IN THE SUPREME COURT OF THE STATE OF NEVADA

WILLIAM POREMBA Petitioner, vs. SOUTHERN NEVADA PAVING; S&C CLAIMS SERVICE and DEPARTMENT OF ADMINISTRATION, APPEALS OFFICER, Respondent.	**Case No.: 66888**

APPENDIX

VOLUME III

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APPENDIX TO APPELLANT'S OPENING BRIEF

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STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:	Claim Number: 739255 Appeal Number: 1306201-SL
WILLIAM POREMBA Claimant. _____/	Hearing Date: July 22, 2013 Hearing Time: 11:00 a.m.

CLAIMANT'S OPPOSITION TO INSURER'S MOTION FOR SUMMARY JUDGMENT

Comes now Claimant, WILLIAM POREMBA, by and through his counsel, Matthew S. Dunkley, Esq., of the law firm of Royal Jones Miles Dunkley & Wilson, and files an Opposition to Insurer's Motion for Summary Judgment regarding Claimant's appeal from the Insurer's November 8, 2012, determination letter which denying the reopening of his claim.

POINTS AND AUTHORITIES

I.

STATEMENT OF FACTS

This case stems from a motor vehicle accident that occurred on July 22, 2005. At the time of the accident, Mr. Poremba was working for Southern Nevada Paving and driving a tractor trailer dump

truck. An employee of Pratte Development Company was driving a backhoe. As Mr. Poremba was driving his truck on a paved road in a neighborhood that was under development, the backhoe ran a stop sign hitting the driver's side of Mr. Poremba's truck.

Mr. Poremba treated with Dr. Joseph Nicola, D.C. and Dr. Easton, D.C. at Integrated Health Care of Nevada. Mr. Poremba began treatment on July 25, 2005 and treated until May 1, 2006. The treatment consisted of electrical stimulation, ice/hot packs, spinal manipulations and therapeutic exercises. While at Integrated Health Care, Mr. Poremba was also seen by Teresa T. Charniga, M.D. The original diagnosis at Integrated included the following:

1. Cervical Spine Sprain/Strain
2. Thoracolumbar Sprain/Strain
3. Post-Concussive Syndrome
4. Possible Bilateral Upper Extremity Radiculopathy
5. Left Knee Pain
6 Secondary to MVA

A CT scan of the Cervical Spine on July 25, 2005 included the following interpretation:

> Left posterolateral disk osteophyte complex protrusion C5-C6 with additional central disk protrusion at this level.

Originally, Mr. Poremba made a worker's compensation claim. As part of that claim he was seen by Concentra and then sent to Mary Angela Thomas, M.D. On August 5, 2005, he was seen by Dr. Thomas and presented with chief complaints of neck, back and knee pain and headaches. Dr. Thomas's diagnosis was as follows:

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Industrial diagnosis:

1. Cervical sprain/strain

2. Lumbar sprain/strain

3. Left knee sprain

4. Right trochanteric bursitis; this is all secondary to a motor vehicle accident.

An MRI of the left knee on August 19, 2005, revealed the following:

1. Mild left knee joint effusion

2. Grade I anterior cruciate ligament and posterior cruciate ligament strain

3. Bony structures, tendon structures and menisci of the knee are intact.

Due to continued knee pain, Mr. Poremba was referred to Gary J. LaTourette, M.D.. Dr. LaTourette preformed on Mr. Poremba's left knee a arthroscopic evaluation with major synovectomy and partial medial meniscectomy on May 10, 2006. Dr. LaTourette at his deposition stated that the treatment provided by his office was related to a reasonable degree of medical probability to the motor vehicle accident.

A lawsuit was filed against Pratte Development Company in Nevada District Court. A mediation was held with Pratte Development on July 30, 2009. At the mediation the following medical bills were contemplated as part of the settlement:

1.	Integrated Health Care of Nevada Joseph Nicola, D.C./Eric Easton, D.C.	$ 10,385.00
2.	Integrated Health Care of Nevada Theresa Charniga, M.D.	$ 180.00
3.	Lake Mead Radiologists/Nevada Imaging Centers	$ 3,881.00
4.	Gary J. La Tourette, M.D.	$ 25,756.34
5.	Mary Angela Thomas, M.D.	$ 2,621.66
6.	Spine & Orthopedic Rehabilitation Specialists Albert Yeh, M.D. & Ty Weller, M.D.	$ 12,506.80
7.	Pain Wellness Center Harvey Smith, PA	$ 4,822.50

8.	Anesthesiology Consulting Group, Inc.	$ 2,400.00
9.	Healthsouth	$ 1,631.00
10.	Valley Hospital	$ 12,880.00
	Total	**$ 77,064.30**

The District Court case against Pratte Development settled on July 30, 2009, for 63,500.00. (See Distribution Letter dated September 25, 2009 attached hereto as Exhibit "1"). Mr. Poremba ended up netting $34,631.51. (See Id.) Mr. Poremba has had ongoing treatment since the settlement. Additionally, there were records that were not included in the settlement due to them being unavailable at the time of the mediation.

