USC,G1
	APPLIC MODAL 1/> AREAS; ELEC STIM						
03/27/12	97620	1	$ 63.96	$ 0.00	$ 20.75	$ 43.21	USC
	INDIVIDUALIZED PROCED REQ CUMPUTER EQUIP 30 MIN+						
03/27/12	97250	1	$ 60.00	$ 26.79	$ 10.77	$ 22.44	USC,G1
	MYOFASC RELEAS/SOFT TISS MOBILIZ						
	Analysis Totals:		$ 183.96	$ 72.95	$ 36.01	75.00	

Explanation of Reason Codes
USC: Payment according to Universal SmartComp contractual agreement
G1: The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.

When calculating payments to match your contracted rate with SmartComp, your contracted rate is distributed across all lines. Please call Customer Service at 724-206-1500 for any questions you might have regarding this analysis.

To sign up for SmartLink and have 24 hour real time access to Claim Search, Payment Status, Payment Information and SmartComp information please visit our website at www.universalsmartcomp.com and click on SmartLink.
To expedite payments to your facility sign up for EFT Payments by e-mailing EFTinfo@universalsmartcomp.com

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JUN 04 2012

Universal SmartComp

Explanation of Payment Analysis

Report #: [redacted]
Preparation Date: 05/16/2012
EOS #: [redacted]
Date of Injury: 09/19/2008

P.O. Box 800
Meadowlands, PA 15347
Telephone 724-206-1500
Facsimile 724-206-1555

Provider: [redacted]
Provider ID: CALI0035
Provider Tax ID: [redacted]
Insurer: Gallagher Bassett
PO Box 23812
Tucson AZ 85734
Insurer ID: [redacted]

Employer:
Patient: [redacted]
Claim: [redacted]
Service ZIP: 94558
ICD9 Code: 724.5 Backache

Date of Service	Procedure Code	Units	Provider Charge	FS/UC/BR/ Reductions	SmartComp Reductions	Allow Amount	Reason Code
03/23/12	97620	1	$ 63.96	$ 0.00	$ 18.88	$ 45.08	USC
	INDIVIDUALIZED PROCED REQ CUMPUTER EQUIP 30 MIN+						
03/23/12	97014	1	$ 35.00	$ 25.77	$ 2.72	$ 6.51	USC,G1
	APPLIC MODAL 1/> AREAS; ELEC STIM						
03/23/12	97250	1	$ 60.00	$ 26.79	$ 9.80	$ 23.41	USC,G1
	MYOFASC RELEAS/SOFT TISS MOBILIZ						
	Analysis Totals:		$ 158.96	$ 52.56	$ 31.40	75.00	

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Universal SmartComp

Explanation of Payment Analysis

Report #: [redacted]
Preparation Date: 05/16/2012
EOS #: [redacted]
Date of Injury: 09/19/2008

P.O. Box 800
Meadowlands, PA 15347
Telephone 724-206-1500
Facsimile 724-206-1555

Provider: [redacted]

Provider ID: CALI0035
Provider Tax ID: [redacted]
Insurer: Gallagher Bassett
PO Box 23812
Tucson AZ 85734
Insurer ID: [redacted]

Employer:

Patient: [redacted]

Claim: 003519000031WC01
Service ZIP: 94558
ICD9 Code: 724.5 Backache

Date of Service	Procedure Code	Units	Provider Charge	FS/UC/BR/ Reductions	SmartComp Reductions	Allow Amount	Reason Code
03/29/12	97014	1	$ 35.00	$ 25.77	$ 2.72	$ 6.51	USC,G1
	APPLIC MODAL 1/> AREAS; ELEC STIM						
03/29/12	97250	1	$ 60.00	$ 26.79	$ 9.80	$ 23.41	USC,G1
	MYOFASC RELEAS/SOFT TISS MOBILIZ						
03/29/12	97620	1	$ 63.96	$ 0.00	$ 18.88	$ 45.08	USC
	INDIVIDUALIZED PROCED REQ CUMPUTER EQUIP 30 MIN+						
	Analysis Totals:		$ 158.96	$ 52.56	$ 31.40	75.00	

Explanation of Reason Codes
USC: Payment according to Universal SmartComp contractual agreement
G1: The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.

