Las Vegas Pain Institute & Med Cntr, LLC

Patient Ledger

November 10, 2009

WILLIAM POREMBA
168 RED ARCHES COURT
HENDERSON, NV 89012

Account Number: LVPC[illegible]
Work Phone:
Home Phone: (702)[illegible]

Date	Patient	Bill No.	Description	Amount
04/17/2009	WILLIAM	4233301	99204 - OFFICE/OP VISIT, NEW PT, 3 KEY COMPOI	$450.00
10/30/2009	WILLIAM	4233301	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($62.24)
10/30/2009	WILLIAM	4233301	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($367.76)
04/17/2009	WILLIAM	4233301	COCREDIT - CREDIT CARD COPAY	($20.00)
			Total for Bill No. 4233301	$0.00
04/17/2009	WILLIAM	4233545	96365 - IV INFUSION THERAPY	$270.00
05/26/2009	WILLIAM	4233545	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($189.00)
05/26/2009	WILLIAM	4233545	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($81.00)
04/17/2009	WILLIAM	4233545	J1885 - 2 ML	$80.00
05/26/2009	WILLIAM	4233545	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($6.80)
05/26/2009	WILLIAM	4233545	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($73.20)
04/17/2009	WILLIAM	4233545	J2001 - 5 ML	$80.00
05/26/2009	WILLIAM	4233545	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($1.56)
05/26/2009	WILLIAM	4233545	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($78.44)
04/17/2009	WILLIAM	4233545	J3420 - 1ML	$15.00
05/26/2009	WILLIAM	4233545	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($14.14)
			Total for Bill No. 4233545	$0.86
04/23/2009	WILLIAM	4233637	99213 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$180.00
10/30/2009	WILLIAM	4233637	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($10.72)
10/30/2009	WILLIAM	4233637	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($149.28)
04/23/2009	WILLIAM	4233637	CREDIT - PATIENT COPAYMENT CREDIT CARD	($20.00)
			Total for Bill No. 4233637	$0.00
04/28/2009	WILLIAM	4233965	64483 - INJECTION, ANESTHETIC/STEROID, TRAN!	$1,450.00
06/06/2009	WILLIAM	4233965	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($52.45)
04/28/2009	WILLIAM	4233965	64483 - INJECTION, ANESTHETIC/STEROID, TRAN!	$1,450.00
06/06/2009	WILLIAM	4233965	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($102.45)
04/28/2009	WILLIAM	4233965	64484 - INJECTION, ANESTHETIC/STEROID, TRAN!	$700.00
06/06/2009	WILLIAM	4233965	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($82.19)
04/28/2009	WILLIAM	4233965	64484 - INJECTION, ANESTHETIC/STEROID, TRAN!	$700.00
06/06/2009	WILLIAM	4233965	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($82.19)
04/28/2009	WILLIAM	4233965	64484 - INJECTION, ANESTHETIC/STEROID, TRAN!	$700.00
06/06/2009	WILLIAM	4233965	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($82.19)
04/28/2009	WILLIAM	4233965	64484 - INJECTION, ANESTHETIC/STEROID, TRAN!	$700.00
06/06/2009	WILLIAM	4233965	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($82.19)
04/28/2009	WILLIAM	4233965	77003 - FLUOROSCOPIC GUIDE & LOCALIZATION,	$500.00
06/06/2009	WILLIAM	4233965	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($26.14)
06/06/2009	WILLIAM	4233965	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($473.86)
			Total for Bill No. 4233965	$5,216.34

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Date	Patient	Bill No.	Description	Amount
04/29/2009	WILLIAM	4234081	64479 - INJECTION, ANESTHETIC/STEROID, TRAN	$1,750.00
06/06/2009	WILLIAM	4234081	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($33.77)
10/30/2009	WILLIAM	4234081	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($33.77)
10/30/2009	WILLIAM	4234081	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($1,632.46)
04/29/2009	WILLIAM	4234081	64480 - INJECTION, ANESTHETIC/STEROID, TRAN	$900.00
06/06/2009	WILLIAM	4234081	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($105.93)
10/30/2009	WILLIAM	4234081	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($105.93)
10/30/2009	WILLIAM	4234081	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($688.14)
04/29/2009	WILLIAM	4234081	77003 - FLUOROSCOPIC GUIDE & LOCALIZATION,	$500.00
06/06/2009	WILLIAM	4234081	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($26.14)
10/30/2009	WILLIAM	4234081	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($66.35)
10/30/2009	WILLIAM	4234081	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($408.51)
			Total for Bill No. 4234081	$50.00
04/30/2009	WILLIAM	4234142	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
09/02/2009	WILLIAM	4234142	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($27.36)
09/02/2009	WILLIAM	4234142	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($222.64)
04/29/2009	WILLIAM	4234142	CHECKCOPAY - Patient copayment by personal chec	($20.00)
			Total for Bill No. 4234142	$0.00
05/05/2009	WILLIAM	4234487	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
10/30/2009	WILLIAM	4234487	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($27.36)
10/30/2009	WILLIAM	4234487	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($222.64)
			Total for Bill No. 4234487	$20.00
05/12/2009	WILLIAM	4234902	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
10/30/2009	WILLIAM	4234902	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($27.36)
10/30/2009	WILLIAM	4234902	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($222.64)
05/12/2009	WILLIAM	4234902	CHECKCOPAY - Patient copayment by personal chec	($20.00)
			Total for Bill No. 4234902	$0.00
05/15/2009	WILLIAM	4235232	64479 - INJECTION, ANESTHETIC/STEROID, TRAN	$1,750.00
06/04/2009	WILLIAM	4235232	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($33.77)
06/04/2009	WILLIAM	4235232	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($1,666.23)
05/15/2009	WILLIAM	4235232	64480 - INJECTION, ANESTHETIC/STEROID, TRAN	$900.00
06/04/2009	WILLIAM	4235232	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($105.93)
06/04/2009	WILLIAM	4235232	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($794.07)
05/15/2009	WILLIAM	4235232	64480 - INJECTION, ANESTHETIC/STEROID, TRAN	$900.00
06/04/2009	WILLIAM	4235232	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($105.93)
06/04/2009	WILLIAM	4235232	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($794.07)
05/15/2009	WILLIAM	4235232	20610 - ARTHROCENTESIS, ASPIRATION &/OR INJ	$260.00
05/15/2009	WILLIAM	4235232	77003 - FLUOROSCOPIC GUIDE & LOCALIZATION,	$500.00
06/04/2009	WILLIAM	4235232	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($26.14)
06/04/2009	WILLIAM	4235232	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($473.86)
			Total for Bill No. 4235232	$310.00

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Date	Patient	Bill No.	Description	Amount
05/21/2009	WILLIAM	4235586	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
10/30/2009	WILLIAM	4235586	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($27.36)
10/30/2009	WILLIAM	4235586	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($222.64)
05/21/2009	WILLIAM	4235586	CREDIT - PATIENT COPAYMENT CREDIT CARD	($20.00)
			Total for Bill No. 4235586	$0.00
05/28/2009	WILLIAM	4236084	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
06/22/2009	WILLIAM	4236084	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($27.36)
06/22/2009	WILLIAM	4236084	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($222.64)
05/28/2009	WILLIAM	4236084	CHECKCOPAY - Patient copayment by personal chec	($20.00)
			Total for Bill No. 4236084	$0.00
05/29/2009	WILLIAM	4236241	64483 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,450.00
10/30/2009	WILLIAM	4236241	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($16.30)
10/30/2009	WILLIAM	4236241	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($1,381.70)
05/29/2009	WILLIAM	4236241	64484 - INJECTION, ANESTHETIC/STEROID, TRANS	$700.00
10/30/2009	WILLIAM	4236241	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($82.19)
10/30/2009	WILLIAM	4236241	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($617.81)
05/29/2009	WILLIAM	4236241	64484 - INJECTION, ANESTHETIC/STEROID, TRANS	$700.00
10/30/2009	WILLIAM	4236241	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($82.19)
10/30/2009	WILLIAM	4236241	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($617.81)
05/29/2009	WILLIAM	4236241	77003 - FLUOROSCOPIC GUIDE & LOCALIZATION,	$500.00
10/30/2009	WILLIAM	4236241	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($26.14)
10/30/2009	WILLIAM	4236241	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($473.86)
05/29/2009	WILLIAM	4236241	99144 - CONSCIOUS SEDATION W/WO ANALGESI/	$200.00
10/30/2009	WILLIAM	4236241	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($38.08)
10/30/2009	WILLIAM	4236241	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($161.92)
			Total for Bill No. 4236241	$50.00
06/01/2009	WILLIAM	4236256	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
06/29/2009	WILLIAM	4236256	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($27.36)
06/29/2009	WILLIAM	4236256	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($222.64)
06/01/2009	WILLIAM	4236256	CREDIT - PATIENT COPAYMENT CREDIT CARD	($20.00)
			Total for Bill No. 4236256	$0.00
06/08/2009	WILLIAM	4236692	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
06/29/2009	WILLIAM	4236692	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($27.36)
06/29/2009	WILLIAM	4236692	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($222.64)
06/08/2009	WILLIAM	4236692	CHECKCOPAY - Patient copayment by personal chec	($20.00)
			Total for Bill No. 4236692	$0.00
06/09/2009	WILLIAM	4236827	20610 - ARTHROCENTESIS, ASPIRATION &/OR INJ	$260.00
09/08/2009	WILLIAM	4236827	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($34.87)
09/08/2009	WILLIAM	4236827	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($225.13)
06/09/2009	WILLIAM	4236827	64479 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,750.00

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Date	Patient	Bill No.	Description	Amount
06/29/2009	WILLIAM	4236827	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($33.77)
06/29/2009	WILLIAM	4236827	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($1,666.23)
06/09/2009	WILLIAM	4236827	64480 - INJECTION, ANESTHETIC/STEROID, TRANS	$900.00
06/29/2009	WILLIAM	4236827	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($105.93)
06/29/2009	WILLIAM	4236827	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($794.07)
06/09/2009	WILLIAM	4236827	64480 - INJECTION, ANESTHETIC/STEROID, TRANS	$900.00
06/29/2009	WILLIAM	4236827	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($105.93)
06/29/2009	WILLIAM	4236827	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($794.07)
06/09/2009	WILLIAM	4236827	77003 - FLUOROSCOPIC GUIDE & LOCALIZATION,	$500.00
06/29/2009	WILLIAM	4236827	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($26.14)
06/29/2009	WILLIAM	4236827	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($473.86)
06/09/2009	WILLIAM	4236827	99144 - CONSCIOUS SEDATION W/WO ANALGESIA	$200.00
06/29/2009	WILLIAM	4236827	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($38.08)
06/29/2009	WILLIAM	4236827	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($161.92)
			Total for Bill No. 4236827	$50.00
06/11/2009	WILLIAM	4236941	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
08/07/2009	WILLIAM	4236941	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($108.00)
08/07/2009	WILLIAM	4236941	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($54.00)
08/07/2009	WILLIAM	4236941	INA - IN-NETWORK ADJUSTMENT	($88.00)
06/11/2009	WILLIAM	4236941	CHECKCOPAY - Patient copayment by personal chec	($20.00)
			Total for Bill No. 4236941	$0.00
06/23/2009	WILLIAM	4237607	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
08/10/2009	WILLIAM	4237607	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($27.36)
08/10/2009	WILLIAM	4237607	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($222.64)
06/23/2009	WILLIAM	4237607	CHECKCOPAY - Patient copayment by personal chec	($20.00)
			Total for Bill No. 4237607	$0.00
07/27/2009	WILLIAM	5167142	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
09/21/2009	WILLIAM	5167142	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($27.36)
09/21/2009	WILLIAM	5167142	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($222.64)
			Total for Bill No. 5167142	$20.00
07/27/2009	WILLIAM	5167172	96365 - IV INFUSION THERAPY	$270.00
09/05/2009	WILLIAM	5167172	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($52.27)
09/05/2009	WILLIAM	5167172	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($217.73)
			Total for Bill No. 5167172	$0.00
08/03/2009	WILLIAM	5167508	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
			Total for Bill No. 5167508	$270.00
08/24/2009	WILLIAM	5198552	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
10/23/2009	WILLIAM	5198552	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($216.00)
10/23/2009	WILLIAM	5198552	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($54.00)

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Date	Patient	Bill No.	Description	Amount
			Total for Bill No. 5198552	$0.00
09/07/2009	WILLIAM	5199386	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
09/07/2009	WILLIAM	5199386	CHECKCOPAY - Patient copayment by personal chec	($20.00)
			Total for Bill No. 5199386	$250.00
08/24/2009	WILLIAM	5200103	MED - MEDICAL RECORDS CHARGES	$26.40
08/28/2009	WILLIAM	5200103	RECORDS - MEDICAL RECORDS PAYMENT	($26.40)
			Total for Bill No. 5200103	$0.00
10/07/2009	WILLIAM	5201824	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
10/07/2009	WILLIAM	5201824	CHECKCOPAY - Patient copayment by personal chec	($20.00)
			Total for Bill No. 5201824	$250.00
10/26/2009	WILLIAM	5203106	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
10/26/2009	WILLIAM	5203106	CHECKCOPAY - Patient copayment by personal chec	($20.00)
			Total for Bill No. 5203106	$250.00
11/02/2009	WILLIAM	5203543	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
11/02/2009	WILLIAM	5203543	CASHCOPAY - cash copayment from patient	($20.00)
			Total for Bill No. 5203543	$250.00
11/04/2009	WILLIAM	5203695	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
			Total for Bill No. 5203695	$270.00
11/09/2009	WILLIAM	5203994	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
11/09/2009	WILLIAM	5203994	CASHCOPAY - cash copayment from patient	($20.00)
			Total for Bill No. 5203994	$250.00
			Estimated Insurance Responsibility	$7,256.34
			Estimated Patient Responsibility	$250.66

Current	> 30 Days	> 60 Days	> 90 Days	> 120 Days	Balance
$1,080.00	$270.00	$512.40	$369.63	$5,275.17	$7,507.20

Report Totals

Current	> 30 Days	> 60 Days	> 90 Days	> 120 Days	Report Balance
$1,080.00	$270.00	$512.40	$369.63	$5,275.17	$7,507.20