Since the settlement, Mr. Poremba has had continuous medical treatment for his work related injuries in this case. Since 2009, Mr. Porema has treated with Dr. Aury Nagy, Dr. Eric Easton, Dr. Jeremy Lipshutz, Dr. Roger Metha, Dr. Karl, Dr. Maduka, Dr. Ghani and Dr. Gutpa. (See Affidavit of William Poremba attached hereto as Exhibit "5"). Mr Poremba is currently seeing Dr. Roger Metha, from Southwest Medical Associates at the Siena Heights office. (See Id.)

Since receiving the settlement, Mr. Poremba has spent approximately $14,000.00 for medical insurance payments, prescriptions, and co-pays in medical expenses for injuries relating to my accident of July 22, 2005. (See Id.) The medical bills incurred have exceeded the total net he received of $34,631.51. (See Id.) A small amount of the bills incurred since the settlement are included in Exhibits "2" and "3", and show a bill from Las Vegas Pain institute for $4,520.90 and from Dr. Nagy for $23,580.00.

Since the accident of July 22, 2005, Mr. Poremba has not been able to work due to the injuries he suffered in the subject accident. He tried to go back to work but suffered severe pain to his spine. Dr. Aury Nagy told Mr. Poremba not to go back to work due to his injuries and symptoms. (See Exhibit "5"). Since the settlement, Mr. Poremba has averaged an annual income of only $5,197.55.

V.

ARGUMENT

A. Claimant Has Exhausted the Third Party Settlement Funds

The Insurer is relying on *Employers Ins. Co. of Nevada v. Chandler,* 23 P.3d 255 (Nev. 2001) for the argument that a claimant must exhaust third party settlement funds before the insurer is responsible for reopening the case. *Employers Ins. Co. Of Nevada v. Chandler* stated that "the contemplated purpose of NRS 616C.215 is to make the insurer whole and to prevent an employee from receiving an impermissible double recovery." Id. at 258.

In this case, it is clear that Poremba has exhausted the third party settlement proceeds and is not receiving a double recovery. Since the date of the mediation, July 30, 2009, Poremba has incurred well over $34,631.51 in medical expenses including a surgery that was done and one that is needed. (See E.P.2 showing some of the bills, and note from Dr. Nagy attached at E.P. 3). Mr. Poremba has had to come out of pocket approximately $14,000.00 for medical insurance payments, prescriptions, and co-pays.

Additionally, Mr. Poremba has not been able to work due to his injuries since the date of the mediation. This means that he no longer has the income he was making prior to the accident. His average annual income since the mediation has been approximately $5,000.00. Mr. Poremba was the sole provider in the home. The money received in the settlement has long been exhausted by expense related to medical care, mortgage payments, and living expense for himself and his family. Accordingly, we would ask that the Insurer's motion for summary judgment be denied at this time and that the matter proceed to the hearing that is currently set for July 22, 2013.

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By the hearing, Mr. Poremba will have had more time to obtain his recent medical bills and provide them to the Appeal's Officer and will have had time to provide more specifics on how the settlement money from 2009 was exhausted.

B. Claimant's Claim Should Be Reopened

NRS 616C.390(1) provides as follows:

Except as otherwise provided in NRS 616C.392:

1. If an application to reopen a claim to increase or rearrange compensation is made in writing more than 1 year after the date on which the claim was closed, the insurer shall reopen the claim if:

(a) A change of circumstances warrants an increase or rearrangement of compensation during the life of the claimant;

(b) The primary cause of the change of circumstances is the injury for which the claim was originally made; and

(c) The application is accompanied by the certificate of a physician or a chiropractor showing a change of circumstances which would warrant an increase or rearrangement of compensation.