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Universal SmartComp

Explanation of Payment Analysis

Report #: [redacted]
Preparation Date: 05/16/2012
EOS #: [redacted]
Date of Injury: 11/20/2010

P.O. Box 800
Meadowlands, PA 15347
Telephone 724-206-1500
Facsimile 724-206-1555

Provider: [redacted]

Provider ID: CALI0035
Provider Tax ID: [redacted]
Insurer: Gallagher Bassett
PO Box 23812
Tucson AZ 85734
Insurer ID: [redacted]

Employer:

Patient: [redacted]

Claim: 000541008871WC01
Service ZIP: 94558
ICD9 Code: 732.3 Juvenile osteochondrosis of uppe

Date of Service	Procedure Code	Units	Provider Charge	FS/UC/BR/ Reductions	SmartComp Reductions	Allow Amount	Reason Code
03/16/12	97014	1	$ 35.00	$ 35.00	$ 0.00	$ 0.00	G1
	APPLIC MODAL 1/> AREAS; ELEC STIM						
03/16/12	97250	1	$ 60.00	$ 26.79	$ 7.58	$ 25.63	USC,G1
	MYOFASC RELEAS/SOFT TISS MOBILIZ						
03/16/12	97620	1	$ 63.96	$ 0.00	$ 14.59	$ 49.37	USC
	INDIVIDUALIZED PROCED REQ CUMPUTER EQUIP 30 MIN+						
	Analysis Totals:		$ 158.96	$ 61.79	$ 22.17	75.00	

Explanation of Reason Codes
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Explanation of Review (EOR)

State Compensation Insurance Fund
P.O. Box 65500
Fresno, CA 93650-5500
Questions & Appeals: 559-687-3900

Provider Number: [redacted]

[redacted]

Check #: [redacted]

Issue Date: 05/31/12
Doc #: [redacted]

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
	Patient Name: [redacted]				**Claim #:** [redacted]		**Date of Injury:** 01/06/11		
SSN: XXX-XX-9977	Employer name: [redacted]				Employer ID: [redacted]				
	ICD-9 Code:816.01 FX MID/PRX PHAL, HAND-CL								
1	SF1-SFCA-9984285	05/02/12	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
2	SF1-SFCA-9984285	05/02/12	97250	Myofascial Release	1	60.00	26.79	326 PM8	33.21
3	SF1-SFCA-9984285	05/02/12	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
4	SF1-SFCA-9993490	05/07/12	97250	Myofascial Release	1	60.00	26.79	326 397 465 G1 G5 PM8	33.21
5	SF1-SFCA-9993490	05/07/12	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
6	SF1-SFCA-9993490	05/07/12	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
							Total Allowances:		**$212.80**

JUN 04 2012

[redacted]

To read and download the new paper medical billing regulations go to:
http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling_Regulations.htm

ERMARK

[redacted]

Provider Number: [redacted]

[redacted]

Issue Date: 05/31/12
Doc #: 024823639

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
			Patient Name: [redacted]		**Claim #:** [redacted]		**Date of Injury:** 01/06/11		
SSN: XXX-XX-9977		Employer name: [redacted]			Employer ID: [redacted]				
		ICD-9 Code:816.01	FX MID/PRX PHAL, HAND-CL						
1	SF1-SFCA-9984285	05/02/12	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
2	SF1-SFCA-9984285	05/02/12	97250	Myofascial Release	1	60.00	26.79	326 PM8	33.21
3	SF1-SFCA-9984285	05/02/12	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
4	SF1-SFCA-9993490	05/07/12	97250	Myofascial Release	1	60.00	26.79	326 397 465 G1 G5 PM8	33.21
5	SF1-SFCA-9993490	05/07/12	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
6	SF1-SFCA-9993490	05/07/12	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
							Total Allowances:		**$212.80**

01382308024823639012

JUN 04 2012

[redacted]

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http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling_Regulations.htm

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State Compensation Insurance Fund

San Francisco District Office
P.O Box 65005
Pinedale CA 93650-5005

[redacted]

Union Bank
Los Angeles, California

91-158
1227

Medical
NO

Payee I.R.S Number [redacted]

VOID After 365 Days

Check Date	Check Amount
May 31, 2012	$******212.80

PAY ****Two Hundred Twelve and 80/100 Dollars****ONLY

To The Order Of [redacted]