Spring Valley Surgery Center, LLC

Patient Ledger

November 10, 2009

WILLIAM POREMBA
168 ROD ARCHES STREET
HENDERSON, NV 89012

Account Number: SVPO000039
Work Phone:
Home Phone: (702)263-2936

Date	Patient	Bill No.	Description	Amount
04/28/2009	WILLIAM	4211679	64483 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
04/28/2009	WILLIAM	4211679	64483 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
04/28/2009	WILLIAM	4211679	64484 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
04/28/2009	WILLIAM	4211679	64484 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
04/28/2009	WILLIAM	4211679	64484 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
04/28/2009	WILLIAM	4211679	64484 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
05/18/2009	WILLIAM	4211679	INSP - INSURANCE PAYMENT	($3,200.00)
05/18/2009	WILLIAM	4211679	INSA - INSURANCE ADJUSTMENT	($5,950.00)
04/28/2009	WILLIAM	4211679	77003 - FLUOROSCOPIC GUIDE & LOCALIZATION,	$250.00
			Total for Bill No. 4211679	$100.00
04/29/2009	WILLIAM	4211706	64479 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
05/21/2009	WILLIAM	4211706	INSP - INSURANCE PAYMENT	($850.00)
05/21/2009	WILLIAM	4211706	INSA - INSURANCE ADJUSTMENT	($600.00)
04/29/2009	WILLIAM	4211706	64480 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
05/21/2009	WILLIAM	4211706	INSP - INSURANCE PAYMENT	($450.00)
05/25/2009	WILLIAM	4211706	INSA - INSURANCE ADJUSTMENT	($1,050.00)
04/29/2009	WILLIAM	4211706	77003 - FLUOROSCOPIC GUIDE & LOCALIZATION,	$250.00
05/21/2009	WILLIAM	4211706	INSP - INSURANCE PAYMENT	($150.00)
05/21/2009	WILLIAM	4211706	INSA - INSURANCE ADJUSTMENT	($100.00)
			Total for Bill No. 4211706	$50.00
05/15/2009	WILLIAM	4211991	64479 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
05/15/2009	WILLIAM	4211991	64480 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
05/15/2009	WILLIAM	4211991	64480 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
05/15/2009	WILLIAM	4211991	20610 - INJECTION (S) MAJOR JOINT	$1,000.00
05/15/2009	WILLIAM	4211991	77003 - FLUOROSCOPIC GUIDE & LOCALIZATION,	$250.00
06/04/2009	WILLIAM	4211991	INSP - INSURANCE PAYMENT	($2,350.00)
06/04/2009	WILLIAM	4211991	INSA - INSURANCE ADJUSTMENT	($3,350.00)
			Total for Bill No. 4211991	$50.00
05/29/2009	WILLIAM	4212252	64483 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
06/11/2009	WILLIAM	4212252	INSP - INSURANCE PAYMENT	($850.00)
06/11/2009	WILLIAM	4212252	INSA - INSURANCE ADJUSTMENT	($600.00)
05/29/2009	WILLIAM	4212252	64484 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
06/11/2009	WILLIAM	4212252	INSP - INSURANCE PAYMENT	($450.00)
06/11/2009	WILLIAM	4212252	INSA - INSURANCE ADJUSTMENT	($1,050.00)
05/29/2009	WILLIAM	4212252	64484 - INJECTION, ANESTHETIC/STEROID, TRANS	$1,500.00
06/11/2009	WILLIAM	4212252	INSP - INSURANCE PAYMENT	($450.00)
06/11/2009	WILLIAM	4212252	INSA - INSURANCE ADJUSTMENT	($1,050.00)
05/29/2009	WILLIAM	4212252	77003 - FLUOROSCOPIC GUIDE & LOCALIZATION,	$250.00
06/11/2009	WILLIAM	4212252	INSP - INSURANCE PAYMENT	($150.00)

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Date	Patient	Bill No.	Description	Amount
06/11/2009	WILLIAM	4212252	INSA - INSURANCE ADJUSTMENT	($100.00)
05/29/2009	WILLIAM	4212252	99144 - CONSCIOUS SEDATION W/WO ANALGESI/	$0.00
			Total for Bill No. 4212252	$50.00
06/09/2009	WILLIAM	4212438	20610 - INJECTION (S) MAJOR JOINT	$1,000.00
06/29/2009	WILLIAM	4212438	INSP - INSURANCE PAYMENT	($850.00)
06/29/2009	WILLIAM	4212438	INSA - INSURANCE ADJUSTMENT	($100.00)
06/09/2009	WILLIAM	4212438	64479 - INJECTION, ANESTHETIC/STEROID, TRAN	$1,500.00
06/29/2009	WILLIAM	4212438	INSP - INSURANCE PAYMENT	($450.00)
06/29/2009	WILLIAM	4212438	INSA - INSURANCE ADJUSTMENT	($1,050.00)
06/09/2009	WILLIAM	4212438	64480 - INJECTION, ANESTHETIC/STEROID, TRAN	$1,500.00
06/29/2009	WILLIAM	4212438	INSP - INSURANCE PAYMENT	($450.00)
06/29/2009	WILLIAM	4212438	INSA - INSURANCE ADJUSTMENT	($1,050.00)
06/09/2009	WILLIAM	4212438	64480 - INJECTION, ANESTHETIC/STEROID, TRAN	$1,500.00
06/29/2009	WILLIAM	4212438	INSP - INSURANCE PAYMENT	($450.00)
06/29/2009	WILLIAM	4212438	INSA - INSURANCE ADJUSTMENT	($1,050.00)
06/09/2009	WILLIAM	4212438	77003 - FLUOROSCOPIC GUIDE & LOCALIZATION,	$250.00
06/29/2009	WILLIAM	4212438	INSA - INSURANCE ADJUSTMENT	($250.00)
06/09/2009	WILLIAM	4212438	99144 - CONSCIOUS SEDATION W/WO ANALGESI/	$0.00
			Total for Bill No. 4212438	$50.00
07/27/2009	WILLIAM	4213195	96365 - IV THERAPY INFUSION	$1,500.00
08/19/2009	WILLIAM	4213195	INSP - INSURANCE PAYMENT	($850.00)
08/19/2009	WILLIAM	4213196	INSA - INSURANCE ADJUSTMENT	($600.00)
07/27/2009	WILLIAM	4213195	J1885 - 2 ML KETOROLAC TROMETHAMINE	$0.00
07/27/2009	WILLIAM	4213195	J2001 - LIDOCAINE 4 ML	$0.00
07/27/2009	WILLIAM	4213195	J3475 - 4 ML MAGNESIUM	$0.00
07/27/2009	WILLIAM	4213195	J3420 - 1 ML VIT B-12 CYANOCOBALAMIN	$0.00
07/27/2009	WILLIAM	4213195	J2175 - INJ. DEMEROL (MEPERIDINE HCL) PER 50	$0.00
			Total for Bill No. 4213195	$50.00
			Estimated Insurance Responsibility	$50.00
			Estimated Patient Responsibility	$300.00
			Balance	$350.00

Report Totals

Current	> 30 Days	> 60 Days	> 90 Days	> 120 Days	Report Balance
			$350.00		$350.00

Las Vegas Pain Institute

CHIRO

Patient Ledger

November 10, 2009

WILLIAM POREMBA
168 RED ARCHES COURT
HENDERSON, NV 89012

Account Number: CHPO000012
Work Phone:
Home Phone: (702)263-2936

Date	Patient	Bill No.	Description	Amount
04/29/2009	WILLIAM	5166277	99243 - OFFICE CONSULTATION, 3 KEY COMPONE	$450.00
06/29/2009	WILLIAM	5166277	INS - PRIMARY INSURANCE PAYMEMT	($61.28)
06/29/2009	WILLIAM	5166277	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($388.72)
04/29/2009	WILLIAM	5166277	97035 - Ultrasound (Mcare OK) (Mcaid OK)	$40.00
06/29/2009	WILLIAM	5166277	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($29.44)
04/29/2009	WILLIAM	5166277	97140 - Manual Therapy MFR (Mcare OK) Per 15 Min	$50.00
06/29/2009	WILLIAM	5166277	INS - PRIMARY INSURANCE PAYMEMT	($10.72)
06/29/2009	WILLIAM	5166277	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($29.84)
			Total for Bill No. 5166277	$40.00
05/15/2009	WILLIAM	5166624	97035 - Ultrasound (Mcare OK) (Mcaid OK)	$40.00
09/09/2009	WILLIAM	5166624	ADJ - adjustment	($29.44)
			Total for Bill No. 5166624	$10.56
06/09/2009	WILLIAM	5167196	97035 - Ultrasound (Mcare OK) (Mcaid OK)	$40.00
08/07/2009	WILLIAM	5167196	INS - PRIMARY INSURANCE PAYMEMT	($16.00)
08/07/2009	WILLIAM	5167196	INSADJUST - PRIMARY INSURANCE ADJUSTMENT	($8.00)
08/07/2009	WILLIAM	5167196	ERROR - CHARGES ENTERED IN ERROR DO NOT	$0.00
			Total for Bill No. 5167196	$16.00
			Estimated Insurance Responsibility	$10.56
			Estimated Patient Responsibility	$56.00

Current	> 30 Days	> 60 Days	> 90 Days	> 120 Days	Balance
				$66.56	$66.56

Report Totals

Current	> 30 Days	> 60 Days	> 90 Days	> 120 Days	Report Balance
				$66.56	$66.56

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

MATTHE... DUNKLEY, ATTORNEY
2920 N. GREEN VALLEY PKWY
SUITE 424
HENDERSON NV 89104

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) [X] | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): POREMBA WILLIAM M

3. PATIENT'S BIRTH DATE MM DD YY: 06 30 64 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): POREMBA WILLIAM M

5. PATIENT'S ADDRESS (No., Street): 168 RED ARCHES COURT

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 168 RED ARCHES COURT

CITY: HENDERSON STATE: NV

8. PATIENT STATUS: Single Married [X] Other; Employed Full-Time Student Part-Time Student

CITY: HENDERSON STATE: NV

ZIP CODE: 89012 TELEPHONE (Include Area Code): ((702)263-2936

ZIP CODE: 89012 TELEPHONE (Include Area Code): (702)263-2936

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): POREMBA WILLIAM M

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 347669782

a. EMPLOYMENT? (Current or Previous) YES NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 06 30 64 SEX M [X] F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 06 30 64 SEX M [X] F

b. AUTO ACCIDENT? YES NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: MATTHEW DUNKLEY, ATTORNEY

d. INSURANCE PLAN NAME OR PROGRAM NAME: TEAMSTER LOCAL 631

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 03/11/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED Signature on file

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)

1. 723.4
2. 724.4
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
12 31 09		11		99214		12	270 00	1		NPI	1679675060
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 880404982

26. PATIENT'S ACCOUNT NO.: 5207119

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE: $ 270 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 270 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

JEREMY M LIPSHUTZ, MD

SIGNED 03/11/2010 DATE

32. SERVICE FACILITY LOCATION INFORMATION

LAS VEGAS PAIN INSTITUTE
3835 S JONES #104
LAS VEGAS NV 89103

a. 1659431443 b.

33. BILLING PROVIDER INFO & PH #: (702)880-4193

Las Vegas Pain Institute & Med Cntr, L
4616 W. Sahara # 337
Las Vegas NV 89102-3627

a. 1679675060 b.

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

ADD 185 3300

ROYAL ... ES DUNKLEY AND WILSON
2920 N. GREEN VALLEY PARKWAY SUITE 424
LAS VEGAS 89014

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
				X		

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
POREMBA WILLIAM M	06 30 64 M X F	POREMBA WILLIAM M
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
168 RED ARCHES COURT	Self X Spouse Child Other	168 RED ARCHES COURT
CITY / STATE	8. PATIENT STATUS	CITY / STATE
HENDERSON / NV	Single Married X Other	HENDERSON / NV
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (Include Area Code)
89012 / (702)263-2936		89012 / (702)263-2936
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
POREMBA WILLIAM M		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
347669782	YES NO X	06 30 64 M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	b. AUTO ACCIDENT? / PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
06 30 64 M X F	YES NO X	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO X	ROYAL JONES DUNKLEY AND WILSON
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
TEAMSTER LOCAL 631		X YES NO If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 04/26/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on file

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE: CORRECTED CLAIM		20. OUTSIDE LAB? YES X NO / $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 724.4 3. 2. 4.

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 24 10	11		99214		1	270 00	1		NPI	1548363583
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
880404982 X	5210980	X YES NO	$ 270 00	$	$ 270 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
Godwin O. Maduka, MD, Pharm	LAS PAIN INSTITUTE & MEDICAL CEN 2705 W HORIZON RIDGE PKWY HENDERSON NV 89052	(702)880-4193 Las Vegas Pain Institute & Med Cntr, L 4616 W. Sahara # 337 Las Vegas NV 89102-3627
SIGNED 04/26/2010 DATE	a. 1659431443 b.	a. 1548363583 b.

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

70

AIT086

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

ROYAL J[illegible]S DUNKLEY AND WILSON
2920 N. GREEN VALLEY PARKWAY SUITE 424
LAS VEGAS 89014

CARRIER

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) POREMBA WILLIAM M	3. PATIENT'S BIRTH DATE MM DD YY 06 30 64 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) POREMBA WILLIAM M
5. PATIENT'S ADDRESS (No., Street) 168 RED ARCHES COURT	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) 168 RED ARCHES COURT
CITY HENDERSON STATE NV	8. PATIENT STATUS Single [ ] Married [X] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	CITY HENDERSON STATE NV
ZIP CODE 89012 TELEPHONE (Include Area Code) (702)263-2936		ZIP CODE 89012 TELEPHONE (Include Area Code) (702)263-2936
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) POREMBA WILLIAM M	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER 347669782	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY 06 30 64 SEX M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY 06 30 64 SEX M [X] F [ ]	b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [X]	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME ROYAL JONES DUNKLEY AND WILSON
d. INSURANCE PLAN NAME OR PROGRAM NAME TEAMSTER LOCAL 631	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 05/17/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED Signature on file

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI [ ]	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE CORRECTED CLAIM		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. L 722.4 3. [ ] 2. L 722.52 4. [ ]		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 24 10	11		99214		12	270 00	1		NPI	1548363583
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER 880404982 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO. 5213208	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 270 00	29. AMOUNT PAID $	30. BALANCE DUE $ 270 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Godwin O. Maduka, MD, Pharml
SIGNED 05/17/2010 DATE

32. SERVICE FACILITY LOCATION INFORMATION
LAS PAIN INSTITUTE & MEDICAL CEN
2705 W HORIZON RIDGE PKWY
HENDERSON NV 89052
a. 1659431443 b.

33. BILLING PROVIDER INFO & PH # (702)880-4193
Las Vegas Pain Institute & Med Cntr, L
4616 W. Sahara # 337
Las Vegas NV 89102-3627
a. 1548363583 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

ROYAL J[illegible]'S DUNKLEY AND WILSON
2920 N. GR[illegible]N VALLEY PARKWAY SUITE 424
LAS VEGAS NV 89014

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID) [X]	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
POREMBA WILLIAM M			06 30 64	M [X] F [ ]			POREMBA WILLIAM M		
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
168 RED ARCHES COURT			Self [X] Spouse [ ] Child [ ] Other [ ]				168 RED ARCHES COURT		
CITY		STATE	8. PATIENT STATUS				CITY		STATE
HENDERSON		NV	Single [ ] Married [X] Other [ ]				HENDERSON		NV
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE	TELEPHONE (Include Area Code)	
89012	(702)263-2936		Employed [ ] Full-Time Student [ ] Part-Time Student [ ]				89012	(702)263-2936	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
POREMBA WILLIAM M									
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX	
347669782			YES [ ] NO [X]				06 30 64	M [X] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX		b. AUTO ACCIDENT?	PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME		
06 30 64	M [X] F [ ]		YES [ ] NO [X]						
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES [ ] NO [X]				ROYAL JONES DUNKLEY AND WILSON		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
TEAMSTER LOCAL 631							[X] YES [ ] NO If yes, return to and complete item 9 a-d		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 07/12/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED Signature on file

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI [ ]	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X]	$ CHARGES
CORRECTED CLAIM			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
1. 723.1 2. 723.4 3. 721.3 4. 724.4		23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
04 22 10		11		99214		1234	270 00	1		NPI	1326115429
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
880404982	[ ] [X]	5215888	YES [X] NO [ ]	$ 270 00	$	$ 270 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (702)880-4193
SUDHIR KHEMKA, MD	LAS PAIN INSTITUTE & MEDICAL CEN 2705 W HORIZON RIDGE PKWY HENDERSON NV 89052	Las Vegas Pain Institute & Med Cntr, L 4616 W. Sahara # 337 Las Vegas NV 89102-3627
SIGNED 07/12/2010 DATE	a. 1659431443 b.	a. 1326115429 b.