The letter from Sudhir Khemka, M.D. satisfies the requirements for reopening the claim in this matter. (See Exhibit "4"). Dr. Khemka states that "new MRI's show that the patient's Cervical, Thoracic, Lumbar and Left Knee show that the patient's pain has progressed. . . ." Dr. Khemka then requests that the claim be reopened.

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Based on the foregoing, the Claimant requests that the Motion for Summary Judgment be denied and that the matter be allowed to go forward to the Appeal's Hearing set for July 22, 2013.

Dated this 11 day of April, 2013.

DUNKLEY LAW

By: _____

MATTHEW S. DUNKLEY, ESQ.
Nevada Bar No. 6627
2450 St. Rose Parkway, Suite 210
Henderson, Nevada 89074
Attorneys for Claimant

CERTIFICATE OF SERVICE

I certify that on this 11th day of April, 2013, the foregoing **CLAIMANT'S OPPOSITION TO INSURER'S MOTION FOR SUMMARY JUDGMENT** was served on the following by

[ ] hand delivery
[X] Facsimile
[ ] Facsimile and U.S. Mail first class postage prepaid
[ ] U.S. Mail first class postage prepaid

addressed as follows:

Alyssa M. Fischer, Esq. (Facsimile: 702-366-9563)
LEWIS BRISBOIS BISGAAARD & SMITH LLP
2300 West Sahara, Suite 300, Box 28
Las Vegas, NV 89102-4375

An Employee of Dunkley Law

EXHIBIT 1

Michael A. Royal*
Cory M. Jones
Gregory A. Miles*
Matthew S. Dunkley*
Justin L. Wilson

Taylor J. Turner

*Also Admitted in Utah

ROYAL JONES MILES DUNKLEY & WILSON

LAWYERS

1522 W. Warm Springs Road
Henderson, NV 89014
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702.531.6777

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September 25, 2009

William Poremba
168 Red Arches Court
Henderson, Nevada 89012

Re: Poremba vs. Pratte Construction, District Court Case No. A-544177
Our File No. : 1135-05

Dear Bill:

Your settlement with the at fault driver has been finalized and the settlement check of $63,500.00 has been received, deposited and cleared. As we discussed, Las Vegas Pain Institute and Valley Surgery Center has submitted their invoice to your insurance company and is pending their approval at which time we will request a lien reduction from the balance due, at this time, we will disburse part of the settlement funds, retaining enough to cover the health care providers with liens. The partial settlement funds are distributed as follows:

William Poremba	$ 19,667.61 *
Integrated Health Care of Nevada - Dr. Eric Easton	$ 8,325.50 (reduced $8,325.00)
Lake Mead Radiology	$ 1,515.75
Gary J. LaTourette, M.D.	$ 15,441.76 (reduced $15,441.82)
Amount Withheld Pending Insurance Payment & Liens Reductions	$ 14,963.90
Costs to date	$ 3,585.48
Attorney Fees	$ 00.00 (waived $25,400.00)
Total Settlement	$ 63,500.00

** Advancements of settlement proceeds were disbursed on August 27, 2009 in the amount of $1,000.00 and September 18, 2009 in the amount of $10,000.00.*

We have deducted from your settlement only those bills for which we have liens. Other bills may exist for which we do not have liens. You will be responsible for any unpaid medical bills.

Please sign this letter below acknowledging your understanding of the foregoing terms and receipt of your partial settlement draft pending any liens reductions obtained. I want to thank you for allowing me to assist you with your case. I wish you all the best for a healthy and happy future.

Very truly yours,

ROYAL JONES MILES
DUNKLEY & WILSON

Matthew S. Dunkley, Esq.

MSD/jl

I agree with the above outlined settlement and distribution and acknowledge receipt of my portion of the distribution.

_____ _____

WILLIAM POREMBA DATE

EXHIBIT 2

Las Vegas Pain Institute & Med Cntr, LLC

Patient Ledger

November 10, 2009

WILLIAM POREMBA
168 RED ARCHES COURT
HENDERSON, NV 89012

Account Number: LVPO000052
Work Phone:
Home Phone: (702)263-2936

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	($82.24)
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

Las Vegas Pain Institute & Med Cntr, LLC

Patient Ledger

November 10, 2009

Date	Patient	Bill No.	Description	Amount
04/29/2009	WILLIAM	4234081	64479 - INJECTION, ANESTHETIC/STEROID, TRANS	$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, TRANS	$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	($568.14)
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	($65.36)
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, TRANS	$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, TRANS	$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, TRANS	$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