[redacted]

Explanation of Review (EOR)

State Compensation Insurance Fund
PO Box 65000
Fresno, CA 93650-5000
Questions & Appeals: (559) 696-7500

Provider Number: [redacted]

[redacted]

Check #: [redacted]

Issue Date: 05/31/12
Doc #: [redacted]

Summary

Bill ID.	Claim Number	Invoice / Account Number	Billed Amounts	Reductions	Allowances	Penalty & Interest	Totals
[redacted]	[redacted]	[redacted]	158.96	52.56	106.40	.00	106.40
Provider NPI: [redacted]	Rendering Provider NPI: [redacted]		Rendering Provider: [redacted]				
Patient Acct #: [redacted]	ReviewerID: 4B	Carrier Receive Date: 05/17/12	Review Date: 05/30/12	Payment Code: 1	UB04:		
[redacted]285	[redacted]	[redacted]	158.96	52.56	106.40	.00	106.40
Provider NPI: [redacted]	Rendering Provider NPI: [redacted]		Rendering Provider: [redacted]				
Patient Acct #: [redacted]	ReviewerID: P2	Carrier Receive Date: 05/15/12	Review Date: 05/30/12	Payment Code: 1	UB04:		

The preceding invoice totals reflect the amount of reviewed and/or approved billing items from the associated invoices that are included in this payment and are generated to assist your organization to balance your paperwork.

Charges that are either denied payment or found in excess of the allowance are objected to for the above reasons. If you disagree with the reductions, you may contact us at the address and phone number listed, or you may file an application or lien with the Workers' Compensation Appeals Board. Liens are subject to the statute of limitations spelled out in Labor Code Section 4903.5. California Labor Code Section 3751(b) prohibits attempts to collect any balance due from the injured worker.

EOR Reduction Code Explanation:

325 : ALLOWANCE IS MADE AT 50% OF THE OMFS OR THE BILLED CHARGE, WHICHEVER IS LOWER, AS PER THE MULTIPLE PHYSICAL MEDICINE PROCEDURES RULE.

326 : ALLOWANCE IS MADE AT 75% OF THE OMFS OR THE BILLED CHARGE, WHICHEVER IS LOWER, AS PER THE MULTIPLE PHYSICAL MEDICINE PROCEDURES RULE.

397 : ALLOWANCE IS BASED ON UTILIZATION REVIEW PRE-AUTHORIZATION.

465 : Reimbursement allowed for services exceeding treatment limitations scheduled allowance.

G5 : This charge was adjusted for the reasons set forth in the attached letter.

PM8 : Physical Medicine rule 1 (e) regarding multiple services (cascade) was applied to this service.

0138230802482363901 2

Explanation of Review (EOR)

[redacted]

Provider Number: [redacted]

Check #: [redacted]

[redacted]

Issue Date: 06/01/12
Doc #: [redacted]

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
		Patient Name: [redacted]				**Claim #:** [redacted]	**Date of Injury:** 06/29/11		
SSN: XXX-XX-4982	Employer name: [redacted]					Employer ID: STAT[redacted]			
		ICD-9 Code:726.32 LATERAL EPICONDYLITIS							
		ICD-9 Code:726.31 MEDIAL EPICONDYLITIS							
1	SF1-SFSC-4699614	04/20/12	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
2	SF1-SFSC-4699614	04/20/12	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
3	SF1-SFSC-4699614	04/20/12	97250	Myofascial Release	1	60.00	26.79	326 PM8	33.21
								Subtotal:	**106.40**
		Patient Name: [redacted]				**Claim #:** [redacted]	**Date of Injury:** 05/08/11		
SSN: XXX-XX-1638	Employer name: [redacted]					Employer ID: [redacted]			
		ICD-9 Code:959.4 HAND INJURY NOS							
		ICD-9 Code:719.44 JOINT PAIN-HAND							
4	SF1-SFSC-4755246	05/13/11	098774	Training Checkout Reviewed As 97700	1	115.00	70.10	790 G1	44.90
5	SF1-SFSC-4755246	05/13/11	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
6	SF1-SFSC-4755246	05/13/11	97612	Pm Tx 1 Area Ind.Ins	1	55.00	30.09	326 PM8	24.91
				Sub-Totals:		233.96	100.19		133.77
				Adjustment:		-233.96	-145.09		-88.87
				Adj-Totals:		.00	-44.90		44.90
7	SF1-SFSC-4755246			Medical Penalty					6.74
8	SF1-SFSC-4755246			Medical Interest					1.33
								Subtotal:	52.97
							Total Allowances:		**$159.37**

