Fire Pension Board Meeting Agenda

July 16, 2025, 9:30 a.m. via Microsoft Teams

1.) Approval of minutes for May 21, 2025

2.) Bills and Pension Rolls:

PENSION ROLL		
Budgeted Amount	$709,000.00	
April 2025	$56,017.15	
Remaining budget	**$452,808.18**	**63.87%**
MEDICAL CLAIMS		
Budgeted amount	$1,946,000.00	
April 2025	$109,235.49	
April 2025 HMA fees	$14,905.35	
Remaining budget	**$1,299,567.95**	**66.78%**
PENSION ROLL		
Budgeted Amount	$709,000.00	
May 2025	$54,670.51	
Remaining budget	**$398,137.67**	**56.15%**
MEDICAL CLAIMS		
Budgeted amount	$1,946,000.00	
May 2025	$191,816.64	
May 2025 HMA fees	$14,905.35	
Remaining budget	**$1,092,845.96**	**56.16%**

3.) Action Items:

Member #29	Request for reimbursement in the amount of 828.82 (benefit of $2500 has been exhausted) to restore a dental implant for lost tooth
Member #128	Request for reimbursement of $440.79 for chiropractic care (from last meeting - processed through HMA)

4.) Other Items:

Adjusting medical benefit caps for inflation (requested from last meeting)

DRAFT

Fire Pension Board Minutes
City Of Everett
May 21, 2025

The regular meeting of the Fire Pension Board was called to order at 9:30 a.m. on May 21, 2025. Board Members Neyens, Schwab and Vitalich were present. Board Members Jorve and Franklin were excused. Ana Mechler, Human Resources; Ramsey Ramerman , Board Attorney and Richard Gray and Wai Poon, Finance were also present.

APPROVAL OF MINUTES

The minutes of the meeting of April 16, 2025 were approved.

BILLS AND PENSION ROLLS

PENSION ROLL		
Budgeted Amount	$709,000.00	
March 2025	$65,911.05	
Remaining budget	**$508,825.33**	**71.77%**
MEDICAL CLAIMS		
Budgeted amount	$1,946,000.00	
March 2025	$132,582.32	
March 2025 HMA fees	$14,905.35	
Remaining budget	**$1,423,708.79**	**73.16%**

Moved by Neyens, seconded by Vitalich, to approve the pension rolls claims as presented.

Roll was called with all members voting yes except Board Members Jorve and Franklin who were excused.

Motion carried.

Moved by Neyens, seconded by Vitalich, to approve the medical claims as presented.

Roll was called with all members voting yes except Board Members Jorve and Franklin who were excused.

Motion carried.

ACTION ITEM

Member #128 Request for reimbursement of $440.79 for chiropractic care.

Moved by Neyens, seconded by Vitalich, to conditionally approve the request for reimbursement of $440.79 for chiropractic care if HMA does not reimburse member.

Roll was called with all members voting yes except Board Members Jorve and Franklin who were excused.

Motion carried.

Member #101 Request for reimbursement of $215.68 for compounded medication.

Moved by Vitalich, seconded by Neyens, to approve the request for reimbursement of $215.68 for compounded medication.

Roll was called with all members voting yes except Board Members Jorve and Franklin who were excused.

Motion carried.

OTHER:

Michael Brittain from RBC presented the 2024 financial report.

James Weewie passed away on 5/10/2025.

Dave Neyens asked that the idea of adjusting medical benefit caps on a regular basis for inflation be added to the next agenda.

The Board meeting adjourned at 10:03 a.m.

_____
Rick Gray, Acting Board Secretary

EVERETT
WASHINGTON

City of Everett
Fire & Police Pension
2930 Wetmore EVERETT,
WA 98201
(425) 257-7024

CLAIM FORM

PENSION BOARD APPROVAL:
I certify that the named patient is authorized to receive the described medical care at the expense of the City of Everett Uniformed Personnel Pension Fund. Payment is approved by board action this date. I am authorized to authenticate and certify said claim.

City Clerk or Secretary of Board _____ Date _____

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE'S NAME	☐ ACTIVE ☑ RETIRED	DATE OF BIRTH	TELEPHONE NO.	☐ POLICE ☑ FIRE
[redacted]		[redacted]	[redacted]	
COMPLETE HOME ADDRESS [redacted]			SOCIAL SECURITY NO. [redacted]	☑ MALE ☐ FEMALE

THIS SPACE FOR OFFICE USE ONLY

ACCOUNT NUMBER	VOUCHER NO.	VENDOR NO.	DESCRIPTION	AMOUNT
☐ 6375380000250 ☐ 6385380000250			☐ MED SERV ☐ RX ☐ CHIRO SERV ☐ REIMB ☐ OTHER	

I certify that the information and charges here shown are true and correct, and that these services and/or medications were received by me and that I am liable for these charges. I hereby authorize all doctors, pharmacists, hospitals or other instiutions rendering care and treatment to furnish the Fire/Police Pension Board with full information regarding treatment rendered (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish the Fire/Police Pension Board with information regarding benefits to which I may be entitled. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby assign benefit to the supplier/vendor below.

DATE 6/12/25 EMP [redacted]

STATEMENT OF ATTENDING PHYSICIAN OR OTHER SUPPLIER/VENDOR CHARGES

DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIAGNOSIS CODE OTHER THAN ICDA USED, GIVE NAME)

REPORT OF SERVICES (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE IF USED (IF CODE OTHER THAN CPT ★★ USED, GIVE NAME	CHARGES
3/12/2	dentis	cone beam limited and limited oral	D0364 & D0140	486.00
3/28/25	dentis	bone craft at time of implant	D6104	340.82

DO NOT WRITE IN THIS SPACE

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

TOTAL CHARGES $ 828.82

TOTAL PAYMENTS $ _____

DATE	SUPPLIER/VENDOR NAME (PRINT)	SIGNATURE	TELEPHONE
STREET ADDRESS	CITY OR TOWN	STATE OR PROVIDENCE	ZIP CODE

514-409 (REV. 6/06)

PENSION BOARD

ANDREW SHOLUDKO

10830 19TH AVE S.E. #A
EVERETT, WA 98208
(425)338-7134

June 03, 2025

[redacted]

ID: 870

Account Aging	
Current:	$0.00
30 Days:	$0.00
60 Days:	$828.82
90 Days:	$0.00
Contract:	$0.00
Balance Due:	$828.82
Estimated Insurance:	$0.00
Balance Due Now:	**$828.82**