Las Vegas Pain Institute & Med Cntr, LLC

Patient Ledger

November 10, 2009

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	($18.30)
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 ANALGESIA	$200.00
10/30/2009	WILLIAM	4236241	INSPAYMENT - PRIMARY INSURANCE PAYMENT	($36.08)
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

Las Vegas Pain Institute & Med Cntr, LLC

Patient Ledger

November 10, 2009

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	($1,683.23)
06/09/2009	WILLIAM	4236827	64480 - INJECTION, ANESTHETIC/STEROID, TRAN	$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, TRAN	$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 ANALGESI/	$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)

Las Vegas Pain Institute & Med Cntr, LLC

Patient Ledger

November 10, 2009

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	5203105	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPON	$270.00
10/26/2009	WILLIAM	5203105	CHECKCOPAY - Patient copayment by personal chec	($20.00)
			Total for Bill No. 5203105	$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	$250.86

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: SVP0000039
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)

Spring Valley Surgery Center, LLC

Patient Ledger

November 10, 2009

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, TRANS	$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, TRANS	$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, TRANS	$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	4213195	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	($368.72)
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
09/07/2009	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

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 [ ]

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 [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: 880404982 SSN [ ] EIN [X]

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

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

APP163

ROYAL J[illegible]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

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

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
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 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. 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	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
Godwin O. Maduka, MD, Pharm	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 04/26/2010 DATE	a. 1659431443 b.	a. 1548363583 b.

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

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

APP164

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ROYAL JO[illegible]S DUNKLEY AND WILSON
2920 N. GREEN VALLEY PARKWAY SUITE 424
LAS VEGAS 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)
[ ]	[ ]	[ ]	[ ]	[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		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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	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 / MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES
CORRECTED CLAIM		YES [ ] NO [X]

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

1. 722.4 3. [ ]
2. 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	

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]	5213208	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.)

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.

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

APP165

ROYAL JO[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

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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? [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 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 723.1 3. L 723.4 2. L 721.3 4. L 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. #
1 04 22 10		11		99214		1234	270 00	1		NPI	1326115429
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]	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 SIGNED 07/12/2010 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. 1326115429

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)

APP166

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

ROYAL JO[illegible] 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 (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 ZIP CODE: 89012 TELEPHONE (Include Area Code): (702)263-2936	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
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.

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
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. L723.1 3. L723.4
2. L721.3 4. L724.4

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 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	YES [X] 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.

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)

APP167

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

ROYAL JG (S DUNKLEY AND WILSON
2920 N. GREEN VALLEY PARKWAY SUITE 424
LAS VEGAS 89014

CARRIER

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 [ ]		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 [X]		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? 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? [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
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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
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	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		96365		1234	270 00	1		NPI	1548363583
2	04 22 10		11		U2001		1234	80 00	4		NPI	1548363583
3	04 22 10		11		U1885		1234	80 00	4		NPI	1548363583
4	04 22 10		11		U3475		1234	14 40	4		NPI	1548363583
5	04 22 10		11		U3420		1234	7 50	1		NPI	1548363583
6	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.

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 OMS-1500 (09-05)

APP168

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

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare #) [ ] (Medicaid #) [ ] (Sponsor's SSN) [ ] (Member ID#) [X] (SSN or ID) [ ] (SSN) [ ] (ID)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) POREMBA WILLIAM M	3. PATIENT'S BIRTH DATE MM DD YY SEX 06 30 64 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 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 [ ] 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? [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 07/22/2010

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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	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

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	$ 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.)	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. 1326115429

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CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

APP169

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

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

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)
				X			

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.

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.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
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

PATIENT AND INSURED INFORMATION

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		20. OUTSIDE LAB? $ CHARGES
CORRECTED CLAIM		YES X NO
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. 729.5 3. 2. 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. #
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	$	$ 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.

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

APP170

ROYAL J(ES DUNKLEY AND WILSON
2920 N. GREEN VALLEY PARKWAY SUITE 424
LAS VEGAS NV 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 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 07/22/2010

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
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
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
1 721.3 3		23. PRIOR AUTHORIZATION NUMBER
2 724.4 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 05 25 10 05 25 10	11		99214		12	270 00	1		NPI	1326115429
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	5219253	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
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 07/22/2010 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

APP171

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

ROYAL J[illegible]ES MILES DUNKLEY & WILSON
1522 WES[illegible] WARM SPRINGS ROAD
HENDERSON NV 89014