[redacted]

To read and download the new paper medical billing regulations go to:
http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling_Regulations.htm

Explanation of Benefits (EOB)

[redacted]

Provider Number: [redacted]

Check #: [redacted]

[redacted]

Issue Date: 06/01/12
Doc #: [redacted]

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
			Patient Name: [redacted]		**Claim #:** [redacted]		**Date of Injury:**	06/29/11	
SSN: XXX-XX-4982	Employer name: [redacted]				Employer ID: [redacted]				
	ICD-9 Code:726.32 LATERAL EPICONDYLITIS								
	ICD-9 Code:726.31 MEDIAL EPICONDYLITIS								
1	SF1-SFSC-4699614	04/20/12	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
2	SF1-SFSC-4699614	04/20/12	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
3	SF1-SFSC-4699614	04/20/12	97250	Myofascial Release	1	60.00	26.79	326 PM8	33.21
								Subtotal:	**106.40**
			Patient Name: [redacted]		**Claim #:** [redacted]		**Date of Injury:**	05/08/11	
SSN: XXX-XX-1638	Employer name: [redacted]				Employer ID: [redacted]				
	ICD-9 Code:959.4 HAND INJURY NOS								
	ICD-9 Code:719.44 JOINT PAIN-HAND								
4	SF1-SFSC-4755246	05/13/11	098774	Training Checkout	1	115.00	70.10	790 G1	44.90
-				Reviewed As 97700					
5	SF1-SFSC-4755246	05/13/11	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
6	SF1-SFSC-4755246	05/13/11	97612	Pm Tx 1 Area Ind.Ins	1	55.00	30.09	326 PM8	24.91
				Sub-Totals:		233.96	100.19		133.77
				Adjustment:		-233.96	-145.09		-88.87
				Adj-Totals:		.00	-44.90		44.90
7	SF1-SFSC-4755246			Medical Penalty					6.74
8	SF1-SFSC-4755246			Medical Interest					1.33
								Subtotal:	**52.97**
								Total Allowances:	**$159.37**

[redacted]

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State Compensation Insurance Fund

Rohnert Park State Contracts
P.O. Box 3171
Suisun City, CA 94585

[redacted]

Union Bank
Los Angeles, California

Medical
TX

Payee IRS Number: [redacted]

VOID After 365 Days	
Check Date	Check Amount
June 01, 2012	$*******159.37

PAY ****One Hundred Fifty-Nine and 37/100 Dollars****ONLY

To The Order Of [redacted]

[redacted]

State Compensation Insurance Fund
[redacted]
Suisun City, CA 94585
Questions & Appeals: (800) 672-7030

Provider Number: [redacted]

[redacted]

Check #: [redacted]

Issue Date: 06/01/12
Doc #: [redacted]

Summary

Bill ID.	Claim Number	Invoice / Account Number	Billed Amounts	Reductions	Allowances	Penalty & Interest	Totals
[redacted]	[redacted]	[redacted]	233.96	100.19	133.77	8.07	141.84
Provider NPI: [redacted] Rendering Provider NPI: [redacted] Rendering Provider: [redacted]							
Patient Acct #[redacted] ReviewerID: XL Carrier Receive Date: 02/28/12 Review Date: 05/31/12 Payment Code: 1 UB04:							
SF1-SFSC-4699614	05714090	C21930437	158.96	52.56	106.40	.00	106.40
Provider NPI: [redacted] Rendering Provider NPI: [redacted] Rendering Provider: [redacted]							
Patient Acct #[redacted] ReviewerID: RX Carrier Receive Date: 05/03/12 Review Date: 05/31/12 Payment Code: 1 UB04:							
			Adjustment:				-88.87
			Totals:				44.90

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EOR Reduction Code Explanation:

325 : ALLOWANCE IS MADE AT 50% OF THE OMFS OR THE BILLED CHARGE, WHICHEVER IS LOWER, AS PER THE MULTIPLE PHYSICAL MEDICINE PROCEDURES RULE.