NUCC Instruction Manual available at www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

72

APP088

ROYAL JO[illegible] DUNKLEY AND WILSON
2920 N. GREEN VALLEY PARKWAY SUITE 424
LAS VEGAS 89014

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID) X	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
POREMBA WILLIAM M			06 30 64	M X F			POREMBA WILLIAM M		
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
168 RED ARCHES COURT			Self X Spouse Child Other				168 RED ARCHES COURT		
CITY		STATE	8. PATIENT STATUS				CITY		STATE
HENDERSON		NV	Single Married X Other				HENDERSON		NV
ZIP CODE	TELEPHONE (Include Area Code)		Employed Full-Time Student Part-Time Student				ZIP CODE	TELEPHONE (Include Area Code)	
89012	(702)263-2936						89012	(702)263-2936	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
POREMBA WILLIAM M									
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX	
347669782			YES X NO				06 30 64	M X F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX		b. AUTO ACCIDENT?	PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME		
06 30 64	M X F		YES X NO						
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES X NO				ROYAL JONES DUNKLEY AND WILSON		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
TEAMSTER LOCAL 631							X YES NO If yes, return to and complete item 9 a-d.		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED Signature on file DATE 07/05/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED Signature on file

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
	17b. NPI		
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
1. 723.1 3. 723.4		23. PRIOR AUTHORIZATION NUMBER	
2. 721.3 4. 724.4			

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 22 10	11		S1015		1234	10 00	1		NPI	1548363583
2 04 22 10	11		A4216		1234	1 00	1		NPI	1548363583
3 04 22 10	11		A4244		1234	5 00	1		NPI	1548363583
4 04 22 10	11		A4213		1234	1 00	1		NPI	1548363583
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
880404982	X	5216344	X YES NO	$ 17 00	$	$ 17 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Godwin O. Maduka, MD, Pharml

SIGNED 07/05/2010 DATE

32. SERVICE FACILITY LOCATION INFORMATION

LAS PAIN INSTITUTE & MEDICAL CEN
2705 W HORIZON RIDGE PKWY
HENDERSON NV 89052
a. 1659431443 b.

33. BILLING PROVIDER INFO & PH #

(702)880-4193
Las Vegas Pain Institute & Med Cntr, L
4616 W. Sahara # 337
Las Vegas NV 89102-3627
a. 1548363583 b.

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PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION | CARRIER

ROYAL JONES DUNKLEY AND WILSON
2920 N. GREEN VALLEY PARKWAY SUITE 424
LAS VEGAS 89014

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
				X		

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
POREMBA WILLIAM M	06 30 54 M X F	POREMBA WILLIAM M
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
168 RED ARCHES COURT	Self X Spouse Child Other	168 RED ARCHES COURT
CITY / STATE	8. PATIENT STATUS	CITY / STATE
HENDERSON NV	Single Married X Other	HENDERSON NV
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (Include Area Code)
89012 (702)263-2936		89012 (702)263-2936
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
POREMBA WILLIAM M		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
347669782	YES X NO	06 30 64 M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
06 30 64 M X F	YES X NO	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	ROYAL JONES DUNKLEY AND WILSON
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
TEAMSTER LOCAL 631		X YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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SIGNED Signature on file DATE 07/05/2010

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14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO / $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 723.1
2. 721.3
3. 723.4
4. 724.4

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
04 22 10		11		96365		1234	270 00	1		NPI	1548363583
04 22 10		11		J2001		1234	80 00	4		NPI	1548363583
04 22 10		11		J1885		1234	80 00	4		NPI	1548363583
04 22 10		11		J3475		1234	14 40	4		NPI	1548363583
04 22 10		11		J3420		1234	7 50	1		NPI	1548363583
04 22 10		11		A6220		1234	2 00	1		NPI	1548363583

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? For govt. claims, see back	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
880404982	X	5216344	X YES NO	$ 453 90	$	$ 453 90

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Godwin O. Maduka, MD, Pharml

SIGNED 07/05/2010 DATE

32. SERVICE FACILITY LOCATION INFORMATION

LAS PAIN INSTITUTE & MEDICAL CEN
2705 W HORIZON RIDGE PKWY
HENDERSON NV 89052
a. 1659431443 b.

33. BILLING PROVIDER INFO & PH #

(702)880-4193
Las Vegas Pain Institute & Med Cntr, L
4616 W. Sahara # 337
Las Vegas NV 89102-3627
a. 1548363583 b.

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PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

ROYAL JONES DUNKLEY AND WILSON
2920 N. GREEN VALLEY PARKWAY SUITE 424
LAS VEGAS NV 89014

CARRIER

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN [X] (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) POREMBA WILLIAM M	3. PATIENT'S BIRTH DATE MM DD YY 06 30 64 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial) POREMBA WILLIAM M
5. PATIENT'S ADDRESS (No., Street) 168 RED ARCHES COURT	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street) 168 RED ARCHES COURT
CITY: HENDERSON STATE: NV	8. PATIENT STATUS Single [ ] Married [X] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY: HENDERSON STATE: NV
ZIP CODE: 89012 TELEPHONE (Include Area Code): (702)263-2936
ZIP CODE: 89012 TELEPHONE (Include Area Code): (702)263-2936
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) POREMBA WILLIAM M	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER 347669782	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY 06 30 64 SEX M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY 06 30 64 SEX M [X] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME ROYAL JONES DUNKLEY AND WILSON
d. INSURANCE PLAN NAME OR PROGRAM NAME TEAMSTER LOCAL 631	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on file DATE 07/22/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature on file

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE CORRECTED CLAIM	20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 729.5 2. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
05 25 10	11		96365		1	270 00	1		NPI	1326115429
05 25 10	11		J2001		1	80 00	4		NPI	1326115429
05 25 10	11		J3475		1	14 40	4		NPI	1326115429
05 25 10	11		J1885		1	80 00	4		NPI	1326115429
05 25 10	11		J3420		1	7 50	1		NPI	1326115429
05 25 10	11		A6220		1	2 00	1		NPI	1326115429

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER 880404982	SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO. 5219836	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 453 90	29. AMOUNT PAID $	30. BALANCE DUE $ 453 90

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
I certify that the statements on the reverse apply to this bill and are made a part thereof.
SUDHIR KHEMKA, MD
SIGNED 07/22/2010 DATE

32. SERVICE FACILITY LOCATION INFORMATION
LAS VEGAS PAIN INSTITUTE
2705 W HORIZON RIDGE PKWY
HENDERSON NV 89052
a. b.

33. BILLING PROVIDER INFO & PH # (702)880-4193
Las Vegas Pain Institute & Med Cntr, L
4616 W. Sahara # 337
Las Vegas NV 89102-3627
a. 1326115429 b.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ROYAL J[illegible]S DUNKLEY AND WILSON
2920 N. GREEN VALLEY PARKWAY SUITE 424
LAS VEGAS NV 89014

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
				X		

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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POREMBA WILLIAM M	06 30 64 M X F	POREMBA WILLIAM M
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168 RED ARCHES COURT	Self X Spouse Child Other	168 RED ARCHES COURT
CITY: HENDERSON — STATE: NV	8. PATIENT STATUS: Single Married X Other	CITY: HENDERSON — STATE: NV
ZIP CODE: 89012 — TELEPHONE (Include Area Code): (702)263-2936	Employed Full-Time Student Part-Time Student	ZIP CODE: 89012 — TELEPHONE (Include Area Code): (702)263-2936
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POREMBA WILLIAM M		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH (MM DD YY) SEX
347669782	YES X NO	06 30 64 M X F
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
06 30 64 M X F	YES X NO	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	ROYAL JONES DUNKLEY AND WILSON
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
TEAMSTER LOCAL 631		X YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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19. RESERVED FOR LOCAL USE: CORRECTED CLAIM		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line): 1. 729.5 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
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3 05 25 10	11		A4244		1	5 00	1		NPI	1326115429
4 05 25 10	11		A4213		1	1 00	1		NPI	1326115429
5									NPI	
6									NPI	

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880404982	X	5219836	X YES NO	$ 17 00	$	$ 17 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (702)880-4193
SUDHIR KHEMKA, MD	LAS VEGAS PAIN INSTITUTE 2705 W HORIZON RIDGE PKWY HENDERSON NV 89052	Las Vegas Pain Institute & Med Cntr, L 4616 W. Sahara # 337 Las Vegas NV 89102-3627
SIGNED 07/22/2010 DATE	a. b.	a. 1326115429 b.

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7. INSURED'S ADDRESS (No., Street) 168 RED ARCHES COURT
CITY: HENDERSON — STATE: NV	8. PATIENT STATUS Single [ ] Married [X] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY: HENDERSON — STATE: NV
ZIP CODE: 89012 — TELEPHONE (Include Area Code): (702)263-2936
ZIP CODE: 89012 — TELEPHONE (Include Area Code): (702)263-2936
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) POREMBA WILLIAM M	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER 347669782	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY 06 30 64 SEX M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY 06 30 64 SEX M [X] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME ROYAL JONES DUNKLEY AND WILSON
d. INSURANCE PLAN NAME OR PROGRAM NAME TEAMSTER LOCAL 631	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

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13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature on file

14. DATE OF CURRENT: MM DD YY (ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP))	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI [ ]
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE CORRECTED CLAIM	20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 721.3 3. [ ] 2. 724.4 4. [ ]	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
05 25 10	05 25 10	11		99214		12	270 00	1		NPI	1326115429
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
880404982	[ ] [X]	5219253	YES [X] NO [ ]	$ 270 00	$	$ 270 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SUDHIR KHEMKA, MD SIGNED 07/22/2010 DATE	LAS PAIN INSTITUTE & MEDICAL CEN 2705 W HORIZON RIDGE PKWY HENDERSON NV 89052 a. 1659431443 b.	(702)880-4193 Las Vegas Pain Institute & Med Cntr, L 4616 W. Sahara # 337 Las Vegas NV 89102-3627 a. 1326115429 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

ROYAL ES MILES DUNKLEY & WILSON
1522 WEST WARM SPRINGS ROAD
HENDERSON NV 89014

CARRIER

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) X / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	347669782	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
POREMBA WILLIAM M	06 30 64 M X F	POREMBA WILLIAM M
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
168 RED ARCHES COURT	Self X Spouse Child Other	168 RED ARCHES COURT
CITY / STATE	8. PATIENT STATUS	CITY / STATE
HENDERSON NV	Single Married X Other	HENDERSON NV
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (Include Area Code)
89012 (702)263-2936		89012 (702)263-2936
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
POREMBA WILLIAM M		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO X	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
347669782		06 30 64 M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	b. AUTO ACCIDENT? YES NO X PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
06 30 64 M X F		
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO X	c. INSURANCE PLAN NAME OR PROGRAM NAME
		ROYAL JONES MILES DUNKLEY & WILSON
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
TEAMSTER LOCAL 631		X YES NO If yes, return to and complete item 9 a-d.

SECOND FOLD

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 09/28/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on file

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 1G	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
BRANDON NGUYEN	17b. NPI 1508882564	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. 723.1 3. 721.3		23. PRIOR AUTHORIZATION NUMBER
2. 721.0 4. 724.2		

FIRST FOLD PHOTOCOPY VOID-TO-SHRINK

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 05 25 10	11		S1015		1	10 00	1		NPI	1326115429
2 05 25 10	11		A4216		1	1 00	1		NPI	1326115429
3 05 25 10	11		A4244		1	5 00	1		NPI	1326115429
4 05 25 10	11		A4213		1	1 00	1		NPI	1326115429
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
880404982 X	5219836	X YES NO	$ 17 00	$ 6 80	$ 10 20

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (702)880-4193
SUDHIR KHEMKA MD	LAS PAIN INSTITUTE & MEDICAL CEN 2706 W HORIZON RIDGE PKWY HENDERSON NV 89052	Las Vegas Pain Institute & Med Cntr, L 4616 W. Sahara # 337 Las Vegas NV 89102-3627
SIGNED 09/28/2010 DATE	a. 1659431443 b.	a. 1326115429 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

APP094 76

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ROYAL JONES MILES DUNKLEY & WILSON
1522 WEST WARM SPRINGS ROAD
HENDERSON NV 89014

CARRIER

PICA ☐ PICA ☐

1. MEDICARE (Medicare #) ☐	MEDICAID (Medicaid #) ☐	TRICARE CHAMPUS (Sponsor's SSN) ☐	CHAMPVA (Member ID#) ☐	GROUP HEALTH PLAN (SSN or ID) ☒	FECA BLK LUNG (SSN) ☐	OTHER (ID) ☐	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 347669782

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): POREMBA WILLIAM M	3. PATIENT'S BIRTH DATE MM DD YY: 06 30 64 SEX M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial): POREMBA WILLIAM M
5. PATIENT'S ADDRESS (No., Street): 168 RED ARCHES COURT	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street): 168 RED ARCHES COURT
CITY: HENDERSON STATE: NV	8. PATIENT STATUS: Single ☐ Married ☒ Other ☐	CITY: HENDERSON STATE: NV
ZIP CODE: 89012 TELEPHONE (Include Area Code): (702)263-2936	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE: 89012 TELEPHONE (Include Area Code): (702)263-2936
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): POREMBA WILLIAM M	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 347669782	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒	a. INSURED'S DATE OF BIRTH MM DD YY: 06 30 64 SEX M ☒ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 06 30 64 SEX M ☒ F ☐	b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☒	c. INSURANCE PLAN NAME OR PROGRAM NAME: ROYAL JONES MILES DUNKLEY & WILSON
d. INSURANCE PLAN NAME OR PROGRAM NAME: TEAMSTER LOCAL 631	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☒ NO ☐ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on file DATE: 09/28/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: Signature on file

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: BRANDON NGUYEN	17a. 1G 17b. NPI 1508882564	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 723.1 3. 721.3 2. 721.0 4. 724.2		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J RENDERING PROVIDER ID. #
05 25 10	11		96365		1	270 00	1		NPI	1326115429
05 25 10	11		J2001		1	80 00	4		NPI	1326115429
05 25 10	11		J3475		1	14 40	4		NPI	1326115429
05 25 10	11		J1885		1	80 00	4		NPI	1326115429
05 25 10	11		J3420		1	7 50	1		NPI	1326115429
05 25 10	11		A6220		1	2 00	1		NPI	1326115429

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
880404982	☐	☒	5219836	YES ☒ NO ☐	$ 453 90	$ 144 56	$ 309 34

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (702)880-4193
SUDHIR KHEMKA, MD	LAS PAIN INSTITUTE & MEDICAL CEN	Las Vegas Pain Institute & Med Cntr, L
SIGNED: 09/28/2010 DATE	2705 W HORIZON RIDGE PKWY	4616 W. Sahara # 337
	HENDERSON NV 89052	Las Vegas NV 89102-3627
	a. 1659431443 b.	a. 1326115429 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-150000

79

APP095

ROYAL JONES MILES DUNKLEY & WILSON
1522 WEST WARM SPRINGS ROAD
HENDERSON NV 89014

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID) X	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 347669782

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
POREMBA WILLIAM M	06 30 64 M X F	POREMBA WILLIAM M
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
168 RED ARCHES COURT	Self X Spouse Child Other	168 RED ARCHES COURT
CITY: HENDERSON / STATE: NV	8. PATIENT STATUS: Single Married X Other	CITY: HENDERSON / STATE: NV
ZIP CODE: 89012 / TELEPHONE (Include Area Code): (702)263-2936	Employed Full-Time Student Part-Time Student	ZIP CODE: 89012 / TELEPHONE (Include Area Code): (702)263-2936
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): POREMBA WILLIAM M	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 347669782	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 06 30 64 M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: 06 30 64 M X F	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: ROYAL JONES MILES DUNKLEY & WILSON
d. INSURANCE PLAN NAME OR PROGRAM NAME: TEAMSTER LOCAL 631	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on file DATE: 09/28/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: Signature on file

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: BRANDON NGUYEN	17a. 1G / 17b. NPI 1508882564	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line): 1. 723.1 2. 721.0 3. 721.3 4. 724.2		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
07 21 10 07 21 10	11		99214		1234	270 00	1		NPI	1508882564
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
880404982 X	6224934	X YES NO	$ 270 00	$	$ 270 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (702)880-4193
BRANDON NGUYEN, DO SIGNED 09/28/2010 DATE	LAS PAIN INSTITUTE & MEDICAL CEN 2705 W HORIZON RIDGE PKWY HENDERSON NV 89052 a. 1659431443 b.	Las Vegas Pain Institute & Med Cntr, L 4616 W. Sahara # 337 Las Vegas NV 89102-3627 a. 1508882564 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ROYAL JONES DU EY AND WILSON 75318
2920 N GREEN VALLEY PARKWAY SUI

LAS VEGAS 89014

PICA ITM 22513465

FICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) X FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 347669782

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): POREMBA, WILLIAM M

3. PATIENT'S BIRTH DATE MM DD YY: 06 30 1964 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): POREMBA, WILLIAM M

5. PATIENT'S ADDRESS (No., Street): 168 RED ARCHES COURT

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 168 RED ARCHES COURT

CITY: HENDERSON STATE: NV

8. PATIENT STATUS: Single Married X Other; Employed Full-Time Student Part-Time Student

CITY: HENDERSON STATE: NV

ZIP CODE: 89012 TELEPHONE (Include Area Code): (702) 263-2936

ZIP CODE: 89012 TELEPHONE (Include Area Code): (702) 263-2936

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): POREMBA WILLIAM M

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 00000076637

a. EMPLOYMENT? (Current or Previous): YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 06 30 1964 SEX M X F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 06 30 1964 SEX M X F

b. AUTO ACCIDENT? YES NO X PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: ROYAL JONES DUNKLEY

d. INSURANCE PLAN NAME OR PROGRAM NAME: NV MEDICAID

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 12/06/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: BRANDON NGUYEN

17a.