CARRIER

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) [ ] (Medicaid #) [ ] (Sponsor's SSN) [ ] (Member ID#) [X] (SSN or ID) [ ] (SSN) [ ] (ID)	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 [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 [ ]	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 [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 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 [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: 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
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
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. 723.1 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. #
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	

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
880404932 [ ] [X]	5219836	YES [X] 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 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: 09/28/2010 DATE	a. 1659431443 b.	a. 1326115429 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-Env - WHCF-10-Env-ES

NUCC Instruction Manual available at: www.nucc.org

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

WCMS-150005

APP172

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ROYAL J[illegible]ES MILES DUNKLEY & WILSON
1522 WES[illegible] WARM SPRINGS ROAD
HENDERSON NV 89014

PICA

PICA

CARRIER

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

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
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
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

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 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 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. 1326115429 b.

NUCC Instruction Manual available at: www.nucc.org

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

WCMS-150000

APP173

ROYAL J(S 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) 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 SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
POREMBA WILLIAM M	06 30 64 M ☒ 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 ☒ Spouse ☐ Child ☐ Other ☐	168 RED ARCHES COURT
CITY / STATE	8. PATIENT STATUS	CITY / STATE
HENDERSON NV	Single ☐ Married ☒ 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	a. INSURED'S DATE OF BIRTH SEX
347669782		06 30 64 M ☒ F ☐
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☒ NO	b. EMPLOYER'S NAME OR SCHOOL NAME
06 30 64 M ☒ F ☐		
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	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
TEAMSTER LOCAL 631		☒ 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 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 ☒ 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		

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	

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 ☐ ☒	6224934	☒ 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	LAS PAIN INSTITUTE & MEDICAL CEN	Las Vegas Pain Institute & Med Cntr, I
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. 1508882564 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

WCMS-1500CS

APP174

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

LAS VEGAS 89014

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA ITM.22513465 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): 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 1964 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
00000076637	YES NO X	06 30 1964 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 1964 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
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
NV MEDICAID		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 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
BRANDON NGUYEN	1508882564	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? / $ CHARGES
CORRECTED CLAIM		YES X NO
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 V23.1 3 V21.3 2 V21.0 4 V24.2		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 / 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	7282112	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)227-4040
BRANDON NGUYEN, DO	LAS PAIN INSTITUTE & MEDI 2705 W HORIZON RIDGE PKWY HENDERSON, NV 89052	LAS VEGAS PAIN INSTITUTE 4616 W SAHARA AVE # 337 LAS VEGAS, NV 89102-3654
SIGNED 12/06/2010 DATE	a 1659431443 b	a 1508882564 b

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

EXHIBIT 3

Patient History - Detail

LAS VEGAS NEUROSURGERY & SPINE CARE

By Date of Service
Date ranges 08/04/2009 to 05/16/2011
All Providers
Show last billed date
All Items

Chart #:	4000	**Home Phone:**	(702) 263-2936
Patient Name:	POREMBA,WILLIAM	**Office Phone:**	702
Address:	168 RED ARCHES CT	**Resp. Party:**	POREMBA,WILLIAM
City, State, Zip:	HENDERSON, NV 89012	**Resp. Acct#**	115867

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	99024		N	N	11/3/2009	NAGAU	430064	$0.00	$0.00	$0.00	$0.00	$0.00			115867
	99024		N	N	9/22/2009	NAGAU	429296	$0.00	$0.00	$0.00	$0.00	$0.00			115867
	99024		N	N	8/26/2009	NAGAU	416246	$0.00	$0.00	$0.00	$0.00	$0.00			115867
	63075		Y	Y	8/13/2009	NAGAU	415864	$5,600.00	$5,600.00	$0.00	$0.00	$0.00	TEAM2	10/08/2009	115867
	PI	I	Y	Y	10/23/2009	NAGAU	1962147		($1,915.59)						
	WOINS	I	Y	Y	10/23/2009	NAGAU			($3,634.41)						
	WOCOLL	P	Y	Y	5/6/2010	NAGAU			($50.00)						
	69990		Y	Y	8/13/2009	NAGAU	415864	$3,125.00	$3,125.00	$0.00	$0.00	$0.00	TEAM2	10/08/2009	115867
	WOIND	I	Y	Y	11/4/2009	NAGAU			($3,125.00)						
	22554		Y	Y	8/13/2009	NAGAU	415864	$5,600.00	$5,600.00	$0.00	$0.00	$0.00	TEAM2	10/08/2009	115867
	PI	I	Y	Y	10/23/2009	NAGAU	1962147		($918.57)						
	WOINS	I	Y	Y	10/23/2009	NAGAU			($4,681.43)						
	22845		Y	Y	8/13/2009	NAGAU	415864	$6,000.00	$6,000.00	$0.00	$0.00	$0.00	TEAM2	10/08/2009	115867
	PI	I	Y	Y	10/23/2009	NAGAU	1962147		($1,099.01)						
	WOINS	I	Y	Y	10/23/2009	NAGAU			($4,900.99)						
	22851		Y	Y	8/13/2009	NAGAU	415864	$1,995.00	$1,995.00	$0.00	$0.00	$0.00	TEAM2	10/08/2009	115867
	PI	I	Y	Y	10/23/2009	NAGAU	1962147		($610.35)						