326 : ALLOWANCE IS MADE AT 75% OF THE OMFS OR THE BILLED CHARGE, WHICHEVER IS LOWER, AS PER THE MULTIPLE PHYSICAL MEDICINE PROCEDURES RULE.

790 : THIS BILL WAS REVIEWED USING THE OFFICIAL MEDICAL FEE SCHEDULE OF CA. scheduled allowance.

PM8 : Physical Medicine rule 1 (e) regarding multiple services (cascade) was applied to this service.

01382352024828470012

[redacted] Explanation of Review (EOR)

[redacted]

Provider Number: [redacted]

Check #: [redacted]

[redacted]

Issue Date: 05/31/12

Doc #: [redacted]

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
Patient Name: [redacted]					**Claim #:** [redacted]		**Date of Injury:** 05/14/07		
SSN: XXX-XX-9585	Employer name: [redacted]					Employer ID: [redacted]			
ICD-9 Code:727.03 TRIGGER FINGER									
1	SF1-SFSC-4754318	12/05/11	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
2	SF1-SFSC-4754318	12/05/11	97250	Myofascial Release	1	60.00	26.79	326 PM8	33.21
3	SF1-SFSC-4754318	12/05/11	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
4	SF1-SFSC-4754318			Medical Penalty					15.96
5	SF1-SFSC-4754318			Medical Interest					3.02

Total Allowances: **$125.38**

JUN 04 2012

[redacted]

To read and download the new paper medical billing regulations go to:
http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling_Regulations.htm

[redacted]

Provider Number: [redacted]

Check #: [redacted]

[redacted]

Issue Date: 05/31/12
Doc #: [redacted]

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
				Patient Name: [redacted]		**Claim #:** [redacted]	**Date of Injury:**	05/14/07	
SSN: XXX-XX-9585		**Employer name:** [redacted] RTW COORDIN				**Employer ID:** ST[redacted]			
		ICD-9 Code:727.03 TRIGGER FINGER							
1	SF1-SFSC-4754318	12/05/11	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
2	SF1-SFSC-4754318	12/05/11	97250	Myofascial Release	1	60.00	26.79	326 PM8	33.21
3	SF1-SFSC-4754318	12/05/11	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
4	SF1-SFSC-4754318			Medical Penalty					15.96
5	SF1-SFSC-4754318			Medical Interest					3.02

Total Allowances: **$125.38**

0138229802482127301 2

JUN 04 2012

[redacted]

To read and download the new paper medical billing regulations go to:
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THIS IS WATERMARKED PAPER — HOLD TO LIGHT TO VERIFY WATERMARK

State Compensation Insurance Fund

Medical
Rohnert Park State Contracts
P.O. Box 3171
Suisun City, CA 94585

[redacted]

Union Bank
Los Angeles, California

99-4150
1222

Payee's IRS Number: 680314282

VOID After 365 Days

Check Date	Check Amount
May 31, 2012	$*******125.38

PAY: ***One Hundred Twenty-Five and 38/100 Dollars****ONLY

To The Order Of [redacted]

[redacted]

State Compensation Insurance Fund
P.O. Box [redacted]
Stockton, CA 95[redacted]
Questions & Appeals: (800) 697-7300

Provider Number: [redacted]

[redacted]

Check #: [redacted]

Issue Date: 05/31/12
Doc #: [redacted]

Summary

Bill ID.	Claim Number	Invoice / Account Number	Billed Amounts	Reductions	Allowances	Penalty & Interest	Totals
[redacted]	[redacted]	[redacted]	158.96	52.56	106.40	18.98	125.38

Provider NPI: 1[redacted] Rendering Provider NPI: [redacted] Rendering Provider: [redacted]
Patient Acct #: [redacted] ReviewerID: RU Carrier Receive Date: 03/02/12 Review Date: 05/30/12 Payment Code: 1 UB04:

The preceding invoice totals reflect the amount of reviewed and/or approved billing items from the associated invoices that are included in this payment and are generated to assist your organization to balance your paperwork.

Charges that are either denied payment or found in excess of the allowance are objected to for the above reasons. If you disagree with the reductions, you may contact us at the address and phone number listed, or you may file an application or lien with the Workers' Compensation Appeals Board. Liens are subject to the statute of limitations spelled out in Labor Code Section 4903.5. California Labor Code Section 3751(b) prohibits attempts to collect any balance due from the injured worker.