Date	Patient	Provider	Transaction	Tth	Surface	Fee
3/28/2025	[redacted]	Andrew Sholudko	06010 - SURGICAL PLACEMENT OF IMPLANT BODY (Standard Fee $2,342.00) (Adjust $0.00) (Fee $2,342.00)	14		$2,342.00
	[redacted]	Andrew Sholudko	06104 - BONE GRAFT AT TIME OF IMPLANT (Standard Fee $504.00) (Adjust $0.00) (Fee $504.00) (Est Insurance $346.00)	14		$504.00
3/12/2025	[redacted]	Shelby Case	04910 - PERIO MAINTENANCE (Standard Fee $200.00) (Adjust $0.00) (Fee $200.00)			$200.00
	[redacted]	Andrew Sholudko	00140 - LIMITED ORAL EVALUATION (Standard Fee $97.00) (Adjust $0.00) (Fee $97.00) (Est Insurance $69.00)			$97.00
	[redacted]	Andrew Sholudko	D0364 - CONE BEAM: LIMITED VIEW (Standard Fee $389.00) (Adjust $0.00) (Fee $389.00)			$389.00

SubTotal:	$3,532.00
Tax:	$0.00
Charge(s):	$3,532.00
Balance Due:	$828.82

Contract Balance	Estimated Insurance	Previous Balance	Charge(s)	Payment(s)	Adjustment(s)	Balance Due Now
$0.00	$0.00	($2,703.18)	$3,532.00	$0.00	$0.00	**$828.82**

Thank You for Visiting our Office.

Current Dental Terminology (CDT)

Electronic Payment Clearinghouse
Healthcare Management Administrators
PO Box 85008
Bellevue, WA 98015-8508

HUNTINGTON NATIONAL BANK
Westerville OH 43081
Electronic Payment Clearinghouse
Echo Health, Inc

56-1512
441

DRAFT NO. 369694993
DRAFT DATE 06/02/2025

HMA

PAYABLE THROUGH DRAFT Two Hundred& 00 / 100 DOLLARS

AMOUNT
**********$200.00

VOID AFTER 180 DAYS

TO THE ORDER OF
ANDREW P SHOLUDKO DMD
10830 19TH AVE S E A
EVERETT WA 98208

VOID

NON-NEGOTIABLE

⑈369694993⑈ ⑆044115126⑆ 0166950861 2⑈

Your name, ANDREW P SHOLUDKO DMD, and Tax ID have been verified by the IRS.

For online access to eligibility and claims information, visit http://accesshma.com

Tax ID: 473481963 *EPC Draft #:* 369694993 *Payment Week:* 22 *Payment Date:* 06/02/2025 Page 1 of 1

Service Date	Code or Description	Explanation Code	Billed Amount	Discount Amount	Other Plan Payment	Other Adjustment	Patient Obligation	Net Payment Amount	Messages
Provider: ANDREW P SHOLUDKO DMD Network: Patient Acct #: [redacted]			Patient Name: [redacted] Member Number: [redacted] Claim Number: 8594076501				Group/Check Number: 020188/69467262 Customer Service #: (833)865-0141 Administered By: HMA		
03/12/25	D4910		200.00	0.00	0.00	0.00	0.00	200.00	
03/12/25	D0140	DX	97.00	0.00	0.00	0.00	97.00	0.00	
03/12/25	D0364	DX	389.00	0.00	0.00	0.00	389.00	0.00	
		Total:	686.00	0.00	0.00	0.00	486.00	200.00	

Statement Summary Administered By	Billed Amount	Discount Amount	Other Plan Payment	Other Adjustment	Patient Obligation	Net Payment Amount	Customer Service Phone Number
HMA	686.00	0.00	0.00	0.00	486.00	200.00	(800) 869-7093

Statement Totals	Billed Amount	Discount Amount	Other Plan Payment	Other Adjustment	Patient Obligation	Net Payment Amount
	686.00	0.00	0.00	0.00	486.00	200.00

Explanations

Administered by	Code	Description
HMA	DX	THE DENTAL MAXIMUM BENEFIT HAS BEEN MET.

HMA

Select Provider: All Providers

Current Patient: [redacted]

Eligibility | Claims

Show/Hide Search

Claim Number(s):

Begin Date: 2/5/2025

End Date: 5/5/2025

Search

Claim Information

Claim #:	8557538301	Patient Name:	[redacted]	Employee Name:	[redacted]
Claim Status:	Processed	Patient ID:		Plan Name:	
Receive Date:	04/07/2025	Patient DOB:		Employer Name:	CITY OF EVERETT
Provider Name:	ANDREW SHOLUDKO	Patient Account #:		Diagnosis Code(s):	K009
TIN:	473481963	Gender:		Network:	[redacted]

Payment Information

Paid To:	ANDREW P SHOLUDKO DMD	Check #:	69357110	Voucher #:	
Payee Name:	ANDREW P SHOLUDKO DMD	Paid Amount:	$2,500.00	Check Amount:	$2,500.00
Remit:		Paid Date:	04/25/2025		

Claim Details

Date of Service	Proc Code	Modifier	Units	Billed	Allowed	Ineligible	Deductible	Copay	Co-Insurance	Remark Code	Payment Amount
03/28/2025 03/28/2025	D8104		1	$504.00	$158.00	$346.00	$0.00	$0.00	$0.00	DX	$158.00
03/28/2025 03/28/2025	D8010		1	$2,342.00	$2,342.00	$0.00	$0.00	$0.00	$0.00		$2,342.00
Column Totals				$2,846.00	$2,500.00	$346.00	$0.00	$0.00	$0.00		$2,500.00

Comments

COB

Remarks

DX - THE DENTAL MAXIMUM BENEFIT HAS BEEN MET.

Claim for [redacted]

Back to Search Results | Print View | Original EOP View

[redacted]

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF [redacted] of the board.

Member Name (please print) [redacted]

1. Diagnosis: Lost Tooth

2. Prognosis: restore with implant

3. Type of Treatment(s) or Procedure: implant

4. Cost of treatments/service: $ 4268.82

5. Request to the board for this specific treatment or procedure:

exhausted Automatic Benefit of $3500.00 more
request part of Supplemental $1500.00

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

SENT 12-5-24

Member Reimbursement Claim Form

Instructions

Please use this form if requesting reimbursement for claims related to all medical, dental, and vision services covered by Healthcare Management Administrators (HMA), your third-party Health Plan Administrator. For prescription claims, contact your pharmacy benefits manager (PBM). You will need to complete and submit this form only if your health care professional isn't filing the claim for you. Your health care professional can still file the claim for you if they are out-of-network with your policy; however, they are not required to do so.

Please include a copy of your itemized receipt, bill, and/or invoice with your completed claim form. Your submission must contain all necessary information based on the type of service for which you're requesting reimbursement. The minimum necessary information for each type of service is described below in the "Attachments" section.

☒ I understand that my claim for reimbursement might be delayed or even denied if I haven't provided all the information needed to process my claim.