* U = Unapplied * I = Bill Insurance * B = Insurance Billed

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Patient History - Detail

LAS VEGAS NEUROSURGERY & SPINE CARE

By Date of Service
Date ranges 08/04/2009 to 05/16/2011
All Providers
Show last billed date
All Items

Chart #:	4000	**Home Phone:**	(702) 263-2936
Patient Name:	POREMBA,WILLIAM	**Office Phone:**	702
Address:	168 RED ARCHES CT	**Resp. Party:**	POREMBA,WILLIAM
City, State, Zip:	HENDERSON, NV 89012	**Resp. Acct#**	115867

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	WOINS	I	Y	Y	10/23/2009	NAGAU			($1,384.65)						
	20930		Y	Y	8/13/2009	NAGAU	415864	$560.00	$560.00	$0.00	$0.00	$0.00	TEAM2	10/08/2009	115867
	PI	I	Y	Y	10/23/2009	NAGAU	1962147		($176.52)						
	WOINS	I	Y	Y	10/23/2009	NAGAU			($383.48)						
	77003		Y	Y	8/13/2009	NAGAU	415864	$350.00	$350.00	$0.00	$0.00	$0.00	TEAM2	10/08/2009	115867
	PI	I	Y	Y	10/23/2009	NAGAU			($42.62)						
	WOINS	I	Y	Y	10/23/2009	NAGAU			($307.38)						
	99214		Y	Y	8/4/2009	NAGAU	416333	$350.00	$350.00	$0.00	$0.00	$0.00	TEAM2	09/03/2009	115867
	PI	I	Y	Y	10/7/2009	NAGAU			$0.00						
	WOINS	I	Y	Y	10/7/2009	NAGAU			($350.00)						
	76000	VOID	Y	N	9/22/2009	NAGAU	415864		$0.00				TEAM2	09/03/2009	115867
	76000	VOID	Y	N	8/13/2009	NAGAU	415864		$0.00				TEAM2	09/03/2009	115867
Grand Total:								**$23,580.00**	**$23,580.00**	**$0.00**	**$0.00**	**$0.00**			

* U = Unapplied * I = Bill Insurance * B = Insurance Billed

Generated 5/16/2011 8:34:08 AM Powered by AdvancedMD

Aury N. Nagy, M.D.
Las Vegas Neurosurgery & Spine Care, LLC
8285 W. Arby Avenue, #220
Las Vegas, NV 89113
(702) 737-7753 Fax 407-7066

FOLLOW-UP OFFICE CONSULTATION REPORT

Patient: POREMBA, WILLIAM
Date: August 4, 2009

Primary Working Diagnosis:
Requested by:

Interval History

Since I last saw him, his neck pain continues. He has brought in his MRI of his cervical spine again which we went over and we talked about the risks and benefits of the procedure and the exact nature of the operation. He also showed me an older cervical spine MRI and showed me a lumbar spine MRI which shows some annular tears at L4-5 and L5-S1 with darkened discs at these levels without significant central canal stenosis or neuroforaminal stenosis. He reports he has severe back pain and leg pain, worse in the left leg than in the right. The pain that he has in the right is more on the right SI joint but is also in the back. I told him we are going to focus on addressing his neck issues first and then hopefully we will get him feeling better from that standpoint and can start to address his back afterwards. He understands and I will see him then. We will see him on the date of surgery if he clears his prep evaluation.

Aury N. Nagy, M.D.
ANN/lp

Dictated but not proofread.
Subject to transcription variance.

CC: Rob Kari

EXHIBIT 4

LAS VEGAS PAIN INSTITUTE & MEDICAL CENTER, L.L.C.