17b. NPI: 1508882564

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: CORRECTED CLAIM

20. OUTSIDE LAB? YES NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 723 1
2. 721 0
3. 721 3
4. 724 2

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
07 29 10	07 29 10	11		99214		1234	270 00	1		NPI	1508882564
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 880404982 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 7282112

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 270 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 270 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
BRANDON NGUYEN, DO
SIGNED 12/06/2010 DATE

32. SERVICE FACILITY LOCATION INFORMATION
LAS PAIN INSTITUTE & MEDI
2705 W HORIZON RIDGE PKWY
HENDERSON, NV 89052
a 1659431443 b

33. BILLING PROVIDER INFO & PH # 702 227-4040
LAS VEGAS PAIN INSTITUTE
4616 W SAHARA AVE # 337
LAS VEGAS, NV 89102-3654
a 1508882564 b

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

PHYSICIAN OR SUPPLIER INFORMATION | PATIENT AND INSURED INFORMATION | CARRIER

S & C Claims Services Inc.
SUPERIOR & COMPREHENSIVE CLAIMS ADMINISTRATION

SCHREINER & COMPANY
3380 West Sahara Avenue
Suite 100
Las Vegas, NV 89102
(702) 873-5115
(800) 362-5198
FAX (702) 876-5584

December 2, 2010

Matthew S. Dunkley, Esq.
1522 W. Warm Springs Rd.
Henderson, NV 89014

RE: Poremba, William
DOI: 7/22/2005
CL: 739255
EMP: Southern Nevada Paving

Dear Mr. Dunkley:

We received your letter of 12/1/10, which was probably in response to the Bar complaint I previously submitted. I find your letter of 3/10/10 suspect at best as we had never seen this document. In addition the letter of 9/25/09 to Mr. Poremba was never sent to our office and there is no reference that it was copied to us timely in accord with NRS 616C.215.

Whether March 2010 or December 2010 it is still obvious that we were not notified timely. In addition there is still no excuse for failure to follow-up with the claim supervisor's contact with Josie in your office in June 2010 or Norma in your office failure to get us the information in October 2010 after a conversation with the claims examiner.

We also requested a copy of the settlement documents. We appreciate the information that you relayed to your client but we'd really like a copy of the actual settlement documents from the carrier or their attorney. We like to verify everything that involves a law office that has withheld required information.

The full lien at this juncture totals $9085.21. Based on the letter to the client it appears that you retained $14,963.90 to cover our lien. Please forward the full amount of the lien. If there are any questions regarding the lien amount please call me at 873-5115, ext. 11.

Sincerely,

David Oakden
Operations Manager

cc: Daniel Schwartz, Esq.
Nevada State Bar
File

Las Vegas Pain Institute & Med Cntr, LLC

4616 W. Sahara # 337
Las Vegas, NV 89102-3627
(702)880-4193

Patient Visit Record

WILLIAM M. POREMBA
168 RED ARCHES COURT
HENDERSON, NV 89012

Date/Time In: 12/11/2010 - 03:27PM

Patient ID: LVPO000052
Birth Date: 6/30/1964
Age: 46 Years, 5 Months
Sex: Male

Attending Provider: DZUNG MD, HO VIET
Vitals Recorded By: HOLLIS, TERI
Accompanied By:

Chief Complaint:
RIGHT SHOULDER, LOWER BACK AND BILATERAL LEG PAIN.

Vitals:

Height:	72in , 182.88cm (79%)	Blood Pressure:	112 / 94
Weight:	193 lbs, 87.54 kgs (88%)	Respirations:	(Not Recorded)
BMI:	26.2	Pulse:	103
Temperature:	(Not Recorded)		

Pain Management Follow-I

HISTORY OF CHIEF COMPLAINT: Patient's pain is located in the lower back bilateral legs and right shoulder. The patient describes current pain as an intermiuttent throbbing, aching, sharp shooting, dull tingling, burning numbness. Average pain is 6/10 The pain has been 6/10 during the last week. Sleeping pattern is good, Patient gets an average of 7-8 hours of jsleep per night. Appetite is good. Bowel movements are good. The patient does exercise on a regular basis. The patient does not feel tense, nervous, depressed or suicidal. The patient states the pain does interfere with activitles of daily life.

Review of Systems Follow

Current Visit: Unchanged since prior visit

Physical Exam Follow Up:

GENERAL: Well developed, well nourished, pleasant male who appears stated age, alert and orientated times three.
PALPATION: Positive for lumbar spine tenderness
IMPRESSION: Lumbar facet arthropathy
Lumbar radiculopathy
Cervicalgia
Cervical radiculopathy
left knee pain status post arthropathy

S & C CLAIMS
JAN 21
RECEIVED

Problem List:

LUMBAGO
CERVICALGIA
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
CERVICALGIA
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
DYSFUNCTION, SACRAL REGION
PAIN IN JOINT SHOULDER
CERVICALGIA
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
CERVICAL SPONDYLOSIS WO MYELOPATHY
LUMBOSACRAL SPONDYLOSIS
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL

Las Vegas Pain Institute & Med Cntr, LLC
4616 W. Sahara # 337
Las Vegas, NV 89102-3627
(702)880-4193

Patient Visit Record

WILLIAM M. POREMBA
168 RED ARCHES COURT
HENDERSON, NV 89012

Date/Time In: 12/11/2010 - 03:27PM

Patient ID:	LVPO000052
Birth Date:	6/30/1964
Age:	46 Years, 5 Months
Sex:	Male

OTH/ DISC DIS CERVICAL REGION
OTH/ DISC DIS THORACIC REGION
CERVICAL SPONDYLOSIS WO MYELOPATHY
BRACHIAL NEURITIS/RADICULITIS NOS
DYSFUNCTION, SACRAL REGION
LUMBOSACRAL SPONDYLOSIS
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
DEGENERATION CERVICAL IV DISC
DEGENER LUMBAR/LUMBOSACRAL IV DISC
CERVICAL SPONDYLOSIS WO MYELOPATHY
LUMBOSACRAL SPONDYLOSIS
BRACHIAL NEURITIS/RADICULITIS NOS
DEGENERATION CERVICAL IV DISC
DEGENER LUMBAR/LUMBOSACRAL IV DISC
CERVICAL SPONDYLOSIS WO MYELOPATHY
LUMBOSACRAL SPONDYLOSIS
BRACHIAL NEURITIS/RADICULITIS NOS
DYSFUNCTION, SACRAL REGION
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL

Diagnostic Studies:

Assessments:
Lumbar facet arthropathy
Lumbar radiculopathy
Cervicalgia
Cervical radiculopathy
left knee pain status post arthropathy

723.4	BRACHIAL NEURITIS/RADICULITIS NOS
724.2	LUMBAGO

Plan:
Continue home exercise
Medication management
MS Contin 15mg t po bid #60
Lyrica 75mg t po q12 #60
Follow up 1 month or sooner as needed
Discussed medications risks, benefits, product information, and narcotic agreement, in addition the benefits and risks of the procedures were discussed with the patent. The Patient verbalized understanding of all these risks and benefits and wishes to proceed.
Discussed narcotics. Discussed NSAIDS. Discussed steroids.

Procedures:

Las Vegas Pain Institute & Med Cntr, LLC
4616 W. Sahara # 337
Las Vegas, NV 89102-3627
(702)880-4193

Patient Visit Record

WILLIAM M. POREMBA
168 RED ARCHES COURT
HENDERSON, NV 89012

Date/Time In: 12/11/2010 - 03:27PM

Patient ID: LVPO000052
Birth Date: 6/30/1964
Age: 46 Years, 5 Months
Sex: Male

99214 OFFICE/OP VISIT, EST PT, 2 KEY COMPONENT

Chronic Medications:

MS Contin Start Date: 2/24/2010
Dose: 15, Frequency: 2x Daily, Dispense: 45 Tablets, Refill: 0
Oxycodone Start Date: 2/24/2010
Dose: 30, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
Lyrica Start Date: 2/24/2010
Dose: 75, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Lyrica Start Date: 1/27/2010
Dose: 75, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
MS Contin Start Date: 1/27/2010
Dose: 15, Frequency: 2x Daily, Dispense: 45 Tablets, Refill: 0
Oxycodone Start Date: 1/27/2010
Dose: 30, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
Lyrica Start Date: 12/31/2009
Dose: 75, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
MS Contin Start Date: 12/31/2009
Dose: 15, Frequency: 2x Daily, Dispense: 45 Tablets, Refill: 0
Oxycodone Start Date: 12/31/2009
Dose: 30, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
MS Contin Start Date: 12/8/2009
Dose: 15, Frequency: 2x Daily, Dispense: 45 Tablets, Refill: 0
Lyrica Start Date: 12/8/2009
Dose: 75, Frequency: 2x Daily, Dispense: 45 Tablets, Refill: 0
Oxycodone Start Date: 12/2/2009
Dose: 30, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
MS Contin Start Date: 11/9/2009
Dose: 15, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Lyrica Start Date: 11/9/2009
Dose: 50, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Lyrica Start Date: 11/9/2009
Dose: 50, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Oxycodone Start Date: 10/7/2009
Dose: 30, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
Oxycodone Start Date: 9/7/2009
Dose: 30, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
Oxycodone Start Date: 8/24/2009
Dose: 30, Frequency: Every 6 hrs., Dispense: 60 Tablets, Refill: 0
Oxycodone Start Date: 8/3/2009
Dose: 15, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
MS Contin Start Date: 8/3/2009
Dose: 15, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Lyrica Start Date: 8/3/2009
Dose: 50, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Lyrica Start Date: 6/23/2009
Dose: 50, Frequency: 2x Daily, Dispense: 30 Tablets, Refill: 0
MS Contin Start Date: 6/23/2009
Dose: 15, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Oxycodone Start Date: 6/23/2009
Dose: 15, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
MS Contin Start Date: 6/11/2009
Dose: 15, Frequency: 2x Daily, Dispense: 30 Tablets, Refill: 0
Oxycodone Start Date: 6/8/2009

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Patient Visit Record

WILLIAM M. POREMBA
168 RED ARCHES COURT
HENDERSON, NV 89012

Date/Time In: 12/11/2010 - 03:27PM

Patient ID: LVPO000052
Birth Date: 6/30/1964
Age: 46 Years, 5 Months
Sex: Male

Dose: 15, Frequency: Every 6 hrs., Dispense: 60 Tablets, Refill: 0
MS Contin Start Date: 6/1/2009
Dose: 15, Frequency: 2x Daily, Dispense: 30 Tablets, Refill: 0
Gabapentin Start Date: 5/28/2009
Dose: 800, Frequency: 3x Daily, Dispense: 45 Tablets, Refill: 0
Gabapentin Start Date: 5/12/2009
Dose: 300, Frequency: 3x Daily, Dispense: 90 Tablets, Refill: 0
Percocet Start Date: 5/5/2009
Dose: 10/325, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0

Acute Medications:

Lyrica Date: 11/9/2009
Dose: 50, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0

Signature: _____ Date: 12/11/2010

Las Vegas Pain Institute & Med Cntr, LLC

4616 W. Sahara # 337
Las Vegas, NV 89102-3627
(702)880-4193

Patient Visit Record

WILLIAM M. POREMBA
168 RED ARCHES COURT
HENDERSON, NV 89012

Date/Time In: 1/11/2011 - 11:25AM

Patient ID: LVPO000052
Birth Date: 6/30/1964
Age: 46 Years, 6 Months
Sex: Male

Attending Provider: KHEMKA, MD, SUDHIR
Vitals Recorded By: HOOKER, SONJA J.
Accompanied By:

Chief Complaint:
LEFT KNEE, NECK AND LOW BACK PAIN

Vitals:

Height:	70in , 177.8cm (54%)	Blood Pressure:	118 / 79
Weight:	193 lbs, 87.54 kgs (88%)	Respirations:	(Not Recorded)
BMI:	27.7	Pulse:	95
Temperature:	(Not Recorded)		

Pain Management Follow-I

HISTORY OF CHIEF COMPLAINT: The patient returns to the clinic today for a follow up. Patient's pain is located in the above ilsted areas. The patient describes current pain as throbbing, burning, aching, numbnesss, sharp, duli, shooting, continuous, tingling and intermittent. Current pain level is 5/10. Sleeping pattern is good. Patient states he gets about 7-8 hours of sleep per night. Appetite is good. Bowel movements are poor. Patient states he feels constipated. The patient was counseled on laxatives. Patient has no bowel or bladd incontinence. No new neurological symptoms. The patient does exercise on a regular basis. The patient does not feel tense, nervous, depressed or sulcidal. The patient states the pain does interfere with activities of daily life.

Review of Systems Follow

Current Visit: Negative except for constipation

Physical Exam Follow Up:

GENERAL: Well developed, well nourished, pleasant male who appears stated age, alert and orientated times three.

PALPATION: Positive for cervical spine and lumbar spine tenderness

MECHANICAL: Lumbar spine with decreased range of motion with bilateral facet loading signs

MUSCULOSKELETAL: Normal curvature of the spine. Normal relexes patella right and left 2+ bilaterally, biceps 2+ bilaterally, right upper extremity flexion and extension 2+, left upper extremity flexion and extension 2+, right lower extremity flexion 2+, left lower extremity flexion 2+, Fabre's right and left is negative, Right straight leg raising and left straight leg raising negative bilaterally,

-JOINT EXAM: Full ROM without tenderness, heat, erythema, or swelling.

Free from crepitus

SENSORY: Lumbar sensory dermatomes intact and symmetrical to light touch. Cervical sensory dermatomes intact and symmetrical to light touch. Thorasic sensory dermatomes intact and symmetrical to light touch.