Note: Providers who are contracted with a PPO Network that is accessible and utilized by your Health Plan are contractually required to bill your Plan and be paid directly by the Plan for services they provide to you. If you have received services from a provider who is in your Plan's PPO Network, we will remit payment to the provider, even if you indicate you want reimbursement to go to you. If you have already paid the provider for your care, you will need to contact them to arrange for a refund, if applicable. Moving forward, be sure to provide your providers with your insurance card so they can bill your Plan directly.

Any questions? We are here to help! Contact Customer Care at 800-869-7093.

Submission Information

Please choose one of the following methods below for submitting your claim reimbursement request (pick any option that works for you):

Electronic Submission Options

✓ **Option 1: DocuSign**:
1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Scroll to **Member Reimbursement Claim Form** and click **Complete Online**
3. Complete and submit the form and a copy of your itemized receipt, bill, and/or invoice through DocuSign

✓ **Option 2: HMA Member Portal**:
1. Login to the member portal at https://memportal.accesshma.com/login
2. In the member portal, click on **Manage Claims & Deductibles**, click on **Submit a Claim**, and follow the prompts - be sure to upload a copy of your itemized receipt, bill, and/or invoice

Paper Submission Options

1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Scroll to **Member Reimbursement Claim Form** and click **Download pdf**
3. Fill out the form in compatible PDF software like Adobe Reader or Acrobat (it is not recommended to try filling out the form in a web browser or on a mobile device, as the form may not work correctly) or print out the form and fill it out by hand
4. Use one of the submission options below:

✓ **Option 1: Fax** the completed form and a copy of your itemized receipt, bill, and/or invoice to: 866-458-5488

✓ **Option 2: Mail** the completed form and a copy of your itemized receipt, bill, and/or invoice to:
HMA
Attn: Claims Department
PO Box 85008
Bellevue, WA 98015-5008

HMA

Member Reimbursement Claim Form

Patient Information

First Name [redacted] **Last Name** [redacted]

Date of Birth [redacted] **Member ID Number**[1] [redacted]

Group/Employer Name City of Everett **Group Number**[1] 020188

Service Type

Please select the type of service for which you're requesting reimbursement. If more than one service type applies, you must submit a separate claim form for each. If you're completing this form electronically, your selection here drives which information will be marked as required in the "Attachments" and "Claim Information" sections below.

Service Type Select...

Attachments

Please include all relevant documentation (such as an itemized receipt, bill, and/or invoice) with your submission. The checkboxes below indicate which information your documentation must contain for each service type. **Failure to provide the requested information may cause your claim to be delayed or denied.**

☒ **Required for all service types:** Date(s) of service and total amount you were billed for each service rendered / equipment purchased

☐ **Required for all service types *except* durable medical equipment (DME) purchased through a store (not purchased through a certified DME vendor):** Patient name, provider full name and mailing address, including city, state, and ZIP code, procedure codes such as CPTs or HCPCs, and one or both of the following: Provider's national provider identifier (NPI) number, provider's tax ID number (TIN)

☐ **Required for all service types *except* DME purchased through a store and massage therapy:** Diagnosis code(s), in ICD format

Claim Information

Please enter all necessary information below or ensure it's listed on the documentation you're attaching with your submission such as an itemized receipt, bill, and/or invoice. **Failure to supply all the required information may cause your claim to be delayed or denied.**

↓ Check each applicable box below if you're including an attachment that contains this information. If so, no need to also write the information below.

☒ **Date(s) of Service**[2] 9-20-24/9-24-24/9-25-24/9-27-24/10-04-24/10-08-24/10-11-24

☐ **Total Billed Amount** $440.79

☐ **Provider Name** CASCADIA CHIROPRACTIC AND MASSAGE

☐ **Provider Mailing Address** 1507 172nd ST. NE SUITE A

City MARYSVILLE **State** WA **ZIP Code** 98271

☐ **Procedure or Service Codes (such as CPTs or HCPCs)**[3] PLEASE SEE "CHART NOTES"

☐ **Diagnosis Codes (in ICD format)**[4] PLEASE SEE "CHART NOTES"

☐ **Provider's NPI Number**[5] **and/or Tax ID Number (TIN)**[6] PROVIDER WOULD NOT PROVIDE

---

1 This information can be located on your insurance ID card. "Member ID" is also called "Employee ID".

2 For DME you purchased through a store, this is the purchase date.

3 Procedure/Service Code (CPT/HCPC) is usually a five-digit number that describes the services/products provided.

4 Diagnosis Code (ICD) is usually a three- to seven-character alphanumeric code that indicates the reason for your healthcare treatment.

5 National Provider Identifier (NPI) is a unique 10-digit ID issued to U.S. healthcare providers by the Centers for Medicare and Medicaid Services (CMS). If you don't know your provider's NPI, please contact your provider to obtain it before submitting your claim for reimbursement. If you submit your claim without this information, it might be denied if we're unable to verify your provider.

6 Tax Identification Number (TIN) is a unique 9-digit ID issued by the IRS. If you don't know your provider's TIN, please contact your provider to obtain it before submitting your claim for reimbursement. If you submit your claim without this information, it might be denied if we're unable to verify your provider.

HMA

Member Reimbursement Claim Form

Accident Information

Is This Claim Due to an Accident? ☒ No (skip to next section) ○ Yes (fill out this section)

Accident Date _____ **Accident Location** ○ Home ○ Work ○ School ○ Auto ○ Other _____

How Did the Accident Happen? _____

Are You Filing a Claim with Labor & Industries (L&I), Homeowner/Auto Insurance, or Any Other Party? ○ Yes ☒ No

Signature

Note: It's a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

By signing below, I indicate the following:

- ☒ I certify that the information I provided on this form is true and complete to the best of my knowledge.
- ☒ I expressly authorize any provider of care to provide Healthcare Management Administrators with any records concerning me or any member of my family for whom benefits or services have been claimed.
- ☒ I understand that my claim for reimbursement might be delayed or even denied if I haven't provided all the information needed to process my claim.

[redacted] _____

Relationship to Patient (If you are the patient, put "Self")

[redacted] _____

12-6-24

Date

PLEASE SEE ATTACHED NOTE.

Healthcare Management Administrators
PO Box 85016
Bellevue, WA 98015-5016

[SF-]

Forwarding Service Requested

**********5-DIGIT 98223
L524 1 AV 0.545 39

[redacted]

Explanation of Benefits

THIS IS NOT A BILL

Customer Care

Have Questions? www.accesshma.com
Toll Free: (800) 869-7093
Hours: Monday - Friday 5 AM to 6 PM PST

Group Name: CITY OF EVERETT
Group #: 020188
Member ID: [redacted]
Date: 02/11/2025

Hi [redacted]

This Explanation of Benefits (EOB) gives you information about how an insurance claim submitted by you or your healthcare provider (such as a doctor, hospital, or pharmacy) was handled on your behalf. There is a lot of information packed into this document:

- The Summary of Activity shows the amount billed by your healthcare provider, any discounts that were applied, the amount your health plan paid, and any balance you owe to your provider (which you may have already paid).
- The Detailed Claim Breakdown section breaks everything down for you.
- The My Spend and Family Spend sections show how much of the claim was applied to your deductible. It also shows the remaining amount needed to meet your deductible, as well as where you are with your out-of-pocket maximum for the year.