3835 S. Jones Blvd., #104
Las Vegas, NV 89103
Fax (702) 880-4197

2705 W. Horizon Ridge Pkwy
Henderson, NV 89052
Fax (702) 492-4719

Phone (702) 880-4193

www.lasvegaspaininstitute.com

To Whom This May Concern: Date: Oct 22, 2010

This letter is in regards to patient William Poremba patient has been treating at our office since April 17, 2009 when Mr. Poremba first came to us as a patient with Cervical, Thoracic, Lumbar, Left Knee Pain his MRI's then stated that the patient had a Cervical posterior annular tear and disc protrusion at the C5-C6. It also states that his Thoracic spine had no bulging or herniation at any level. Patient's Lumber exhibited a 2mm posterior disc bulge with annular tear at his L4-5 and his MRI of the knee has mild joint effusion with a grade I anterior ligament and posterior ligament strain, But new MRI's show that the patient's Cervical, Thoracic, Lumbar and Left Knee show that the patient's pain has progressed cervical spine has and anterior fusion that has worsened since the last MRI, patient's lumbar spine show that the diffuse signal intensity has increased and that patient has disc dehydration and bulging with bilateral foraminal stenosis and the pain in his knee has worsened his new MRI shows that the knee's effusion has increased comparing to the MRI that was done prior, our patient states that he has been in pain for that last couple of months we are asking on behalf of Mr. Poremba that you review his case for reopening.

Please call my office with any questions that you may have at the number listed above

Sincerely,

Sudhir Khemka M.D.

EXHIBIT 5

AFFIDAVIT OF WILLIAM POREMBA

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

WILLIAM POREMBA, being first duly sworn, deposes and says that he has personal knowledge and is competent to testify to the following facts:

1. On September 25, 2009, I settled with a third-party, Pratte Development, for $63,500.00 in regards to the accident of July 22, 2005, that is the subject accident involved in this claim for worker's compensation benefits. I received a total net of $34,631.51.

2. Since receiving the settlement, I have spent approximately $14,000.00 for medical insurance payments, prescriptions, and co-pays in medical expenses for injuries relating to my accident of July 22, 2005. The bills incurred have exceeded the total net I received of $34,631.51.

3. I have earned approximately $5,197.55 per year since the date of the my settlement.

4. Since my accident of July 22, 2005, I have worked a total of five and half month until the present. I tried to return to work on November 1, 2008, earning $15,013.08 for 2008. I worked from January to April 2009 and had to quit my job due to pain in my cervical spine. I was told not to go back to work by my surgeon, Dr. Aury Nagy. I was told my pain is from disc impinging on my spinal cord. Since my accident of 2005 I have three torn discs throughout my spine. I continue to have severe pain to this day in my spine.

5. I filed tax returns for 2009, 2010, 2011. I have not filed yet for 2012. In 2009, I earned, $15,777.00. In 2010 and 2011, I have no wage earnings. I am currently unemployed and cannot work in the field I am trained in due to the injuries suffered in the accident of July 22, 2005.

6. I currently have approximately over $20,000.00 in unpaid medical bills.

7. In 2009, my mortgage was $2,375.35. In September, 2009, my mortgage adjusted to $2,814,46. In just nine months, for my mortgage alone, I ran out of money. This is also including

my utilities during the end of the summer months were totaling around $1,700.00 per month. With my electric bill alone being $600.00 to $700.00 a month. Also, the money was spent on expenses required in supporting two children, one in college and the other in middle school at the time.

8. My treating doctors since 2009 are Dr. Aury Nagy, Dr. Eric Easton, Dr. Jeremy Lipshutz, Dr. Roger Metha, Dr. Karl, Dr. Maduka, Dr. Ghani and Dr. Gutpa. Presently I am seeing Dr. Roger Metha, from Southwest Medical Associates at the Siena Heights office. I've been seeing him for the past year since he is the only doctor presently on my insurance, that I can see with regards to my spinal injuries.

FURTHER, AFFIANT SAYETH NAUGHT.

WILLIAM POREMBA

SUBSCRIBED and SWORN to before me
this 11th day of April, 2013.

JOSIE LEON
Notary Public-State of Nevada
APPT. NO. 96-2387-1
My App. Expires March 30, 2014

Notary Public in and for said
County and State

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 Appeal No.: 1306201-SL Employer: SOUTHERN NEVADA PAVING 3101 E. CRAIG ROAD N. LAS VEGAS, NV 89030 **DOH: 4/23/13 at 10:30 A.M. stack**

INSURER'S REPLY BRIEF IN SUPPORT OF ITS 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 files this Reply Brief in support of its Motion for Summary Judgment because there are no material facts in dispute the Claimant cannot prevail in reopening his claim.