S & C CLAIMS
JAN
RECEIVED

Problem List:

LUMBAGO
CERVICALGIA
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
CERVICALGIA
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
DYSFUNCTION, SACRAL REGION

Las Vegas Pain Institute & Med Cntr, LLC
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WILLIAM M. POREMBA
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Date/Time In: 1/11/2011 - 11:25AM

Patient ID: LVPO000052
Birth Date: 6/30/1964
Age: 46 Years, 6 Months
Sex: Male

PAIN IN JOINT SHOULDER
CERVICALGIA
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
CERVICAL SPONDYLOSIS WO MYELOPATHY
LUMBOSACRAL SPONDYLOSIS
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
OTH/ DISC DIS CERVICAL REGION
OTH/ DISC DIS THORACIC REGION
CERVICAL SPONDYLOSIS WO MYELOPATHY
BRACHIAL NEURITIS/RADICULITIS NOS
DYSFUNCTION, SACRAL REGION
LUMBOSACRAL SPONDYLOSIS
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
DEGENERATION CERVICAL IV DISC
DEGENER LUMBAR/LUMBOSACRAL IV DISC
CERVICAL SPONDYLOSIS WO MYELOPATHY
LUMBOSACRAL SPONDYLOSIS
BRACHIAL NEURITIS/RADICULITIS NOS
DEGENERATION CERVICAL IV DISC
DEGENER LUMBAR/LUMBOSACRAL IV DISC
CERVICAL SPONDYLOSIS WO MYELOPATHY
LUMBOSACRAL SPONDYLOSIS
BRACHIAL NEURITIS/RADICULITIS NOS
DYSFUNCTION, SACRAL REGION
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL
BRACHIAL NEURITIS/RADICULITIS NOS
UNS THORACIC/LUMB NEURITIS/RADICUL

Diagnostic Studies:

Assessments:
Lumbar facet arthropathy
Lumbar radiculopathy
Cervicalgia
Cervical radiculopathy
Left knee, status post arthropathy

721.3	LUMBOSACRAL SPONDYLOSIS
724.2	LUMBAGO
723.4	BRACHIAL NEURITIS/RADICULITIS NOS
724.4	UNS THORACIC/LUMB NEURITIS/RADICUL

Plan:
Continue home exercises/physical therapy
Follow up 1 month or sooner as needed

Las Vegas Pain Institute & Med Cntr, LLC
4616 W. Sahara # 337
Las Vegas, NV 89102-3627
(702)880-4193

Patient Visit Record

WILLIAM M. POREMBA
168 RED ARCHES COURT
HENDERSON, NV 89012

Date/Time In: 1/11/2011 - 11:25AM

Patient ID:	LVPO000052
Birth Date:	6/30/1964
Age:	46 Years, 6 Months
Sex:	Male

Oxycodone 30mg 1 tablet every 6 hours as needed for pain #120
Lidoderm patch 5% 1 patch every 12 hours as needed #30
MS Contin 15mg 1 tablet every 12 hours #60
Lyrica 75mg 1 tablet every 12 hours #60
Discussed medications risks, benefits, product information, and narcotic agreement, in addition the benefits and risks of the procedures were discussed with the patent. The Patient verbalized understanding of all these risks and benefits and wishes to proceed.
Discussed narcotics. Discussed NSAIDS. Discussed steroids.

Seen by Lynda Le, PA-C with Sudhir S. Khemka, MD

Procedures:
99214 OFFICE/OP VISIT, EST PT, 2 KEY COMPONENT

Chronic Medications:

MS Contin Start Date: 2/24/2010
Dose: 15, Frequency: 2x Daily, Dispense: 45 Tablets, Refill: 0
Oxycodone Start Date: 2/24/2010
Dose: 30, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
Lyrica Start Date: 2/24/2010
Dose: 75, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Lyrica Start Date: 1/27/2010
Dose: 75, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
MS Contin Start Date: 1/27/2010
Dose: 15, Frequency: 2x Daily, Dispense: 45 Tablets, Refill: 0
Oxycodone Start Date: 1/27/2010
Dose: 30, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
Lyrica Start Date: 12/31/2009
Dose: 75, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
MS Contin Start Date: 12/31/2009
Dose: 15, Frequency: 2x Daily, Dispense: 45 Tablets, Refill: 0
Oxycodone Start Date: 12/31/2009
Dose: 30, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
MS Contin Start Date: 12/8/2009
Dose: 15, Frequency: 2x Daily, Dispense: 45 Tablets, Refill: 0
Lyrica Start Date: 12/8/2009
Dose: 75, Frequency: 2x Daily, Dispense: 45 Tablets, Refill: 0
Oxycodone Start Date: 12/2/2009
Dose: 30, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
MS Contin Start Date: 11/9/2009
Dose: 15, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Lyrica Start Date: 11/9/2009
Dose: 50, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Lyrica Start Date: 11/9/2009
Dose: 50, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Oxycodone Start Date: 10/7/2009
Dose: 30, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
Oxycodone Start Date: 9/7/2009
Dose: 30, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
Oxycodone Start Date: 8/24/2009
Dose: 30, Frequency: Every 6 hrs., Dispense: 60 Tablets, Refill: 0
Oxycodone Start Date: 8/3/2009
Dose: 15, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0

Las Vegas Pain Institute & Med Cntr, LLC
4616 W. Sahara # 337
Las Vegas, NV 89102-3627
(702)880-4193

Patient Visit Record

WILLIAM M. POREMBA
168 RED ARCHES COURT
HENDERSON, NV 89012

Date/Time In: 1/11/2011 - 11:25AM

Patient ID:	LVPO000052
Birth Date:	6/30/1964
Age:	46 Years, 6 Months
Sex:	Male

MS Contin Start Date: 8/3/2009
Dose: 15, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Lyrica Start Date: 8/3/2009
Dose: 50, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Lyrica Start Date: 6/23/2009
Dose: 50, Frequency: 2x Daily, Dispense: 30 Tablets, Refill: 0
MS Contin Start Date: 6/23/2009
Dose: 15, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0
Oxycodone Start Date: 6/23/2009
Dose: 15, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0
MS Contin Start Date: 6/11/2009
Dose: 15, Frequency: 2x Daily, Dispense: 30 Tablets, Refill: 0
Oxycodone Start Date: 6/8/2009
Dose: 15, Frequency: Every 6 hrs., Dispense: 60 Tablets, Refill: 0
MS Contin Start Date: 6/1/2009
Dose: 15, Frequency: 2x Daily, Dispense: 30 Tablets, Refill: 0
Gabapentin Start Date: 5/28/2009
Dose: 800, Frequency: 3x Daily, Dispense: 45 Tablets, Refill: 0
Gabapentin Start Date: 5/12/2009
Dose: 300, Frequency: 3x Daily, Dispense: 90 Tablets, Refill: 0
Percocet Start Date: 5/5/2009
Dose: 10/325, Frequency: Every 6 hrs., Dispense: 120 Tablets, Refill: 0

Acute Medications:

Lyrica Date: 11/9/2009
Dose: 50, Frequency: 2x Daily, Dispense: 60 Tablets, Refill: 0

Signature: _____ Date: 1/11/2011

S & C CLAIMS
JAN 21
RECEIVED

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:

WILLIAM POREMBA
168 RED ARCHES CT
HENDERSON, NV 89012-6004

/

Hearing Number: 82071-DH
Claim Number: 739255

SOUTHERN NEVADA PAVING
3101 CRAIG RD
N LAS VEGAS, NV 89030

The Claimant's request for hearing was filed on December 16, 2010 and a hearing was scheduled for January 4, 2011. The hearing was continued, rescheduled and heard on February 24, 2011, in accordance with Chapters 616 and 617 of the Nevada Revised Statutes.

The Claimant was present. The Claimant was represented by SCOTT PETTIT ESQ. The Employer was not present. The Self Insured Employer (SIE) was represented by ALYSSA M FISCHER ESQ.

ISSUE

The Claimant appealed the determination of S & C CLAIMS SERVICES INC dated November 8, 2010.

The issue before the Hearing Officer is REOPENING.

DECISION AND ORDER

Based on information presented the determination is proper and hereby AFFIRMED.

> **NRS 616C.390(1)** {NRS 616.545(1)} provides if application to reopen a claim to increase or rearrange compensation is made in writing more than 1 year after the date of claim closure, the insurer shall reopen the claim if a change of circumstances warrants an increase or rearrangement of compensation during the life of an injured employee, the primary cause of the change of circumstances is the injury for which the claim was originally made, and the application is accompanied by the certificate of a physician or chiropractor showing a change of circumstances which would warrant an increase or rearrangement of compensation.

NRS 616C.215 Actions and proceedings to recover damages in tort or from proceeds of vehicle insurance: Reduction of compensation by amount of recovery; rights of injured employee or dependents and of insurer or Administrator; notification and payment of insurer or Administrator; instructions to jury; calculation of employer's premium.

1. If an injured employee or, in the event of his or her death, the dependents of the employee, bring an action in tort against his or her employer to recover payment for an injury which is compensable pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS and, notwithstanding the provisions of NRS 616A.020, receive payment from the employer for that injury:

(a) The amount of compensation the injured employee or the dependents of the employee are entitled to receive pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, including any future compensation, must be reduced by the amount paid by the employer.

(b) The insurer, or in the case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, has a lien upon the total amount paid by the employer if the injured employee or the dependents of the employee receive compensation pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS.

This subsection is applicable whether the money paid to the employee or the dependents of the employee by the employer is classified as a gift, a settlement or otherwise. The provisions of this subsection do not grant to an injured employee any right of action in tort to recover damages from the employer for the injury.

2. When an employee receives an injury for which compensation is payable pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS and which was caused under circumstances creating a legal liability in some person, other than the employer or a person in the same employ, to pay damages in respect thereof:

(a) The injured employee, or in case of death the dependents of the employee, may take proceedings against that person to recover damages, but the amount of the compensation the injured employee or the dependents of the employee are entitled to receive pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, including any future compensation, must be reduced by the amount of the damages recovered, notwithstanding any act or omission of the employer or a person in the same employ which was a direct or proximate cause of the employee's injury.

(b) If the injured employee, or in case of death the dependents of the employee, receive compensation pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, the insurer, or in case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, has a right of action against the person so liable to pay damages and is subrogated to the rights of the injured employee or of the employee's dependents to recover therefor.

3. When an injured employee incurs an injury for which compensation is payable pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS and which was caused under circumstances entitling the employee, or in the case of death the dependents of the employee, to receive proceeds under his or her employer's policy of uninsured or underinsured vehicle coverage:

(a) The injured employee, or in the case of death the dependents of the employee, may take proceedings to recover those proceeds, but the amount of compensation the injured employee or the dependents of the employee are entitled to receive pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, including any future compensation, must be reduced by the amount of proceeds received.

(b) If an injured employee, or in the case of death the dependents of the employee, receive compensation pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of

NRS, the insurer, or in the case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, is subrogated to the rights of the injured employee or the dependents of the employee to recover proceeds under the employer's policy of uninsured or underinsured vehicle coverage. The insurer and the Administrator are not subrogated to the rights of an injured employee or the dependents of the employee under a policy of uninsured or underinsured vehicle coverage purchased by the employee.

(c) Any provision in the employer's policy of uninsured or underinsured vehicle coverage which has the effect of:

(1) Limiting the rights of the injured employee or the dependents of the employee to recover proceeds under the policy because of the receipt of any compensation pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS;

(2) Limiting the rights of subrogation of the insurer or Administrator provided by paragraph (b); or

(3) Excluding coverage which inures to the direct or indirect benefit of the insurer or Administrator,

➥ is void.

4. In any action or proceedings taken by the insurer or the Administrator pursuant to this section, evidence of the amount of compensation, accident benefits and other expenditures which the insurer, the Uninsured Employers' Claim Account or a subsequent injury account have paid or become obligated to pay by reason of the injury or death of the employee is admissible. If in such action or proceedings the insurer or the Administrator recovers more than those amounts, the excess must be paid to the injured employee or the dependents of the employee.

5. In any case where the insurer or the Administrator is subrogated to the rights of the injured employee or of the employee's dependents as provided in subsection 2 or 3, the insurer or the Administrator has a lien upon the total proceeds of any recovery from some person other than the employer, whether the proceeds of such recovery are by way of judgment, settlement or otherwise. The injured employee, or in the case of his or her death the dependents of the employee, are not entitled to double recovery for the same injury, notwithstanding any act or omission of the employer or a person in the same employ which was a direct or proximate cause of the employee's injury.

6. The lien provided for pursuant to subsection 1 or 5 includes the total compensation expenditure incurred by the insurer, the Uninsured Employers' Claim Account or a subsequent injury account for the injured employee and the dependents of the employee.

7. An injured employee, or in the case of death the dependents of the employee, or the attorney or representative of the injured employee or the dependents of the employee, shall notify the insurer, or in the case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, in writing before initiating a proceeding or action pursuant to this section.

8. Within 15 days after the date of recovery by way of actual receipt of the proceeds of the judgment, settlement or otherwise:

(a) The injured employee or the dependents of the employee, or the attorney or representative of the injured employee or the dependents of the employee; and

(b) The third-party insurer,

➥ shall notify the insurer, or in the case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, of the recovery and pay to the insurer

or the Administrator, respectively, the amount due pursuant to this section together with an itemized statement showing the distribution of the total recovery. The attorney or representative of the injured employee or the dependents of the employee and the third-party insurer are jointly and severally liable for any amount to which an insurer is entitled pursuant to this section if the attorney, representative or third-party insurer has knowledge of the lien provided for in this section.

9. An insurer shall not sell its lien to a third-party insurer unless the injured employee or the dependents of the employee, or the attorney or representative of the injured employee or the dependents of the employee, refuses to provide to the insurer information concerning the action against the third party.

10. In any trial of an action by the injured employee, or in the case of his or her death by the dependents of the employee, against a person other than the employer or a person in the same employ, the jury must receive proof of the amount of all payments made or to be made by the insurer or the Administrator. The court shall instruct the jury substantially as follows:

> Payment of workmen's compensation benefits by the insurer, or in the case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, is based upon the fact that a compensable industrial accident occurred, and does not depend upon blame or fault. If the plaintiff does not obtain a judgment in his or her favor in this case, the plaintiff is not required to repay his or her employer, the insurer or the Administrator any amount paid to the plaintiff or paid on the behalf of the plaintiff by the plaintiff's employer, the insurer or the Administrator.
>
> If you decide that the plaintiff is entitled to judgment against the defendant, you shall find damages for the plaintiff in accordance with the court's instructions on damages and return your verdict in the plaintiff's favor in the amount so found without deducting the amount of any compensation benefits paid to or for the plaintiff. The law provides a means by which any compensation benefits will be repaid from your award.

11. To calculate an employer's premium, the employer's account with the private carrier must be credited with an amount equal to that recovered by the private carrier from a third party pursuant to this section, less the private carrier's share of the expenses of litigation incurred in obtaining the recovery, except that the total credit must not exceed the amount of compensation actually paid or reserved by the private carrier on the injured employee's claim.

12. As used in this section, "third-party insurer" means an insurer that issued to a third party who is liable for damages pursuant to subsection 2, a policy of liability insurance the proceeds of

which are recoverable pursuant to this section. The term includes an insurer that issued to an employer a policy of uninsured or underinsured vehicle coverage.

IT IS SO ORDERED this 7 day of March, 2011.

Daphne L Hodge
Hearing Officer

APPEAL RIGHTS

Pursuant to NRS 616C.345(1), should any party desire to appeal this final decision of the Hearing Officer, a request for appeal must be filed with Appeals Officer within thirty (30) days after the date of the decision by the Hearing Officer.

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Hearings Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing DECISION AND ORDER was duly mailed, postage prepaid OR placed in the appropriate addressee runner file at the Department of Administration, Hearings Division, 2200 S. Rancho Drive., #210, Las Vegas, Nevada, to the following:

WILLIAM POREMBA
168 RED ARCHES CT
HENDERSON NV 89012-6004

MATTHEW S DUNKLEY ESQ
1522 W WARM SPRINGS RD
HENDERSON NV 89014

SOUTHERN NEVADA PAVING
3101 CRAIG RD
N LAS VEGAS NV 89030

S & C CLAIMS SERVICES INC
3380 W SAHARA AVE STE 100
LAS VEGAS NV 89102

ALYSSA M FISCHER ESQ,
LEWIS BRISBOIS BISGAARD & SMITH LLP
400 S FOURTH ST STE 500
LAS VEGAS NV 89101

Dated this 7 day of March, 2011.