Each time you receive an EOB, review it closely and compare it to the bill or statement from your healthcare provider. If you have any questions, contact us at the phone number provided in the box at the top of this page.

THIS IS NOT A BILL

SUMMARY OF ACTIVITY

This covers claims processed between 12/26/2024 - 02/11/2025

Total Billed Amount	$1,037.79	This is the total amount of charges during this period.
Discount & Adjustments	$307.82	Healthcare Management Administrators negotiates discounts with health care professionals and facilities to help you save money.
Amount Not Covered	$440.79	This is the portion of your bill that is not covered by your plan. You may or may not need to pay this amount. We'll cover that information for you in the Detailed Claim Breakdown.
What Your Plan Paid	$58.24	This is the total amount your plan paid during this period.
What You Pay	$0.00	This is the amount you owe after your discount and what your plan paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. You may or may not have already paid this amount.
You Saved	$366.06	This is a total of your discount and what your plan paid.

DETAILED CLAIM BREAKDOWN FOR [redacted]

Provider: APURVA OMKAR BADHEKA MD
Claim #: 8386144601

							Paid		Patient Responsibility		
Date & Type of Service	Amount Billed	Member Discount	Amount Not Covered	Reason Code	Amount Covered	Other Insurance Paid	Paid At	What Your Plan Paid	Deductible Amount	Co-Insurance Amount	Co-pay Amount
09/13-09/13/2024 DIAGNOSTIC TESTING	$73.00	$47.80	$0.00	CX	$25.20	$20.16	100%	$5.04	$0.00	$0.00	$0.00
TOTALS	**$73.00**	**$47.80**	**$0.00**		**$25.20**	**$20.16**			**$0.00**	**$0.00**	**$0.00**
							COB Credit:	**$0.00**			
							Adjustments:	**$0.00**			
							Plan Paid:	**$5.04**	Amount You May Owe:		$0.00

DETAILED CLAIM BREAKDOWN FOR [redacted]

Provider: PROVIDER PAID BY EMPLOYEE
Claim #: 8434848001

							Paid		Patient Responsibility		
Date & Type of Service	Amount Billed	Member Discount	Amount Not Covered	Reason Code	Amount Covered	Other Insurance Paid	Paid At	What Your Plan Paid	Deductible Amount	Co-Insurance Amount	Co-pay Amount
09/20-10/11/2024 INELIGIBLE	$440.79	$0.00	$440.79	2U ME	$0.00	$0.00	0%	$0.00	$0.00	$0.00	$0.00
TOTALS	**$440.79**	**$0.00**	**$440.79**		**$0.00**	**$0.00**			**$0.00**	**$0.00**	**$0.00**
							COB Credit:	**$0.00**			
							Adjustments:	**$0.00**			
							Plan Paid:	**$0.00**	Amount You May Owe:		$0.00

DETAILED CLAIM BREAKDOWN FOR [redacted]

Provider: JEFFREY L PAKULA
Claim #: 8432798201

							Paid		Patient Responsibility		
Date & Type of Service	Amount Billed	Member Discount	Amount Not Covered	Reason Code	Amount Covered	Other Insurance Paid	Paid At	What Your Plan Paid	Deductible Amount	Co-Insurance Amount	Co-pay Amount
11/14-11/14/2024 DIAGNOSTIC TESTING	$28.00	$13.98	$0.00	CX	$14.02	$11.22	100%	$2.80	$0.00	$0.00	$0.00
11/14-11/14/2024 PHYSICIAN VISIT	$248.00	$122.01	$0.00	CX	$125.99	$100.79	100%	$25.20	$0.00	$0.00	$0.00
TOTALS	**$276.00**	**$135.99**	**$0.00**		**$140.01**	**$112.01**			**$0.00**	**$0.00**	**$0.00**
							COB Credit:	**$0.00**			
							Adjustments:	**$0.00**			
							Plan Paid:	**$28.00**	Amount You May Owe:		$0.00

DETAILED CLAIM BREAKDOWN FOR [redacted]

Provider: AMANDEEP S SODHI MD
Claim #: 8428531801

Date & Type of Service	Amount Billed	Member Discount	Amount Not Covered	Reason Code	Amount Covered	Other Insurance Paid	Paid At	What Your Plan Paid	Patient Responsibility: Deductible Amount	Co-Insurance Amount	Co-pay Amount
11/25-11/25/2024 PHYSICIAN VISIT	$248.00	$124.03	$0.00	CX	$123.97	$98.77	100%	$25.20	$0.00	$0.00	$0.00
11/25-11/25/2024 MISC. MAJOR MEDICAL	$0.00	$0.00	$0.00		$0.00	$0.00	100%	$0.00	$0.00	$0.00	$0.00
11/25-11/25/2024 MISC. MAJOR MEDICAL	$0.00	$0.00	$0.00		$0.00	$0.00	100%	$0.00	$0.00	$0.00	$0.00
TOTALS	**$248.00**	**$124.03**	**$0.00**		**$123.97**	**$98.77**			**$0.00**	**$0.00**	**$0.00**

COB Credit:	**$0.00**		
Adjustments:	**$0.00**		
Plan Paid:	**$25.20**	Amount You May Owe:	$0.00

Reason Code/Description	
1A	MEMBER SUBMITTED CLAIM. REIMBURSEMENT, IF ANY, IS ENCLOSED.
2U	PLEASE SUBMIT THE PROVIDERS FULL NAME, DEGREE, TAX ID NUMBER (TIN), AND NATIONAL PROVIDER IDENTIFIER (NPI).
IC	BILLING WAS SUBMITTED WITH AN INVALID PROCEDURE CODE. PLEASE PROVIDE THE CPT CODE OF THE SERVICE PERFORMED.
ME	MEDICARE IS THE PRIMARY PAYOR, PLEASE SUBMIT THE EXPLANATION OF BENEFITS (EOB) THAT CORRESPONDS TO THESE CHARGES.
CX	CHARGE REDUCED TO THE MEDICARE ALLOWANCE, THE PATIENT IS NOT RESPONSIBLE FOR THIS AMOUNT.

[SF-]

What if I need help understanding a denied claim? Contact us at (800) 869-7093 if you need help understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part).

How do I file an appeal? Complete and send in the Request for Appeal within 180 days of this notice. The form is available online at https://www.accesshma.com/news-and-resources/member-forms or call us to have one mailed to you.

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. If you wish to designate someone to act as your authorized representative, please complete the Appointment of Authorized Representative section of the Appeal Form available online at https://www.accesshma.com/news-and-resources/member-forms

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted on an expedited basis. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by calling (800) 869-7093.