POINTS AND AUTHORITIES

I.

UNDISPUTED FACTS

Claimant was involved in a vehicle-heavy equipment accident on or about July 22, 2005. He treated on his own outside of worker's compensation arena on August 2, 2005. (Insurer's Document Packet, p. 11-12).

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. Appropriate care was provided.

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).

The Insurer informed the Claimant and his counsel of its lien in August 2005. (Insurer's Document Packet, p. 24).

APR 15 2013

The claim closed. There was no appeal of claim closure.

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 previously sought to reopen his claim, more than one year after it closed. With that attempt, Claimant provided a one page letter from Sudir Khenika MD seeking reopening based on 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 appealed the denial of reopening and the hearing officer affirmed it. (Exhibit pp. 103-107).

Claimant filed another appeal and an Appeals Officer granted the Insurer's Motion for Summary Judgment on May 17, 2011. (Exhibit pp. 108-116).

A year later, on November 8, 2012 the Claimant, through counsel, sought reopening of his claim for a second time. (Exhibit p. 117). **This current request for reopening did not have any medical evidence attached to the letter.**

On November 8, 2012, the Insurer denied the request for reopening. (Exhibit p. 118). Claimant appealed and the parties agreed to by-pass the hearing officer. This Appeal follows.

Per the Opposition, Claimant personally netted $34,631.51 in settlement proceeds. This money has not been spent since claim closure on medical treatment which the Insurer would have been liable for under the claim.

///

///

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).

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).

Here, the Claimant must prove two things and he can prove neither of them: 1) that he has spent his proceeds since claim closure on medical treatment for his industrial injuries and 2) that he meets the requirements of NRS 616C.390 to reopen his claim.

Regarding the first obstacle, the law in Nevada is clear that a Claimant must first prove that he 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, upon information and belief, 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.

It is undisputed that the Claimant personally received $34,631.51 in settlement proceeds. The fact that some of this money was advanced by his personal injury lawyers does not affect the requirements under Chandler. 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 $34,631.51 on his own related health care for treatment that would have been the responsibility of the Insurer.

The bills he relies upon are for services rendered BEFORE September 2009, not after so they do not count against the offset for future medical benefits. By the Claimant's own ADMISSION he has spent approximately $15,000 on medical expenses since September 2009. This proves that legally, his request for reopening may not be granted.

When Claimant says that his bills have exceed his $34,631.51 he is talking about bills incurred BEFORE his settlement, those do not count in the overpayment. He admits that he has only spent $14,000 on medical treatment since receiving the settlement.

His employment situation and how much or how little he earned has nothing to do with the requirements, by law, for him to expend all of his settlement proceeds on medical treatment ONLY that was incurred SUBSEQUENT to his settlement. He cannot prove this.

He admits that he spent his settlement proceeds on his living expenses, mortgage, utility bills and to support his children. That does not affect the law with regard to reopening.

Thus, there is legally no way that the Claimant can prove reopening, even assuming arguendo that he had new medical evidence to show his need for more treatment on an industrial basis.

Secondly, there was no medical documentation provided with the current request to reopen, NONE. The medical reporting provided with the Opposition to the Motion for Summary Judgment is old and was used in the last attempt to reopen, which failed.

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Therefore based upon all of the evidence in the record the Claimant has neither proven that he has expended all of his proceeds from his third party recovery, nor has he submitted any medical evidence to support reopening under NRS 616C.390.

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.

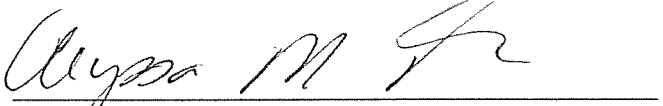
CONCLUSION

For the foregoing reasons, the Insurer respectfully request an Order Granting its Motion for Summary Judgment and vacating the appeal hearing scheduled for April 23, 2013.

DATED: April 11, 2013.

Respectfully submitted,

LEWIS BRISBOIS BISGAARD & SMITH LLP

By: 

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BUILDERS INSURANCE COMPANY

CERTIFICATE OF MAILING

Pursuant to Nevada Rules of Civil Procedure 5(b), I hereby certify that, on the 12th day of April, 2013, 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:

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