Ava B. Tucker
Employee of the State of Nevada

23 P.3d 255
117 Nev. 421

EMPLOYERS INSURANCE COMPANY OF NEVADA, a Mutual Company, f/k/a Employers Insurance Company of Nevada, an Agency of the State of Nevada, Appellant,
v.
Harry CHANDLER, Respondent.

No. 35079.
Supreme Court of Nevada.
May 24, 2001.

[23 P.3d 256]

Shirley D. Lindsey, Associate General Counsel, Employers Insurance Company of Nevada, Las Vegas, for Appellant.

Nancyann Leeder, Nevada Attorney for Injured Workers, and Gary T. Watson, Deputy Nevada Attorney for Injured Workers, Carson City, for Respondent.

Before YOUNG, LEAVITT and BECKER, JJ.

OPINION

PER CURIAM:

Respondent Harry Chandler sustained injuries in a motor vehicle accident that occurred during the course of his employment. Appellant Employers Insurance Company of Nevada (EICON) paid Chandler workers' compensation benefits and eventually closed his claim. After receiving a third-party settlement and reimbursing EICON for benefits paid, Chandler later requested EICON to reopen his workers' compensation claim. EICON denied Chandler's request on the basis that he was required to exhaust the third-party settlement proceeds before it could reopen his claim. EICON's denial was upheld by a hearing officer, but reversed by an appeals officer. The district court subsequently denied EICON's petition for judicial review. On appeal, EICON contends that Chandler is not entitled to receive further workers' compensation benefits, including medical benefits, without first exhausting the entire amount of his third-party settlement proceeds because the term "compensation" in NRS 616C.215 includes payment of medical expenses. We agree and reverse the order of the district court denying the petition for judicial review.

FACTS

Chandler, an employee of Greyhound Lines, Inc., was injured in the course of his employment when the bus he was driving was involved in a motor vehicle accident. The accident was caused by a third-party driver whose vehicle collided head-on with the bus in Kingman, Arizona. Chandler sustained injuries to his left knee and right toe. He also suffered post-traumatic stress disorder

[23 P.3d 257]

as a result of the collision, which killed the third-party driver and his passenger. EICON paid Chandler workers' compensation benefits amounting to $3,267.46 before closing his claim.

Chandler also pursued a claim against the third-party driver's insurer. That case was settled for $7,267.46, and Chandler received $4,000.00 in damages after reimbursing EICON the $3,267.46 in benefits out of the settlement proceeds.

Thereafter, Chandler requested EICON to reopen his claim for further psychological therapy because he continued to experience symptoms of post-traumatic stress disorder following the accident. EICON advised Chandler that he would have to exhaust the third-party settlement proceeds before it would

reopen his workers' compensation claim. Chandler challenged EICON's decision, and the hearing officer affirmed. Chandler appealed. The appeals officer concluded that Chandler was entitled to receive medical benefits without first exhausting the entire amount of the third-party settlement proceeds because the term "compensation" in NRS 616C.215 includes wage replacement benefits but does not include medical benefits. The district court subsequently denied EICON's petition for judicial review after concluding that substantial evidence supported the appeals officer's decision.

DISCUSSION

The question before this court is one of statutory construction, namely, whether the appeals officer properly interpreted the workers' compensation statutes applicable to this case. Questions of law are reviewed de novo.[1] "[A] reviewing court may undertake independent review of the administrative construction of a statute."[2]

NRS 616C.215 grants subrogation rights to workers' compensation insurers and allows them to place liens upon the proceeds recovered by employees from third-party tortfeasors.[3] In particular, subsection 2 provides in relevant part:

> 2. When an employee receives an injury for which compensation is payable pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS and which was caused under circumstances creating a legal liability in some person, other than the employer or a person in the same employ, to pay damages in respect thereof:
>
> (a) The injured employee, or in case of death his dependents, may take proceedings against that person to recover damages, but the amount of the compensation the injured employee or his dependents are entitled to receive pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, including any future compensation, must be reduced by the amount of the damages recovered, notwithstanding any act or omission of the employer or a person in the same employ which was a direct or proximate cause of the employee's injury.[4]

EICON contends that the plain language of NRS 616C.215(2)(a) entitles it to deny Chandler further medical benefits for his work-related injury until he has exhausted his third-party settlement proceeds because, for purposes of NRS 616C.215(2)(a), NRS 616A.090 defines "compensation" to include accident benefits which, according to the express language of NRS 616A.035, includes medical benefits.[5] Chandler contends,

[23 P.3d 258]

however, that the term "compensation" in NRS 616C.215(2)(a) does not include medical benefits because the phrase "money which is payable to an employee or to his dependents" in NRS 616A.090 limits the statutory definition of "compensation" to wage replacement benefits.

When more than one interpretation of a statute can reasonably be drawn from its language, it is ambiguous and the plain meaning rule has no application.[6] However, when the language of a statute is plain and unambiguous, a court should give that language its ordinary meaning and not go beyond it.[7] "Under long established principles of statutory construction, when a statute is susceptible to but one natural or honest construction, that alone is the construction that can be given."[8] Additionally, courts must construe statutes to give meaning to all of their parts and language, and this court will read each sentence, phrase, and word to render it meaningful within the context of the purpose of the legislation.[9]

We do not read the phrase "payable to an employee or to his dependents" in NRS 616A.090 as Chandler reads it. To the contrary, the word "payable" simply means "due" and does not limit the definition of compensation in NRS 616C.215 to money disbursed directly to an employee or to his dependents.[10] In fact, when read within the context of NRS 616A.035, NRS 616A.090, and NRS 617.130, the term "compensation" in NRS 616C.215 clearly and unambiguously includes medical benefits. Further, the contemplated purpose of NRS 616C.215 is to make the insurer whole and to prevent an employee from receiving an impermissible double recovery.[11] Defining the term "compensation" in NRS 616C.215 to include medical benefits prevents an employee from receiving a double recovery. Thus, the plain meaning of NRS 616C.215(2)(a) is consistent with the purpose of the statute.

CONCLUSION

We conclude that an insurer is entitled to withhold payment of medical benefits for a work-related injury until an employee has exhausted any third-party settlement proceeds because the plain meaning of the term "compensation" in NRS 616C.215 includes medical benefits. Accordingly, we reverse the district court's order denying the petition for judicial review and remand this matter to the district court. On remand, the district court shall grant the petition and reverse the appeals officer's decision that Chandler is not required to exhaust his settlement proceeds before receiving medical benefits.

Notes:

1. SIIS v. United Exposition Services Co., 109 Nev. 28, 30, 846 P.2d 294, 295 (1993).

2. American Int'l Vacations v. MacBride, 99 Nev. 324, 326, 661 P.2d 1301, 1302 (1983).

3. See NRS 616C.215.

4. NRS 616C.215(2)(a).

5. NRS 616A.090 provides:

"Compensation" means the money which is payable to an employee or to his dependents as provided for in chapters 616A to 616D, inclusive, of NRS, and includes benefits for funerals, accident benefits and money for rehabilitative services.

NRS 616A.035 provides in relevant part:

1. "Accident benefits" means medical, surgical, hospital or other treatments, nursing, medicine, medical and surgical supplies, crutches and apparatuses, including prosthetic devices.

2. The term includes:

(a) Medical benefits as defined by NRS 617.130.

NRS 617.130 provides in relevant part:

1. "Medical benefits" means medical, surgical, hospital or other treatments, nursing, medicine, medical and surgical supplies, crutches and apparatus, including prosthetic devices.

6. Hotel Employees v. State, Gaming Control Bd., 103 Nev. 588, 591, 747 P.2d 878, 880 (1987).

7. See City Council of Reno v. Reno Newspapers, 105 Nev. 886, 891, 784 P.2d 974, 977 (1989).

8. Randono v. CUNA Mutual Ins. Group, 106 Nev. 371, 374, 793 P.2d 1324, 1326 (1990) (citations omitted).

9. Bd. of County Comm'rs v. CMC of Nevada, 99 Nev. 739, 744, 670 P.2d 102, 105 (1983).

10. See Random House Webster's College Dictionary 957 (2d ed.1997).

11. See NRS 616C.215; see also Breen v. Caesars Palace, 102 Nev. 79, 82, 715 P.2d 1070, 1072 (1986).

FILED

APR 05 2011

APPEALS OFFICE

BEFORE THE APPEALS OFFICER

In the Matter of the Contested Industrial Insurance Claim of:

WILLIAM POREMBA,

Claimant.

Claim No: 739255

Appeal No: 85272-MM

HO: 82671-DH

NOTICE OF APPEAL AND ORDER TO APPEAR

1. **ALL PARTIES IN INTEREST ARE HEREBY NOTIFIED** that a hearing will be held on a **STACKED CALENDAR** by the Appeals Officer, pursuant to NRS 616 and 617 on:

   DATE: MAY 19, 2011
   TIME: 9:30AM STACKED
   PLACE: DEPT OF ADMINISTRATION, HEARINGS DIVISION
   2200 SOUTH RANCHO DRIVE, SUITE 220
   LAS VEGAS NV 89102

2. The **INSURER** shall comply with NAC 616C.300 for the provision of documents in the Claimant's file relating to the matter on appeal.

3. **ALL PARTIES** shall comply with NAC 616C.297 for the filing and serving of information to be considered on appeal.

4. **Pursuant to NRS 239B.030(4), any document/s filed with this agency must have all social security numbers redacted or otherwise removed and an affirmation to this effect must be attached. The documents otherwise may be rejected by the Hearings Division.**

5. Pursuant to NRS 616C.282, any party failing to comply with NAC 616C.274-.336 shall be subject to the Appeals Officer's orders as are necessary to direct the course of the Hearing.

6. In the event that all parties to this action agree to have the matter RE-SCHEDULED AND SET FOR A DATE AND TIME CERTAIN, you are hereby required to submit AT LEAST TWO (2) DAYS prior to the scheduled Hearing date a written request, submitted by letter, facsimile or by email, to the Appeals Office advising the Appeals Office that all parties to the action have agreed to remove the action from the Stacked Calendar. A continuance of the hearing date also may be obtained pursuant to NAC 616C.318. The matter will otherwise proceed as scheduled on the STACKED CALENDAR ON A TIME AVAILABLE BASIS.

7. The injured employee may be represented by a private attorney or seek assistance and advice from the Nevada Attorney for Injured Workers.

IT IS SO ORDERED this 5th day of April, 2011.

MICHELLE L MORGANDO, ESQ.
APPEALS OFFICER

30833-117

100

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Hearings Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing **NOTICE OF APPEAL AND ORDER TO APPEAR** was duly mailed, postage prepaid **OR** placed in the appropriate addressee runner file at the Department of Administration, Hearings Division, 2200 S. Rancho Drive, #220, Las Vegas, Nevada, to the following:

WILLIAM POREMBA
168 RED ARCHES CT
HENDERSON NV 89012-6004

MATTHEW S DUNKLEY ESQ
ROYAL JONES DUNKLEY & WILSON
1522 W WARM SPRINGS RD
HENDERSON NV 89014

SOUTHERN NEVADA PAVING
3101 E CRAIG RD
N LAS VEGAS NV 89030

S & C CLAIMS SERVICES INC
3380 W SAHARA AVE STE 100
LAS VEGAS NV 89102

ALYSSA M FISCHER ESQ
LEWIS BRISBOIS BISGAARD & SMITH LLP
400 S FOURTH ST STE 500
LAS VEGAS NV 89101

Dated this 5th day of April, 2011.

Estela Pinedo, Legal Secretary II
Employee of the State of Nevada

REQUEST FOR HEARING BEFORE THE APPEALS OFFICER
NEVADA DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:

WILLIAM POREMBA
168 RED ARCHES CT
HENDERSON, NV 89012-6004

Hearing Number: 82071-DH
Claim Number: 739255

SOUTHERN NEVADA PAVING
3101 CRAIG RD
N LAS VEGAS, NV 89030

I WISH TO APPEAL THE HEARING OFFICER DECISION DATED: 03-07-11

(Please attach a copy of the Hearing Officer's Decision)

PERSON REQUESTING APPEAL: (circle one) CLAIMANT/EMPLOYER/INSURER

REASON FOR APPEAL: DISAGREE WITH HEARING OFFICER'S DECISION

If you are represented by an attorney or other agent, please print the name and address below.

MATTHEW S. DUNKLEY, ESQ.
Name of Attorney or Representative

1522 W. WARM SPRINGS RD.
Address

HENDERSON, NV 89014
City, State, Zip Code

(702) 471-6777
Telephone Number

MATTHEW S. DUNKLEY
Person requesting this hearing (please print)

Person requesting this hearing (signature)

(702) 471-6777 03-30-11
Telephone Number Date

NOTICE

If the Hearing Officer Decision is appealed, CLAIMANTS are entitled to free legal representation by the Nevada Attorney for Injured Workers (NAIW). If you want NAIW to represent you, please sign below:

Signature Telephone Number

If you are appealing the Hearing Officer's decision, file this form no later than thirty (30) days after that decision at:

NEVADA DEPARTMENT OF ADMINISTRATION
APPEALS OFFICE
2200 S RANCHO DRIVE, SUITE 220
LAS VEGAS, NV 89102
(702) 486-2527

102-
85272 APP118

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:	Hearing Number: 82071-DH Claim Number: 739255
WILLIAM POREMBA 168 RED ARCHES CT HENDERSON, NV 89012-6004	SOUTHERN NEVADA PAVING 3101 CRAIG RD N LAS VEGAS, NV 89030

/

The Claimant's request for hearing was filed on December 16, 2010 and a hearing was scheduled for January 4, 2011. The hearing was continued, rescheduled and heard on February 24, 2011, in accordance with Chapters 616 and 617 of the Nevada Revised Statutes.

The Claimant was present. The Claimant was represented by SCOTT PETTIT ESQ. The Employer was not present. The Self Insured Employer (SIE) was represented by ALYSSA M FISCHER ESQ.

ISSUE

The Claimant appealed the determination of S & C CLAIMS SERVICES INC dated November 8, 2010.

The issue before the Hearing Officer is REOPENING.

DECISION AND ORDER

Based on information presented the determination is proper and hereby AFFIRMED.

> **NRS 616C.390(1)** {NRS 616.545(1)} provides if application to reopen a claim to increase or rearrange compensation is made in writing more than 1 year after the date of claim closure, the insurer shall reopen the claim if a change of circumstances warrants an increase or rearrangement of compensation during the life of an injured employee, the primary cause of the change of circumstances is the injury for which the claim was originally made, and the application is accompanied by the certificate of a physician or chiropractor showing a change of circumstances which would warrant an increase or rearrangement of compensation.

NRS 616C.215 Actions and proceedings to recover damages in tort or from proceeds of vehicle insurance: Reduction of compensation by amount of recovery; rights of injured employee or dependents and of insurer or Administrator; notification and payment of insurer or Administrator; instructions to jury; calculation of employer's premium.

1. If an injured employee or, in the event of his or her death, the dependents of the employee, bring an action in tort against his or her employer to recover payment for an injury which is compensable pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS and, notwithstanding the provisions of NRS 616A.020, receive payment from the employer for that injury:

(a) The amount of compensation the injured employee or the dependents of the employee are entitled to receive pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, including any future compensation, must be reduced by the amount paid by the employer.

(b) The insurer, or in the case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, has a lien upon the total amount paid by the employer if the injured employee or the dependents of the employee receive compensation pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS.

➥ This subsection is applicable whether the money paid to the employee or the dependents of the employee by the employer is classified as a gift, a settlement or otherwise. The provisions of this subsection do not grant to an injured employee any right of action in tort to recover damages from the employer for the injury.