Can I provide additional information about my claim? Yes, you may supply additional information. Please send documentation (medical records, clinical notes, from your treating physician(s), etc.) that you wish to have considered as part of your appeal to: Healthcare Management Administrators, PO Box 85016, Bellevue, WA 98015, ATTN: Appeals Department

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us. All requests need to be submitted in writing. You may complete the Authorization to Disclose Protected Health Information form online at https://www.accesshma.com/news-and-resources/member-forms or mail it to us at: Healthcare Management Administrators, PO Box 85016, Bellevue, WA 98015, ATTN: Appeals Department

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at (866) 444-3272. Additionally, a consumer assistance program may be able to assist you. Please note that not all states have Consumer Assistance programs available. If one is available in your area, we have included that information for you on this document. For the most current program available in your area, please go online to: https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc

Healthcare Management Administrators, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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NOTE

12-6-2024

TO WHOM IT MAY CONCERN:

THE ENCLOSED DOCUMENTS (ITEM #1) WERE SUBMITTED TO NORIDIAN HEALTH SOLUTIONS ON 10-15-2024 BY ME BECAUSE THE PROVIDER IS NOT ENROLLED WITH MEDICARE. NORIDIAN RESPONDED WITH A LETTER DATED NOVEMBER 9, 2024, XREF 2308549138 (ITEM # 2).

I'AM SENDING THE PACKET AND NORIDIAN LETTER ALONG WITH THE "MEMBER REIMBURSEMENT CLAIM FORM" FOR YOUR ACTION.

PLEASE NOTE THE PROVIDE WILL NOT SUPPLY ME WITH ANY FURTHER INFORMATION, INCLUDING THE "TIN".

THANK YOU FOR PROCESSING THIS REIMBURSEMENT CLAIM.

[redacted]

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board

Member Name
(please print) [redacted]

1. Diagnosis: _____

2. Prognosis: _____

3. Type of Treatment(s) or Procedure: CHIROPRACTIC CARE

4. Cost of treatments/service: $ 440.79

5. Request to the board for this specific treatment or procedure:

_____
_____
_____
_____

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient: [redacted]	Acct #: 7864	DOB: [redacted]
Ins Co:	Pol #:	Insured ID:

Date 09/20/2024
Provider Michael Breneman DC

Subjective:
[redacted] has had spinal surgery in the lumbosacral junction for discal damage and protrusion. He has been having severe equilibrium and spatial orientation issues that are affectng all ADLs
we see him today as a professional courtesy due to a full schedule treatment abbreviated services were done to asses his condition and only cervical spine imaging was done however his history of lower spine surgery will be investigated in the near future with imaging of the lumbo pelvic areas AP and Lat

Objective:
Rhombergs is positive for loss of equilibrium and any positional change exacerbates his vertigo.
Imaging reveals loss of lordosis and he is locked out of flexion in the occipito atlantal articulation that in our opinion is causing neurologic consequence and disrupting his equilibrium system
He is cantankerous with staff upon entrance and due to his condition we realize he is fearful and distraught.

Assessment:
The patient's condition is responding to care, but is aggravated by normal activities of daily living. all acitivites of daily living are affected
further assessment needs to be accomplished over time.

Plan:
see 3x close and then reassess
fo lumbar spine imaging
Our goals of continued treatment include the following; relief of symptoms, decrease segmental dysfunction, increase active and passive range of motion, increase proprioception, increase function and arrestment of degeneration.

SECTION 4 - SIGNATURE

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

I authorize any holder of medical or other information about me to release it to the Centers for Medicare & Medicaid Services or its designated contractor or the Social Security Administration for this Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to me.

[redacted]	Date Signed *(mm/dd/yyyy)* 10-15-2024

signature line. Have a witness sign his/her name next to the "X" and complete the section below.

If signing this form on behalf of a Medicare patient, on the 'Signature of Patient' line above, indicate the patient's name followed by "By" and sign your name. Provide your name, address, and relationship to the patient with a brief explanation why the patient cannot sign.

Name of Witness *(Last, First, Middle)*

Street Address

City	State	Zip code

Relationship to the Patient

Signature of Witness	Date Signed *(mm/dd/yyyy)*

Briefly explain why the Patient cannot sign:

Send the completed form and supporting documentation to your Medicare contractor. Reference the Medicare Administrative Contractor Address table for the correct address to mail your claim form. If you still do not know the address of your Medicare contractor, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

SECTION 2 - INFORMATION ABOUT SERVICES FURNISHED

FOR ALL CLAIMS Including Influenza and Pneumococcal Vaccinations, describe the illness or injury for which you received treatment.

CHIROPRACTIC ADJUSTMENT MADE ON MY UPPER AND LOWER SPINE TO RELIEVE SYMPTOMS OF PAIN, MOVEMENT LIMITATIONS, NUMBNESS, AND HEADACHES. TREATMENT TOOK PLACE ON, 9-20-24/9-24-24/9-25-24/9-27-24/10-04-24/10-08-24/10-11-24. I BELIEVE THIS CONDITION WAS CAUSED BY AGING AND DEGENERATION OF DICS.

Attach all supporting documentation to the form including an itemized bill with the following information:

- Date of service
- Place of service
- Description of illness or injury
- Description of each surgical or medical service or supply furnished
- Charge for each service
- The doctor's or supplier's name and address
- The provider or supplier's National Provider Identifier (NPI) If known UNKNOWN

IMPORTANT: If the itemized bill is from:

- A Clinical laboratory for ordered tests
- An independent diagnostic imaging center for ordered imaging procedures
- A supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for ordered DMEPOS

The ordering & referring providers legal name **MUST** be included on the itemized bill.

Please also include the ordering & referring providers National Provider Identifier (NPI) if known.

Was the condition related to:

- ○ Yes ◉ No Employment
- ○ Yes ◉ No Auto Accident
- ○ Yes ◉ No Treatment for chronic dialysis or kidney transplant
- ○ Yes ◉ No Other Accident

SECTION 3 - INFORMATION ABOUT HEALTH INSURANCE OTHER THAN MEDICARE

Complete this section if you are age 65 or older and enrolled in a health insurance plan where you or your spouse are currently working and covered by any medical coverage other than Medicare.

- ○ Yes ◉ No Are you employed and covered under an employee health plan?
- ○ Yes ◉ No Is your spouse employed and are you covered under your spouse's employee health plan?
- ◉ Yes ○ No Do you have any medical coverage other than Medicare, such as private insurance, MEDIGAP, employment related insurance, Medicaid, or the Veterans Administration (VA)?