EOR Reduction Code Explanation:

325 : ALLOWANCE IS MADE AT 50% OF THE OMFS OR THE BILLED CHARGE, WHICHEVER IS LOWER, AS PER THE MULTIPLE PHYSICAL MEDICINE PROCEDURES RULE.

326 : ALLOWANCE IS MADE AT 75% OF THE OMFS OR THE BILLED CHARGE, WHICHEVER IS LOWER, AS PER THE MULTIPLE PHYSICAL MEDICINE PROCEDURES RULE.

PM8 : Physical Medicine rule 1 (e) regarding multiple services (cascade) was applied to this service.

01382980248212730 12

STATE OF CALIFORNIA

WARRANT NUMBER [redacted]

90-1342
1211 Cross

THE TREASURER OF THE STATE WILL PAY OUT OF THE

FUND NO.	FUND NAME	
822	PERSCARE	SUPPLEMENTAL 2012143GG6671999107A6775020

PAYEE I.D. NO. [redacted]

TO 925035
[redacted]

05 | 31 | 2012

DOLLARS	CENTS
$*******37	67

JOHN CHIANG
CALIFORNIA STATE CONTROLLER

[redacted]

DETACH AT PERFORATION

[redacted]

PERSCare SUPPLEMENTAL

Anthem. Blue Cross
P.O. Box 60007 Los Angeles, CA 90060-0007

PHYSICIAN MEMBER: Yes
Provider Number: [redacted]
Sequence Number: [redacted]

PATIENT NAME / PROCEDURE NUMBER	ID NUMBER / UNITS OF SERVICE	PATIENT ACCT. / DATE OF SERVICE FROM	CLAIM NUMBER / DATE OF SERVICE TO	BILLED AMOUNT	AMOUNT ALLOWED	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COPAYMENT AMOUNT	AMOUNT PAID
eceipt Date: 05/22/2012		Group Number: [redacted]			PARTICIPATING PROVIDER				
97140	04	05/03/2012	05/03/2012	180.00	116.52	63.48/01 93.22/02	0.00	0.00	23.30
90283	01	05/03/2012	05/03/2012	35.00	13.39	21.61/01 10.71/02	0.00	0.00	2.68
97004	01	05/03/2012	05/03/2012	65.00	58.46	6.54/01 46.77/02	0.00	0.00	11.69
Totals:				280.00	188.37	242.33	0.00	0.00	37.67

Messages:
01 This provider has accepted Medicare's allowed amount as the total amount due. The member, therefore, is not responsible for the balance.
02 This is the amount paid by Medicare.

For Information Call: Customer Service Department at: 1-877-737-7776

em Blue Cross Life and Health Insurance Company provides administrative services only and does not assume any financial risk or obligation with respect to claims. Blue Cross of California, using the trade e Anthem Blue Cross, administers claims on behalf of Anthem Blue Cross Life and Health Insurance Company and is not liable for benefits payable. Independent licensees of the Blue Cross Association.

STATE OF CALIFORNIA

WARRANT NUMBER [redacted]

90-1342
1211

THE TREASURER OF THE STATE WILL PAY OUT OF THE

FUND NO.	FUND NAME	PAYEE I.D. NO.
822	PERSCARE SUPPLEMENTAL 2012144GD3989999701A5827940	[redacted]

Cross

TO 925036
[redacted]

05 | 31 | 2012

DOLLARS	CENTS
$******23.	98

JOHN CHIANG
CALIFORNIA STATE CONTROLLER

[redacted]

DETACH AT PERFORATION

[redacted]

PERSCare SUPPLEMENTAL

Anthem Blue Cross
P.O. Box 60007 Los Angeles, CA 90060-0007

PHYSICIAN MEMBER: Yes
Provider Number: [redacted]
Sequence Number: [redacted]

PATIENT NAME PROCEDURE NUMBER	ID NUMBER UNITS OF SERVICE	PATIENT ACCT. DATE OF SERVICE FROM	CLAIM NUMBER DATE OF SERVICE TO	BILLED AMOUNT	AMOUNT ALLOWED	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COPAYMENT AMOUNT	AMOUNT PAID
Receipt Date: 05/23/2012		Group Number: [redacted]							
[redacted]		[redacted]				NETWORK: PARTICIPATING PROVIDER			
97140	04	05/07/2012	05/07/2012	180.00	119.92	60.08/01 95.94/02	0.00	0.00	23.98
Totals:				180.00	119.92	156.02	0.00	0.00	23.98

Messages:
01 This provider has accepted Medicare's allowed amount as the total amount due. The member, therefore, is not responsible for the balance.
02 This is the amount paid by Medicare.