2. When an employee receives an injury for which compensation is payable pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS and which was caused under circumstances creating a legal liability in some person, other than the employer or a person in the same employ, to pay damages in respect thereof:

(a) The injured employee, or in case of death the dependents of the employee, may take proceedings against that person to recover damages, but the amount of the compensation the injured employee or the dependents of the employee are entitled to receive pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, including any future compensation, must be reduced by the amount of the damages recovered, notwithstanding any act or omission of the employer or a person in the same employ which was a direct or proximate cause of the employee's injury.

(b) If the injured employee, or in case of death the dependents of the employee, receive compensation pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, the insurer, or in case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, has a right of action against the person so liable to pay damages and is subrogated to the rights of the injured employee or of the employee's dependents to recover therefor.

3. When an injured employee incurs an injury for which compensation is payable pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS and which was caused under circumstances entitling the employee, or in the case of death the dependents of the employee, to receive proceeds under his or her employer's policy of uninsured or underinsured vehicle coverage:

(a) The injured employee, or in the case of death the dependents of the employee, may take proceedings to recover those proceeds, but the amount of compensation the injured employee or the dependents of the employee are entitled to receive pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, including any future compensation, must be reduced by the amount of proceeds received.

(b) If an injured employee, or in the case of death the dependents of the employee, receive compensation pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of

NRS, the insurer, or in the case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, is subrogated to the rights of the injured employee or the dependents of the employee to recover proceeds under the employer's policy of uninsured or underinsured vehicle coverage. The insurer and the Administrator are not subrogated to the rights of an injured employee or the dependents of the employee under a policy of uninsured or underinsured vehicle coverage purchased by the employee.

(c) Any provision in the employer's policy of uninsured or underinsured vehicle coverage which has the effect of:

(1) Limiting the rights of the injured employee or the dependents of the employee to recover proceeds under the policy because of the receipt of any compensation pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS;

(2) Limiting the rights of subrogation of the insurer or Administrator provided by paragraph (b); or

(3) Excluding coverage which inures to the direct or indirect benefit of the insurer or Administrator,

➥ is void.

4. In any action or proceedings taken by the insurer or the Administrator pursuant to this section, evidence of the amount of compensation, accident benefits and other expenditures which the insurer, the Uninsured Employers' Claim Account or a subsequent injury account have paid or become obligated to pay by reason of the injury or death of the employee is admissible. If in such action or proceedings the insurer or the Administrator recovers more than those amounts, the excess must be paid to the injured employee or the dependents of the employee.

5. In any case where the insurer or the Administrator is subrogated to the rights of the injured employee or of the employee's dependents as provided in subsection 2 or 3, the insurer or the Administrator has a lien upon the total proceeds of any recovery from some person other than the employer, whether the proceeds of such recovery are by way of judgment, settlement or otherwise. The injured employee, or in the case of his or her death the dependents of the employee, are not entitled to double recovery for the same injury, notwithstanding any act or omission of the employer or a person in the same employ which was a direct or proximate cause of the employee's injury.

6. The lien provided for pursuant to subsection 1 or 5 includes the total compensation expenditure incurred by the insurer, the Uninsured Employers' Claim Account or a subsequent injury account for the injured employee and the dependents of the employee.

7. An injured employee, or in the case of death the dependents of the employee, or the attorney or representative of the injured employee or the dependents of the employee, shall notify the insurer, or in the case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, in writing before initiating a proceeding or action pursuant to this section.

8. Within 15 days after the date of recovery by way of actual receipt of the proceeds of the judgment, settlement or otherwise:

(a) The injured employee or the dependents of the employee, or the attorney or representative of the injured employee or the dependents of the employee; and

(b) The third-party insurer,

➥ shall notify the insurer, or in the case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, of the recovery and pay to the insurer

or the Administrator, respectively, the amount due pursuant to this section together with an itemized statement showing the distribution of the total recovery. The attorney or representative of the injured employee or the dependents of the employee and the third-party insurer are jointly and severally liable for any amount to which an insurer is entitled pursuant to this section if the attorney, representative or third-party insurer has knowledge of the lien provided for in this section.

9. An insurer shall not sell its lien to a third-party insurer unless the injured employee or the dependents of the employee, or the attorney or representative of the injured employee or the dependents of the employee, refuses to provide to the insurer information concerning the action against the third party.

10. In any trial of an action by the injured employee, or in the case of his or her death by the dependents of the employee, against a person other than the employer or a person in the same employ, the jury must receive proof of the amount of all payments made or to be made by the insurer or the Administrator. The court shall instruct the jury substantially as follows:

> Payment of workmen's compensation benefits by the insurer, or in the case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, is based upon the fact that a compensable industrial accident occurred, and does not depend upon blame or fault. If the plaintiff does not obtain a judgment in his or her favor in this case, the plaintiff is not required to repay his or her employer, the insurer or the Administrator any amount paid to the plaintiff or paid on the behalf of the plaintiff by the plaintiff's employer, the insurer or the Administrator.
>
> If you decide that the plaintiff is entitled to judgment against the defendant, you shall find damages for the plaintiff in accordance with the court's instructions on damages and return your verdict in the plaintiff's favor in the amount so found without deducting the amount of any compensation benefits paid to or for the plaintiff. The law provides a means by which any compensation benefits will be repaid from your award.

11. To calculate an employer's premium, the employer's account with the private carrier must be credited with an amount equal to that recovered by the private carrier from a third party pursuant to this section, less the private carrier's share of the expenses of litigation incurred in obtaining the recovery, except that the total credit must not exceed the amount of compensation actually paid or reserved by the private carrier on the injured employee's claim.

12. As used in this section, "third-party insurer" means an insurer that issued to a third party who is liable for damages pursuant to subsection 2, a policy of liability insurance the proceeds of

which are recoverable pursuant to this section. The term includes an insurer that issued to an employer a policy of uninsured or underinsured vehicle coverage.

IT IS SO ORDERED this 7 day of March, 2011.

Daphne L Hodge
Hearing Officer

APPEAL RIGHTS

Pursuant to NRS 616C.345(1), should any party desire to appeal this final decision of the Hearing Officer, a request for appeal must be filed with Appeals Officer within thirty (30) days after the date of the decision by the Hearing Officer.

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Hearings Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing DECISION AND ORDER was duly mailed, postage prepaid OR placed in the appropriate addressee runner file at the Department of Administration, Hearings Division, 2200 S. Rancho Drive., #210, Las Vegas, Nevada, to the following:

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400 S FOURTH ST STE 500
LAS VEGAS NV 89101

Dated this 7 day of March, 2011.

Ava B. Tucker
Employee of the State of Nevada

NEVADA DEPARTMENT OF ADMINISTRATION

BEFORE THE APPEALS OFFICER

In the Matter of the Contested Industrial Insurance Claim of WILLIAM POREMBA 168 RED ARCHES COURT HENDERSON, NV 89012 Claimant.	Claim No.: 739255 Hearing No.: 82071-DH Appeal No.: 85272-MM Employer: SOUTHERN NEVADA PAVING 3101 E. CRAIG ROAD N. LAS VEGAS, NV 89030 **DOH: 5/19/11 at 9:30 A.M.**

INSURER'S MOTION FOR SUMMARY JUDGMENT

COMES NOW, the Insurer, BUILDERS INSURANCE COMPANY, by and through their attorneys of record, ALYSSA M. FISCHER, ESQ. and LEWIS, BRISBOIS, BISGAARD & SMITH, LLP, and hereby moves this Honorable Court for an Order granting this Motion for Summary Judgment because there are no material facts in dispute the Claimant cannot prevail in reopening his claim. Claimant appealed from a Hearing Officer's Decision and Order, dated March 7, 2011, which affirmed the denial of reopening of his claim.

POINTS AND AUTHORITIES

I.

UNDISPUTED FACTS

Claimant was involved in a vehicle-heavy equipment accident on or about July 22, 2005. He sought medical treatment and filled out a C-4 three days later on July 25, 2005. He was diagnosed with thoracic, cervical strains; a face contusion and a knee contusion. (Insurer's Document Packet, p. 4).

A follow up appointment at Concentra on July 29, 2005 produced the same diagnosis. (Insurer's Document Packet, p. 9).

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Claimant treated on his own outside of worker's compensation arena on August 2, 2005. (Insurer's Document Packet, p. 11-12).

Claimant was informed by the Insurer that he could not treat with non-preferred providers and could only have one treating physician. (Insurer's Document Packet, p. 13-15). Care was transferred to Dr. Angela Thomas. (Insurer's Document Packet, p. 16).

On August 12, 2005, the claim was accepted for cervical strain, lumbar strain and left knee sprain. (Insurer's Document Packet, p. 20). The scope of the claim was never appealed.

On August 12, 2005, Dr. Thomas documented that claimant had a non-industrial history of chronic low back pain. (Insurer's Document Packet, p. 22). Physical therapy was recommended.

Claimant and his counsel were informed of the Insurer's lien in August 2005. (Insurer's Document Packet, p. 24). Appropriate treatment was provided and on January 27, 2066 the Insurer sent a claim closure letter. (Insurer's Document Packet, p. 46). There was no appeal and the claim closed.

On October 5, 2010, the Insurer sought recovery of its worker's compensation lien. (Insurer's Document Packet, p. 45).

On November 3, 2010 Claimant sought to reopen his claim, more than one year after it closed. Claimant provided a one page letter from Sudir Khenika MD which does not have ANY medical records attached. The letter purports to say that the doctor compared MRIs but does not provide any of the alleged reports or films. Finally, the doctor's letter asks for reopening since the Claimant has had increased pain complaints. (Insurer's Document Packet, p. 50).

On November 8, 2010 the Insurer denied reopening as the Claimant has not proven that he has exhausted his third party recovery which he must do before the Insurer would be responsible to pay for reopening and future medical treatment. (Insurer's Document Packet, p. 53).

The Claimant received a settlement of $63,500 from a responsible third party who caused his accident. **Claimant received close to $20,000 personally, there is no evidence that said money has been exhausted prior to this reopening request as is required in Nevada.**

Claimant appealed the denial of reopening and the hearing officer affirmed it. Claimant appealed to create the current appeal hearing.

II.

STANDARD OF REVIEW

Summary judgment is appropriate where no genuine issue of fact remains for trial and one party is entitled to judgment as a matter of law. See NRCP 56(c) and Pacific Pools Construction Co. v. McClain's Concrete, Inc., 101 Nev. 557, 706 P.2d 849 (1985).

When a motion for summary judgment is made and supported as required by NRCP 56, the adverse party must, by affidavit or otherwise, set forth facts demonstrating the existence of a genuine issue for trial. See NRCP 56(e) and Bird v. Casa Royale West, 97 Nev. 67, 628 P.2d 17 (1981).

The non-moving party's documents must be admissible evidence and that party "is not entitled to build a case on the gossamer threads of whimsy, speculation and conjecture". Sprague v. Lucky Stores, Inc., 109 Nev. 247, 250, 849 P.2d 320 (1993) (citation omitted).

The U.S. Supreme Court has held the moving party's burden in such situations is simply to identify the elements of its adversary's case with respect to which it considers there to be a deficiency in proof. If a district court agrees as to the existence of the deficiency, summary judgment should follow as a matter of course.

III.

NEVADA CASE LAW IS CLEAR THAT A CLAIMANT MAY NOT REOPEN IS CLAIM UNTIL HE PROVES HE HAS EXHAUSTED HIS THIRD PARTY SETTLEMENT PROCEEDS

It is the claimant, not the Employer who has the burden of proving his case, and that is by a preponderance of all the evidence. State Industrial Insurance System v. Hicks, 100 Nev. 567, 688 P.2d 324 (1984); Holley v. State ex rel. Wyoming Worker's Compensation Div., 798 P.2d 323 (1990); Hagler v. Micron Technology, Inc., 118 Idaho 596, 798 P.2d 55 (1990).

In attempting to prove his case, the claimant has the burden of going beyond speculation and conjecture. That means that the claimant must establish the work connection of his injuries, the causal relationship between the work-related injury and his disability, the extent of his disability, and all facets of the claim by a preponderance of all of the evidence. To prevail, a claimant must present and prove more evidence than an amount which would make his case and his opponent's "evenly balanced." Maxwell v. SIIS, 109 Nev. 327, 849 P.2d 267 (1993); SIIS v. Khweiss, 108 Nev. 123, 825 P.2d 218 (1992); SIIS v. Kelly, 99 Nev. 774, 671 P.2d 29 (1983); 3, A. Larson, The Law of Workmen's Compensation, § 80.33(a).

NRS 616A.010(2) makes it clear that:

> A claim for compensation filed pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS must be decided on its merit and not according to the principle of common law that requires statutes governing workers' compensation to be liberally construed because they are remedial in nature.

Here, the law in Nevada is clear that a Claimant must first prove that he has expended any third party settlement proceeds on his own subsequent medical care and treatment before he can request reopening. The case of EICON v. Chandler, 23 P.3d 255 (Nev. 2001) case clearly stands for this proposition. (Insurer's Document Packet, pp. 96-99). The Nevada Supreme Court held in Chandler that: "**An insurer is entitled to withhold payment of medical benefits for a work-related injury until an employee has exhausted any third-party settlement proceeds..." Id. at 258.**

The worker's compensation insurer properly asserted its lien in this case. Regardless, it has never been paid its lien out of the settlement proceeds in spite of the legal obligation to notify it within fifteen days of recovery of those funds. See NRS 616C.215.

In this case, Claimant hasn't even paid the worker compensation insurer's lien! In Chandler that lien was paid back and still benefits were denied until he exhausted the money he received from his third party case. The present facts are even stronger in the Insurer's favor.

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It is represented that the Claimant has received $19,667.61 in settlement proceeds to date. (Insurer's Document Packet, p. 59). It is unclear whether this figure could go up since proceeds were withheld pending insurance payments and lien reductions. Id. Thus, at a minimum, according to Chandler Claimant must prove that SINCE September 2009 when he received his settlement money that he spent in excess of $19,667.71 on his own related health care.

The medical records provided to support reopening date back BEFORE September 2009, so these bills were known and contemplated at the time of settlement of the case. These are NOT bills for medical treatment incurred AFTER settlement occurred. (Insurer's Document Packet, p. 61-68).

The bills that have been submitted with a date AFTER September 2009 are contained in the Insurer's Evidence Packet at pp. 69-81. **These bills total approximately $3,300. this is well less than the $19,667.71 he received.**

Finally, the argument made at the hearing officer hearing on behalf of the Claimant was that a doctor was recommending surgery in the FUTURE. There would be no apportionment until AFTER the surgery took place and the Claimant proved that he paid for the surgery out of his settlement proceeds. A declaration of the need for surgery at some point in the future does not affect the Insurer's apportionment as allowed under Chandler.

Therefore, even taking the facts in a light MOST favorable to the Claimant it is clear that there are no facts in dispute and that the Claimant has failed to prove that he has exhausted the approximately $20,000 he received as third party settlement funds. Under this set of undisputed facts, summary judgment is warranted in favor of the Insurer.

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CONCLUSION

For the foregoing reasons, the Insurer respectfully request an Order Granting its Motion for Summary Judgment and vacating the appeal hearing scheduled for May 19, 2011.

DATED: May 16th, 2011.