Name of other Medical Insurance

HEALTHCARE MANAGEMENT ADMINSTRATORS INC

Policy Number Including Medicaid ID Number

EMPLOYEE ID # [redacted] Group Name: CITY OF EVERETT Group #: 020188

Policyholder's Name (Last, First, Middle)

[redacted]

Street Address (or P.O. Box) of other Medical Insurance

[redacted]

City [redacted] State [redacted] Zip code [redacted]

Please attach a copy of your primary insurer's Explanation of Benefits if Medicare is secondary.

WA2429000000132_IBMLSCAN12102220240001000132

ITEM 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-1197

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT: PLEASE READ THE ATTACHED INSTRUCTIONS PRIOR TO SUBMITTING A CLAIM TO MEDICARE

SEND ONLY THE COMPLETED FORM TO YOUR MEDICARE ADMINISTRATIVE CONTRACTOR – Include a copy of the itemized bill and any supporting documents. Make a copy of your claim submission for your records and allow at least 60 days for Medicare to receive and process your request.

Reference the Medicare Administrative Contractor Address Table for the correct address to mail your claim form.

Medicare will not process a beneficiary request for payment for diabetic test strips, Part B drugs, or for items paid for under the DMEPOS Competitive Bidding program.

Your reason for submitting this claim: (see the instructions for additional information, check one box only)

- ○ The provider or supplier refused to file a claim for Medicare Covered Services
- ○ The provider or supplier is unable to file a claim for the Medicare Covered Services
- ◉ The provider or supplier is not enrolled with Medicare

IF YOU NEED HELP, CALL 1-800-MEDICARE (1-800-633-4227). TTY USERS SHOULD CALL 1-877-486-2048.

Type of Patient's Request (see instructions for additional information, check one box only):

- ◉ Influenza/Pneumbcoccal Vaccination, Part B (includes physician, laboratory, imaging services), Foreign Travel (including Canada and Mexico) and/or Shipboard Services
- ○ Durable Medical Equipment, Prosthetics, Orthotics and Supplies

PLEASE TYPE OR PRINT INFORMATION

SECTION 1 - PATIENT INFORMATION

[redacted]

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient: [redacted]	**Acct #: 7864**	**DOB:** [redacted]
Ins Co:	**Pol #:**	**Insured ID:**

Date 09/20/2024

Provider Michael Breneman DC

*** *continued from previous page* ***

Diagnosis

M54.2: Cervicalgia
M99.01: Seg and somatic dysf of cervical reg
R42: Dizziness, veritgo or giddiness
R27.8: Other lack of coordination
M40.292: Other kyphosis, cervical reg (reduced cerv curve)
M99.02: Seg and somatic dysf of thoracic reg
M99.03: Seg and somatic dysf of lumbar reg
M99.04: Seg and somatic dysf of sacral reg
S33.5XXS: Sprain of iumbar ligts, seq
M99.85: Other biomechanical lesions of pelvic region
M51.36: Other intervertebral disc degeneration, lumbar region
M43.27: Fusion of spine, lumbosacral region

Electronically Signed
Michael Breneman DC 09/20/2024 07:12 PM

Cascadia Chiropractic and Massage

1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246 Fax: (360) 654-0611

Receipt

[redacted]

Trans ID	000000054990
Order ID	8476828473877382
Payment Type	Credit
Trans Type	Purchase
Clerk ID	75
Date/Time	2024-09-20 14:54:52
Card Type	Visa
Card Number	XXXXXXXXXXXX4543
Entry Legend	CHIP READ
Entry Method	CONTACT
Approval Code	00914D
AC	6635871425118C08
ATC	0068
AID	A0000000031010
AID NAME	VISA CREDIT
TVR	8080008000
TSI	6800
Resp CD	Z3
TRN REF #	304264768930665
VAL CODE	XGVW

Total Amount USD$20.79

Description:_____

Approved - Thank You

X_____
Cardholder Signature

Buyer agrees to pay total amount above according to cardholder's agreement with issuer.

****Customer Copy****
Retain this copy for statement

Printed: 9/20/2024 2:55:54 PM

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient: [redacted]	Acct #: 7864	DOB: [redacted]
Ins Co:	Pol #:	Insured ID:

Date 09/24/2024
Provider Michael Breneman DC

Subjective:
[redacted] sought treatment today, complaining of frequent tightness discomfort in the back of the neck. He describes that the discomfort increases with movement. On a scale of 1 to 10, with 10 being the most severe, he, using a VAS, describes the intensity as a 8 and indicated that the discomfort occurs approximately 80% of the time. He states the discomfort is worse since his last visit.

Objective:
Rhombergs is positive for loss of equilibrium and any positional change exacerbates his vertigo.
Imaging reveals loss of lordosis and he is locked out of flexion in the occipito atlantal articulation that in our opinion is causing neurologic consequence and disrupting his equilibrium system
He is cantankerous with staff upon entrance and due to his condition we realize he is fearful and distraught.

Assessment:
The patient's condition is responding to care, but is aggravated by normal activities of daily living. all acitivites of daily living are affected
further assessment needs to be accomplished over time.

Plan:
see 3x close and then reassess
fo lumbar spine imaging
Our goals of continued treatment include the following; relief of symptoms, decrease segmental dysfunction, increase active and passive range of motion, increase proprioception, increase function and arrestment of degeneration.

Diagnosis
M54.2: Cervicalgia
M99.01: Seg and somatic dysf of cervical reg
R42: Dizziness, veritgo or giddiness
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M40.292: Other kyphosis, cervical reg (reduced cerv curve)
M99.02: Seg and somatic dysf of thoracic reg
M99.03: Seg and somatic dysf of lumbar reg
M99.04: Seg and somatic dysf of sacral reg
S33.5XXS: Sprain of lumbar ligts, seq
M99.85: Other biomechanical lesions of pelvic region
M51.36: Other intervertebral disc degeneration, lumbar region
M43.27: Fusion of spine, lumbosacral region

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient: [redacted] Acct #: 7864 DOB: [redacted]
Ins Co: Pol #: Insured ID:

Date 09/24/2024
Provider Michael Breneman DC

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Electronically Signed
Michael Breneman DC 09/24/2024 05:06 PM

WA2429500000140_IBMLSCAN1210222024000100014O

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246 Fax: (360) 654-0611

Receipt

[redacted]

Trans ID	000000055115
Order ID	8565858085836668
Payment Type	Credit
Trans Type	Purchase
Clerk ID	75
Date/Time	2024-09-24 15:14:39
Card Type	Visa
Card Number	XXXXXXXXXXXX4543
Entry Legend	CHIP READ
Entry Method	CONTACT
Approval Code	09660D
AC	F25F5DFC7A05B3C7
ATC	006D
AID	A0000000031010
AID NAME	VISA CREDIT
TVR	8080008000
TSI	6800
Resp CD	Z3
TRN REF #	384268800793167
VAL CODE	JGSM

Total Amount USD$70.00

Description:_____

Approved - Thank You

X_____
Cardholder Signature

Buyer agrees to pay total amount above according to cardholder's agreement with issuer.