For Information Call: Customer Service Department at: 1-877-737-7776

JUN 04 2012

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[redacted]

Explanation of Payment Report
United World Life Insurance

REPORT GW2232 PAGE 1
PERIOD ENDING DATE 05/25/12
DRAFT/CHECK NUMBER: [redacted]

IF YOU HAVE ANY QUESTIONS, CALL:
(877) 617-5587

DIRECT INQUIRIES TO:
UNITED WORLD LIFE
INSURANCE COMPANY
3316 FARNAM ST
OMAHA, NE 68175-0001

CLAIMS PROCESSED UNDER TIN/EIN: [redacted]

Insured's Name / Patient / Policy/Plan Number / Cert Number / Claim Number / Account Number	Date of Service From	Date of Service To	Procedure	Submitted Charges	Less Charges Not Covered Amount	Note	Balance	Less Deductible	Considered Charges	Benefit %	Benefit Amount	Remaining Balance Due
[redacted]/S ELF												
[redacted]	031011	031011	97140	180.00								
	031011	031011	G0283	30.00								
					104.06	1			26.02	100	26.02	
					79.92	2						
[redacted]												
			TOTAL	210.00								26.02
			PAYMENT HAS BEEN ADJUSTED DUE TO PRIOR PAYMENT								-	14.73

TAL PAID: 11.29

TES:
U MAY APPEAL OUR DECISION TO THE CALIFORNIA DEPARTMENT OF INSURANCE, 300 SO SPRING ST - SOUTH TOWER, LOS ANGELE 90013; PHONE (213) 897-8921, (800) 927-4357 OR TDD (800) 482-4833, HOTLINE HOURS 8:00 AM - 6:00 PM MON - FRI; BSITE HTTP://WWW.INSURANCE.CA.GOV/0100-CONSUMERS
THIS IS THE AMOUNT PAID BY MEDICARE.
AMOUNTS IN EXCESS OF THE MEDICARE APPROVED CHARGE ARE NOT COVERED.

JUN 01 2012

[redacted]

Explanation of Payment Report
United World Life Insurance

REPORT GW2232 PAGE 1
PERIOD ENDING DATE 05/25/12
DRAFT/CHECK NUMBER: [redacted]

IF YOU HAVE ANY QUESTIONS, CALL:
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DIRECT INQUIRIES TO:
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INSURANCE COMPANY
3316 FARNAM ST
OMAHA, NE 68175-0001

CLAIMS PROCESSED UNDER TIN/EIN: [redacted]

Insured's Name / Patient / Policy/Plan Number / Cert Number / Claim Number / Account Number	Date of Service From	Date of Service To	Procedure	Submitted Charges	Less Charges Not Covered Amount	Note	Balance	Less Deductible	Considered Charges	Benefit %	Benefit Amount	Remaining Balance Due
[redacted]												
ELF												
[redacted]	031011	031011	97140	180.00								
	031011	031011	G0283	30.00								
					104.06	1			26.02	100	26.02	
					79.92	2						
[redacted]												
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:BSITE HTTP://WWW.INSURANCE.CA.GOV/0100-CONSUMERS
THIS IS THE AMOUNT PAID BY MEDICARE.
: AMOUNTS IN EXCESS OF THE MEDICARE APPROVED CHARGE ARE NOT COVERED.

JUN 01 2012

HE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER. THE BACK OF THIS DOCUMENT CONTAINS AN ARTIFICIAL WATERMARK - HOLD AT AN ANGLE TO VIE

UNITED WORLD LIFE INSURANCE COMPANY
A MUTUAL of OMAHA COMPANY
3316 Farnam St., Omaha, NE 68175

PAYABLE THRU FIRST NATIONAL BANK OF OMAHA
OMAHA, NE 68102
FREMONT NATIONAL BANK & TRUST CO.