Respectfully submitted,

LEWIS BRISBOIS BISGAARD & SMITH LLP

By: _____
Alyssa M. Fischer, Esq.
Attorneys for the Insurer
BUILDERS INSURANCE COMPANY

CERTIFICATE OF MAILING

Pursuant to Nevada Rules of Civil Procedure 5(b), I hereby certify that, on the 6th day of May, 2011, service of the foregoing **INSURER'S MOTION FOR SUMMARY JUDGMENT** was made this date by depositing a true copy of the same for mailing, postage prepaid thereon, in an envelope to the following:

Matthew Dunkley, Esq.
1522 W. Warm Springs Rd.
Henderson, NV 89014

VIA FACSIMILE
(702) 531-6777

Southern NV Paving
3101 E. Craig Road
N. Las Vegas, NV 89030

Julie Wood
S & C Claims Services, Inc.
3380 West Sahara, Suite 100
Las Vegas, NV 89102

An employee of LEWIS BRISBOIS BISGAARD & SMITH LLP

NEVADA DEPARTMENT OF ADMINISTRATION

FILED
MAY 17 2011
APPEALS OFFICE

BEFORE THE APPEALS OFFICER

In the Matter of the Contested Industrial Insurance Claim of WILLIAM POREMBA 168 RED ARCHES COURT HENDERSON, NV 89014, Claimant.	Claim No.: 739255 Hearing No.: 82071-DH Appeal No.: 85272-MM Employer: SOUTHERN NEVADA PAVING 3101 E. CRAIG ROAD N. LAS VEGAS, NV 89030

ORDER GRANTING INSURER'S MOTION FOR SUMMARY JUDGMENT

After careful review and consideration of the Insurer's Motion for Summary Judgment and good cause appearing,

IT IS HEREBY ORDERED that the Insurer's Motion for Summary Judgment is **GRANTED.**

DATED this 17th day of May, 2011.

MICHELLE L. MORGANDO, ESQ.
Appeals Officer

Submitted by:

LEWIS BRISBOIS BISGAARD & SMITH LLP

By:
ALYSSA M. FISCHER, ESQ.
Nevada Bar No. 5709
400 S. Fourth Street, Ste. 500
Las Vegas, Nevada 89101
Phone: (702) 893-3383
Fax: (702) 366-9689
Attorneys for Insurer

LEWIS BRISBOIS BISGAARD & SMITH LLP ATTORNEYS AT LAW

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Appeals Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing **ORDER GRANTING INSURER'S MOTION FOR SUMMARY JUDGMENT** was duly mailed, postage prepaid **OR** placed in the appropriate addressee runner file maintained by the Division, 2200 South Rancho Drive, Suite 220, Las Vegas, Nevada, to the following:

Alyssa M. Fischer, Esq.
Lewis, Brisbois, Bisgaard & Smith LLP
400 S. Fourth Street, Ste. 500
Las Vegas, NV 89101

Matthew Dunkley, Esq.
1522 W. Warm Springs Road
Henderson, NV 89014

Julie Wood
S&C Claims Service
3380 W. Sahara Avenue, Ste. 100
Las Vegas, NV 89102

William Poremba
168 Red Arches Court
Henderson, NV 89012

Southern Nevada Paving
3101 E. Craig Road
N. Las Vegas, NV 89030

DATED this 17th day of May, 2011.

An employee of the State of Nevada

Dunkley Law
INJURY ATTORNEYS

November 8, 2012

COPY VIA FACSIMILE (702) 876-5584
ORIGINAL VIA U.S. MAIL

S&C Claims Services, Inc.
Attn: Linda Jackson, Claims Examiner
9075 W. Diablo Dr., Suite #140
Las Vegas, Nevada 89102

Re:	*Our Client*	:	*William Poremba*
	Employer	:	*Southern Nevada Paving*
	Your Claim No.	:	*739255*
	Date of Incident	:	*07/22/05*
	Our File No.	:	*2607-10*

Dear Ms. Jackson:

The above referenced claim was closed on August 17, 2011, Mr. Poremba continues to experience pain and believes that he has not fully recovered from the injuries suffered in the incident of July 22, 2005. We are requesting that Mr. Poremba's industrial claim be considered for reopening. Please send your written determination regarding our request for reopening of our client's claim.

If you have any questions, regarding the contents of this letter, do not hesitate to contact my office.

Sincerely,

DUNKLEY LAW

Matthew S. Dunkley, Esq.

S & C CLAIMS
NOV 09 2012
RECEIVED

MSD/jl
cc: William Poremba

Office 702-413-6565 • 702-570-5940 Fax • DunkleyInjuryLaw.com
2450 St. Rose Pkwy, Suite 210 • Henderson, Nevada 89074

S&C Claims Services Inc.

9075 W. Diablo Drive, Suite 140
Las Vegas, NV 89148

Main - (702) 873-5115
Toll Free - (800) 362-5198
Fax - (702) 876-5584

November 8, 2012

Matthew Dunkley Esq.
2450 St Rose Pkwy #210
Henderson NV 89074

Re: Claimant: William Poremba
Claim No: 739255
DOI: 07/22/2005
Employer: Aggregate Industries

Dear Mr. Dunkley,

S&C Claims Services, Inc. has reviewed your request for reopening. After review, it appears there is no evidence of an objective change in circumstance to warrant reopening. There was no reporting enclosed from any physician with the request. Therefore, your request for reopening is denied.

If you disagree with this determination, you may request a Hearing before a Hearing Officer. If you wish to appeal, complete the Request for Hearing form and mail it to the address on the top of the form within seventy (70) days of the date of this letter. If you do not appeal within seventy (70) days, you lose your appeal rights.

Julie Wood
Julie Wood
Supervisor

Enclosures

cc: Aggregate Industries
William Poremba
File

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:	Hearing Number: 1305062-TH Claim Number: 739255
WILLIAM PROEMBA 168 RED ARCHES CT HENDERSON, NV 89012	SOUTHERN NEVADA PAVING 440 FREHNER RD NORTH LAS VEGAS, NV 89030

_____/

NOTICE OF HEARING BEFORE THE HEARING OFFICER

*Pursuant to the **Claimant's** request for a Hearing Officer review of the Insurer's Determination under Chapters 616 and 617 of the Nevada Revised Statutes, you are hereby notified a hearing will be held:*

DATE: ***February 7, 2013***
TIME: ***10:30AM***
PLACE: *Department of Administration, Hearings Division*
2200 South Rancho Drive, Suite 210
Las Vegas, NV 89102
Phone (702) 486-2525

The matter to be ascertained from this Hearing shall be whether the determination rendered by the Insurer is proper. Failure of the appealing party to attend this Hearing may result in dismissal of the appeal.

NOTE: The Claimant may be represented at the Hearing by a private attorney or may seek assistance and advice from the Nevada Attorney for Injured Worker's at 486-2830. *If you have an attorney or other representative, please confirm with them the date and time for this hearing.*

If you would prefer to testify by telephone, please contact this office one week prior to the hearing date at 486-2525 with the appropriate information. Telephone hearings will generally take place within 1 hour of the time designated for the Hearing (see above).

NOTE: *This Hearing will be scheduled on a **STACKED** calendar.*

Dated this 15th day of January, 2013.

Tracey Hagan
Hearing Officer

S & C CLAIMS
JAN 16 2013
RECEIVED

REQUEST FOR HEARING - CONTESTED CLAIM

(Pursuant to NAC 616C.274)

STATE OF NE
DEPT OF ADMINIS
HEARINGS DIV
13 JAN 10 PM
RECEIVED
AND
FILED

REPLY TO: Department of Administration
Hearings Division
1050 E. William Street, Ste. 400
Carson City, NV 89701
(775) 687-5966

OR Department of Administration
Hearings Division
2200 S. Rancho Drive, Suite 210
Las Vegas, NV 89102
(702) 486-2525

EMPLOYEE INFORMATION
Employee's Name: William Proemba
Address: 168 Red Arches Court
City: Henderson State: NV Zip: 89012
Employee's Telephone Number: (702)263-2936
Claim No.: 739255 Date of Injury: 7/22/2005

INSURER INFORMATION
Insurer's Name:
Address:
City: State: Zip:
Insurer's Telephone Number:

EMPLOYER INFORMATION
Employer's Name: Southern Nevada Paving
Address: 440 Frehner Road
City: North Las Vegas State: NV Zip: 89030
Employer's Telephone Number: (702)649-6250

THIRD-PARTY ADMINISTRATOR (TPA) INFORMATION
TPA's Name: Schreiner & Company S+C
Address: 3380 West Sahara Avenue, Suite 100
City: Las Vegas State: NV Zip: 89102
TPA's Telephone Number: (702) 873-5115

Do Not Complete or Mail This Form Unless You Disagree With the Insurer's Determination.

YOU MUST INCLUDE A COPY OF THE DETERMINATION LETTER OR A HEARING WILL NOT BE SCHEDULED PURSUANT TO NRS 616C.315.

Briefly explain the basis for this appeal:

DISAGREE WITH DETERMINATION LETTER OF NOVEMBER 8, 2012

This request for hearing is filed by, or on behalf of:

☒ **The Injured Employee**

☐ **The Employer**

S & C CLAIMS
JAN 16 2013
RECEIVED

and is dated this 10 day of January, 2013

Signature of Injured Employee/Employer

Injured Employee's/Employer's Rep. (Advisor)

13050627A

D-12a (Rev. 09/04)

APP136

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Hearings Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing **NOTICE OF HEARING BEFORE THE HEARING OFFICER** was duly mailed, postage prepaid **OR** placed in the appropriate addressee runner file at the Department of Administration, Hearings Division, 2200 S. Rancho Drive., #210, Las Vegas, Nevada, 89102 to the following:

WILLIAM PROEMBA
168 RED ARCHES CT
HENDERSON NV 89012

MATTHEW S DUNKLEY ESQ
DUNKLEY LAW
2450 ST ROSE PKWY STE 210
HENDERSON NV 89074

SOUTHERN NEVADA PAVING
440 FREHNER RD
NORTH LAS VEGAS NV 89030

S & C CLAIMS SERVICES INC
9075 W DIABLO DR STE 140
LAS VEGAS NV 89148

ALYSSA M FISCHER ESQ
LEWIS BRISBOIS BISGAARD & SMITH LLP
400 S FOURTH ST STE 500
LAS VEGAS NV 89101

Dated this 15th day of January, 2013.

Carol Tuttle
Employee of the State of Nevada

S&C Claims Services Inc.

9075 W. Diablo Drive, Suite 140
Las Vegas, NV 89148

Main - (702) 873-5115
Toll Free - (800) 362-5198
Fax - (702) 876-5584

November 8, 2012

Matthew Dunkley Esq.
2450 St Rose Pkwy #210
Henderson NV 89074

Re: Claimant: William Poremba
Claim No: 739255
DOI: 07/22/2005
Employer: Aggregate Industries

Dear Mr. Dunkley,

S&C Claims Services, Inc. has reviewed your request for reopening. After review, it appears there is no evidence of an objective change in circumstance to warrant reopening. There was no reporting enclosed from any physician with the request. Therefore, your request for reopening is denied.

If you disagree with this determination, you may request a Hearing before a Hearing Officer. If you wish to appeal, complete the Request for Hearing form and mail it to the address on the top of the form within seventy (70) days of the date of this letter. If you do not appeal within seventy (70) days, you lose your appeal rights.

Julie Wood
Julie Wood
Supervisor

Enclosures

cc: Aggregate Industries
William Poremba
File

NOV 1 3 2012

11/7/13

APP138

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

STATE OF NEVADA
HEARINGS DIVISION
13 FEB 11 AM 10:5
RECEIVED AND FILED

In the matter of the Contested Industrial Insurance Claim of:	Hearing Number: 1305062-TH Claim Number: 739255
WILLIAM PROEMBA 168 RED ARCHES CT HENDERSON, NV 89012	SOUTHERN NEVADA PAVING 440 FREHNER RD NORTH LAS VEGAS, NV 89030

ORDER TRANSFERRING HEARING TO APPEALS OFFICE

The Claimant's Request for Hearing was filed on January 10, 2013 and scheduled for February 7, 2013. The requesting party appealed the Insurer's determination dated November 8, 2012. The hearing was scheduled for February 7, 2013.

The parties have filed a stipulation to waive a hearing at the Hearing Officer level and to proceed directly to the Appeals Officer level.

> **NRS 616C.315(7)** provides that the parties to a contested claim may, if the Claimant is represented by counsel, agree to forego a hearing before a Hearing Officer and submit the contested claim directly to an Appeals Officer.

Therefore, good cause appearing, the Hearing Officer Proceeding shall be and is hereby transferred to the Appeals Officer for further proceedings.

IT IS SO ORDERED this 11th day of February, 2013.

Tracey Hagan
Hearing Officer

NOTICE: If any party objects to this transfer to the Appeals Office, an objection thereto must be filed with the Appeals Office at 2200 South Rancho Drive, Suite 220, Las Vegas, Nevada 89102, within 15 days of this order.

SCHEDULED ON
FEB 14 2013
APPEALS DIVISION

1306201 - SC 123

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Hearings Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing **ORDER TRANSFERRING HEARING TO APPEALS OFFICE** was duly mailed, postage prepaid **OR** placed in the appropriate addressee runner file at the Department of Administration, Hearings Division, 2200 S. Rancho Drive, #210, Las Vegas, Nevada, to the following:

WILLIAM PROEMBA
168 RED ARCHES CT
HENDERSON NV 89012

MATTHEW S DUNKLEY ESQ
DUNKLEY LAW
2450 ST ROSE PKWY STE 210
HENDERSON NV 89074

SOUTHERN NEVADA PAVING
440 FREHNER RD
NORTH LAS VEGAS NV 89030

S & C CLAIMS SERVICES INC
9075 W DIABLO DR STE 140
LAS VEGAS NV 89148

ALYSSA M FISCHER ESQ
LEWIS BRISBOIS BISGAARD & SMITH LLP
400 S FOURTH ST STE 500
LAS VEGAS NV 89101

Dated this 11th day of February, 2013.

Carol Tuttle
Employee of the State of Nevada

REQUEST FOR HEARING - CONTESTED CLAIM

(Pursuant to NAC 616C.274)

STATE OF NEVADA APPEALS
13 JAN 10
RECEIVED AND FILE

REPLY TO: Department of Administration
Hearings Division
1050 E. William Street, Ste. 400
Carson City, NV 89701
(775) 687-5966

OR Department of Administration
Hearings Division
2200 S. Rancho Drive, Suite 210
Las Vegas, NV 89102
(702) 486-2525

EMPLOYEE INFORMATION
Employee's Name: William Proemba
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City: Henderson State: NV Zip: 89012
Employee's Telephone Number: (702)263-2936
Claim No.: 739255 Date of Injury: 7/22/2005

INSURER INFORMATION
Insurer's Name:
Address:
City: State: Zip:
Insurer's Telephone Number:

EMPLOYER INFORMATION
Employer's Name: Southern Nevada Paving
Address: 440 Frehner Road
City: North Las Vegas State: NV Zip: 89030
Employer's Telephone Number: (702)649-6250

THIRD-PARTY ADMINISTRATOR (TPA) INFORMATION
TPA's Name: Schreiner & Company B+C
Address: 3380 West Sahara Avenue, Suite 100
City: Las Vegas State: NV Zip: 89102
TPA's Telephone Number: (702) 873-5115

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YOU MUST INCLUDE A COPY OF THE DETERMINATION LETTER OR A HEARING WILL NOT BE SCHEDULED PURSUANT TO NRS 616C.315.

Briefly explain the basis for this appeal:

DISAGREE WITH DETERMINATION LETTER OF NOVEMBER 8, 2012

This request for hearing is filed by, or on behalf of:

☒ **The Injured Employee**

☐ **The Employer**

and is dated this 10 day of January, 2013.

Signature of Injured Employee/Employer

Injured Employee's/Employer's Rep. (Advisor)

13050627H

D-12a (Rev. 09/04)

S&C Claims Services Inc.

9075 W. Diablo Drive, Suite 140
Las Vegas, NV 89148

Main - (702) 873-5115
Toll Free - (800) 362-5198
Fax - (702) 876-5584

November 8, 2012

Matthew Dunkley Esq.
2450 St Rose Pkwy #210
Henderson NV 89074

Re: Claimant: William Poremba
Claim No: 739255
DOI: 07/22/2005
Employer: Aggregate Industries

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Julie Wood
Julie Wood
Supervisor

Enclosures

cc: Aggregate Industries
William Poremba
File

NOV 13 2012

11/7/13