****Customer Copy****
Retain this copy for statement

Printed: **9/24/2024 3:15:02 PM**

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient [redacted] Acct #: 7864 DOB [redacted]
Ins Co: Pol #: Insured ID:

Date 09/25/2024
Provider Michael Breneman DC

Subjective:
[redacted] sought treatment today, complaining of frequent tightness discomfort in the back of the neck. He describes that the discomfort increases with movement. On a scale of 1 to 10, with 10 being the most severe, he, using a VAS, describes the intensity as a 8 and indicated that the discomfort occurs approximately 80% of the time. He states the discomfort is the same since his last visit.

Objective:
Rhombergs is positive for loss of equilibrium and any positional change exacerbates his vertigo.
Imaging reveals loss of lordosis and he is locked out of flexion in the occipito atlantal articulation that in our opinion is causing neurologic consequence and disrupting his equilibrium system
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The patient's condition is responding to care, but is aggravated by normal activities of daily living. all acitivites of daily living are affected
further assessment needs to be accomplished over time.

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see 3x close and then reassess
fo lumbar spine imaging
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M99.03: Seg and somatic dysf of lumbar reg
M99.04: Seg and somatic dysf of sacral reg
S33.5XXS: Sprain of lumbar ligts, seq
M99.85: Other biomechanical lesions of pelvic region
M51.36: Other intervertebral disc degeneration, lumbar region
M43.27: Fusion of spine, lumbosacral region

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246 Fax: (360) 654-0611

Receipt

[redacted]

Trans ID	000000055156
Order ID	8076657985748590
Payment Type	Credit
Trans Type	Purchase
Clerk ID	75
Date/Time	2024-09-25 16:17:19
Card Type	Visa
Card Number	XXXXXXXXXXXX4543
Entry Legend	CHIP READ
Entry Method	CONTACT
Approval Code	08835D
AC	B61B7BBF2A84668B
ATC	006E
AID	A0000000031010
AID NAME	VISA CREDIT
TVR	8080008000
TSI	6800
Resp CD	Z3
TRN REF #	584269838397517
VAL CODE	49CR

Total Amount USD$70.00

Description:_____

Approved - Thank You

X_____
Cardholder Signature

Buyer agrees to pay total amount above according to cardholder's agreement with issuer.

****Customer Copy****
Retain this copy for statement

Printed: **9/25/2024 4:17:36 PM**

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient: [redacted] Acct #: 7864 DOB: [redacted]
Ins Co: Pol #: Insured ID:

Date 09/25/2024
Provider Michael Breneman DC

*** continued from previous page ***

Electronically Signed
Michael Breneman DC 09/25/2024 06:29 PM

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient: [redacted] Acct #: 7864 DOB: [redacted]
Ins Co: Pol #: Insured ID:

Date 09/27/2024
Provider Michael Breneman DC

Subjective:
[redacted] sought treatment today, complaining of frequent tightness discomfort in the back of the neck. He describes that the discomfort increases with movement. On a scale of 1 to 10, with 10 being the most severe, he, using a VAS, describes the intensity as a 5 and indicated that the discomfort occurs approximately 30% of the time. He states the discomfort is the same since his last visit.

Objective:
Rhombergs is positive for loss of equilibrium and any positional change exacerbates his vertigo.
Imaging reveals loss of lordosis and he is locked out of flexion in the occipito atlantal articulation that in our opinion is causing neurologic consequence and disrupting his equilibrium system
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M99.03: Seg and somatic dysf of lumbar reg
M99.04: Seg and somatic dysf of sacral reg
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M51.36: Other intervertebral disc degeneration, lumbar region
M43.27: Fusion of spine, lumbosacral region

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient: [redacted] Acct #: 7864 DOB: [redacted]
Ins Co: Pol #: Insured ID:

Date 09/27/2024
Provider Michael Breneman DC

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Electronically Signed
Michael Breneman DC 09/27/2024 06:12 PM

WA2429500000146_IBMLSCAN12102220240001000146

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246 Fax: (360) 654-0611

Receipt

[redacted]

Trans ID	000000055247
Order ID	6873838688777765
Payment Type	Credit
Trans Type	Purchase
Clerk ID	75
Date/Time	2024-09-27 16:16:10
Card Type	Visa
Card Number	XXXXXXXXXXXX4543
Entry Legend	CHIP READ
Entry Method	CONTACT
Approval Code	08750D
AC	78DB1F15AA53D16C
ATC	0070
AID	A0000000031010
AID NAME	VISA CREDIT
TVR	8080008000
TSI	6800
Resp CD	Z3
TRN REF #	464271837701120
VAL CODE	3FPM

Total Amount USD$70.00

Description:_____

Approved - Thank You

X_____
Cardholder Signature

Buyer agrees to pay total amount above according to cardholder's agreement with issuer.

****Customer Copy****
Retain this copy for statement

Printed: 9/27/2024 4:16:28 PM

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient: [redacted] Acct #: 7864 DOB: [redacted]
Ins Co: Pol #: Insured ID:

Date 10/04/2024
Provider Michael Breneman DC

Subjective:
[redacted] sought treatment today, complaining of frequent tightness discomfort in the back of the neck. He describes that the discomfort increases with movement. On a scale of 1 to 10, with 10 being the most severe, he, using a VAS, describes the intensity as a 5 and indicated that the discomfort occurs approximately 30% of the time. He states the discomfort is the same since his last visit.

Objective:
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M99.03: Seg and somatic dysf of lumbar reg
M99.04: Seg and somatic dysf of sacral reg
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M51.36: Other intervertebral disc degeneration, lumbar region
M43.27: Fusion of spine, lumbosacral region

NA2429500000149_IBMLSCAN12102220240001000149

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246 Fax: (360) 654-0611

Receipt

[redacted]

Trans ID	000000055508
Order ID	7977806767708870
Payment Type	Credit
Trans Type	Purchase
Clerk ID	72
Date/Time	2024-10-04 15:26:52
Card Type	Visa
Card Number	XXXXXXXXXXXX4543
Entry Legend	CHIP READ
Entry Method	CONTACT
Approval Code	03863D
AC	56C5A4EB8FC06602
ATC	0075
AID	A0000000031010
AID NAME	VISA CREDIT
TVR	8080008000
TSI	6800
Resp CD	Z3
TRN REF #	464278808121261
VAL CODE	JDHF

Total Amount USD$70.00

Description:_____

Approved - Thank You

X_____
Cardholder Signature

Buyer agrees to pay total amount above according to cardholder's agreement with issuer.