00136753 1129 60663 031011

DATE: MAY 25 2012
DRAFT NO.: [redacted]
CLAIM NO.: [redacted]
AMOUNT: **********11.29

PAY TO THE ORDER OF
GYBS-P12052601200700019 1

PLEASE CASH IMMEDIATELY

58

[redacted]

ACCT #[redacted]

POLICY/PLAN NUMBER [redacted]
*

AUTHORIZED SIGNATURE Stephen A. Amdor

[redacted]

JUN 01 2012

[redacted]
c/o York Risk Services Group, Inc.
313 E. Foothill Blvd.
Upland, CA 91786

Payee: [redacted]NC.

IRS/SSN#: [redacted]
Invoice#: [redacted]

DOS From: 05/03/2012
DOS Thru: 05/03/2012
Description: PHYSICAL THERAPY

PPO Name: Rockport/IHP

Reviewed Date: 05/22/2012
Claim#: [redacted]
Date of Injury/Loss: 04/12/2011
Claimant: [redacted]

Check#: [redacted]
Check Date: 05/30/2012
Check Total: $74.50

Diagnosis Codes:
72705 TENOSYNOV HAND/WRIST NEC

Document#: [redacted]
Batch#:

#	Billed Code	Reviewed Code	Units	Begin DOS	End DOS	Service Description	Amount Billed	BR Reduction	PPO Reduction	Other Reductions	Net Allowed	Reason Code
1	97014	97014	1	05/03/12	05/03/12	ELECTRIC STIMULATION	$35.00	$25.77	$0.46	$0.00	$8.77	G1
2	97250	97250	1	05/03/12	05/03/12	MYOFASCIAL RELEASE	$60.00	$15.72	$2.21	$0.00	$42.07	
3	97620	97110	1	05/03/12	05/03/12	THERAPEUTIC EXERCISE	$63.96	$39.05	$1.25	$0.00	$23.66	G1,G2
						TOTAL:	$158.96	$80.54	$3.92	$0.00	$74.50	

Reason Codes:

G1 The charge exceeds the Official Medical Fee Schedule allowance and has been adjusted to the schedule
G2 The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service.

Charges in excess of the allowance are objected to in accordance with applicable Workers' Compensation fee schedules, California Labor Code and associated regulations. Reasons for each reduction are stated above. If you disagree with any reduction you may contact us at the address and phone number listed, or you may file an appeal or lien with Workers' Compensation Appeals Board. California Labor Code Sections 3751(b) and 4600 prohibit attempts to collect any funds from the ill/injured worker.

WellComp Managed Care Services * 800/932-5535 * PO Box 619079, Roseville, CA * 95661

JUN 01 2012

[redacted]
c/o York Risk Services Group, Inc.
313 E. Foothill Blvd.
Upland,CA 91786

Payee: [redacted]

IRS/SSN#: [redacted]
Invoice#: [redacted]

DOS From: 05/03/2012
DOS Thru: 05/03/2012
Description: PHYSICAL THERAPY

PPO Name: Rockport/IHP

Reviewed Date: 05/22/2012
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						TOTAL:	$158.96	$80.54	$3.92	$0.00	$74.50	

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WellComp Managed Care Services * 800/932-5535 * PO Box 619079, Roseville, CA * 95661

ING: AN ARTIFICIAL WATERMARK IN A CRISSCROSS PATTERN IS PRESENT ON THE REVERSE SIDE. HOLD AT AN ANGLE TO VIEW. • PAPER WILL TURN BROWN IF CHEMICALLY ALTERED • FLUORESCENT FIBERS ARE ALSO EMBEDDED INTO THIS DOCUMEN

Napa Valley Unified School District
c/o York Risk Services Group, Inc.
313 E. Foothill Blvd.
Upland, CA 91786

Umpqua Bank
1801 Douglas Blvd.
Roseville, CA 95661
[redacted]

REF. NUMBER	
[redacted]	
DATE	CHECK NO
5/30/2012	[redacted]
AMOUNT	
***$74.50	

PAY SEVENTY-FOUR AND 50/100

TO THE ORDER OF [redacted]

David Parrio

Not negotiable after 90 days

[redacted]