****Customer Copy****
Retain this copy for statement

Printed: 10/4/2024 3:27:07 PM

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient: [redacted] Acct #: 7864 DOB: [redacted]
Ins Co: Pol #: Insured ID:

Date 10/04/2024
Provider Michael Breneman DC

*** continued from previous page ***

Electronically Signed
Michael Breneman DC 10/04/2024 03:57 PM

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient: [redacted]	Acct #: 7864	DOB [redacted]
Ins Co:	Pol #:	Insured ID:

Date 10/08/2024
Provider Michael Breneman DC

Subjective:
[redacted] sought treatment today, complaining of frequent tightness discomfort in the back of the neck. He describes that the discomfort increases with movement. On a scale of 1 to 10, with 10 being the most severe, he, using a VAS, describes the intensity as a 5 and indicated that the discomfort occurs approximately 30% of the time. He states the discomfort is the same since his last visit.

Objective:
Rhombergs is positive for loss of equilibrium and any positional change exacerbates his vertigo.
Imaging reveals loss of lordosis and he is locked out of flexion in the occipito atlantal articulation that in our opinion is causing neurologic consequence and disrupting his equilibrium system
He is cantankerous with staff upon entrance and due to his condition we realize he is fearful and distraught.
He has become "a believer" in only a few visits with results he finds incredible.

Assessment:
The patient's condition is responding to care, but is aggravated by normal activities of daily living. all acitivites of daily living are affected
responding favorably with improved posture, gait and equilibrium

Plan:
see 3x close and then reassess
fo lumbar spine imaging
Our goals of continued treatment include the following; relief of symptoms, decrease segmental dysfunction, increase active and passive range of motion, increase proprioception, increase function and arrestment of degeneration.
check on DC in Surprise Arizona to continue care with

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient: [redacted] Acct #: 7864 DOB: [redacted]
Ins Co: Pol #: Insured ID:

Date 10/08/2024 *** continued from previous page ***

Provider Michael Breneman DC

Diagnosis
M54.2: Cervicalgia
M99.01: Seg and somatic dysf of cervical reg
R42: Dizziness, veritgo or giddiness
R27.8: Other lack of coordination
M40.292: Other kyphosis, cervical reg (reduced cerv curve)
M99.02: Seg and somatic dysf of thoracic reg
M99.03: Seg and somatic dysf of lumbar reg
M99.04: Seg and somatic dysf of sacral reg
S33.5XXS: Sprain of lumbar ligts, seq
M99.85: Other biomechanical lesions of pelvic region
M51.36: Other intervertebral disc degeneration, lumbar region
M43.27: Fusion of spine, lumbosacral region

Electronically Signed
Michael Breneman DC 10/08/2024 02:23 PM

WA2429500000152_IBMLSCAN12102220240001000152

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246 Fax: (360) 654-0611

Receipt

[redacted]

Trans ID	000000055600
Order ID	8377797372787788
Payment Type	Credit
Trans Type	Purchase
Clerk ID	75
Date/Time	2024-10-08 11:55:57
Card Type	Visa
Card Number	XXXXXXXXXXXX4543
Entry Legend	CHIP READ
Entry Method	CONTACT
Approval Code	07293D
AC	9EE7305D5DFD664D
ATC	0077
AID	A0000000031010
AID NAME	VISA CREDIT
TVR	8080008000
TSI	6800
Resp CD	Z3
TRN REF #	584282681579006
VAL CODE	HQ7M

Total Amount USD$70.00

Description:_____

Approved - Thank You

X_____
Cardholder Signature

Buyer agrees to pay total amount above according to cardholder's agreement with issuer.

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Retain this copy for statement

Printed: 10/8/2024 11:56:12 AM

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient: [redacted] Acct #: 7864 DOB: [redacted]
Ins Co: Pol #: Insured ID:

Date 10/11/2024
Provider Michael Breneman DC

Subjective:
[redacted] sought treatment today, complaining of occasional tightness discomfort in the back of the neck. He describes that the discomfort increases with movement. On a scale of 1 to 10, with 10 being the most severe, he, using a VAS, describes the intensity as a 2 and indicated that the discomfort occurs approximately 10% of the time. He states the discomfort is better since his last visit.

Objective:
Rhombergs is positive for loss of equilibrium and any positional change exacerbates his vertigo.
Imaging reveals loss of lordosis and he is locked out of flexion in the occipito atlantal articulation that in our opinion is causing neurologic consequence and disrupting his equilibrium system
He is cantankerous with staff upon entrance and due to his condition we realize he is fearful and distraught.
He has become "a believer" in only a few visits with results he finds incredible.

Assessment:
The patient's condition is responding to care, but is aggravated by normal activities of daily living. all acitivites of daily living are affected
responding favorably with improved posture, gait and equilibrium

Plan:
see 3x close and then reassess
fo lumbar spine imaging
Our goals of continued treatment include the following; relief of symptoms, decrease segmental dysfunction, increase active and passive range of motion, increase proprioception, increase function and arrestment of degeneration.
check on DC in Surprise Arizona to continue care with

WA2429500000155_IBMLSCAN12102220240001000155

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246 Fax: (360) 654-0611

Receipt

[redacted]

Trans ID	000000055723
Order ID	6568748466788275
Payment Type	Credit
Trans Type	Purchase
Clerk ID	75
Date/Time	2024-10-11 11:48:20
Card Type	Visa
Card Number	XXXXXXXXXXXX4543
Entry Legend	CHIP READ
Entry Method	CONTACT
Approval Code	04938D
AC	1DB19AFA03414354
ATC	0078
AID	A0000000031010
AID NAME	VISA CREDIT
TVR	8080008000
TSI	6800
Resp CD	Z3
TRN REF #	304285677004857
VAL CODE	KN87

Total Amount USD$70.00

Description:_____

Approved - Thank You

X_____
Cardholder Signature

Buyer agrees to pay total amount above according to cardholder's agreement with issuer.

****Customer Copy****
Retain this copy for statement

Printed: 10/11/2024 11:48:34 AM

Chart Notes

[redacted]

Cascadia Chiropractic and Massage
1507 172nd St. NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246
Fax: (360) 654-0611

Patient [redacted] Acct #: 7864 DOB: [redacted]
Ins Co: Pol #: Insured ID:

Date 10/11/2024

Provider Michael Breneman DC *** continued from previous page ***

Diagnosis
M54.2: Cervicalgia
M99.01: Seg and somatic dysf of cervical reg
R42: Dizziness, veritgo or giddiness
R27.8: Other lack of coordination
M40.292: Other kyphosis, cervical reg (reduced cerv curve)
M99.02: Seg and somatic dysf of thoracic reg
M99.03: Seg and somatic dysf of lumbar reg
M99.04: Seg and somatic dysf of sacral reg
S33.5XXS: Sprain of lumbar ligts, seq
M99.85: Other biomechanical lesions of pelvic region
M51.36: Other intervertebral disc degeneration, lumbar region
M43.27: Fusion of spine, lumbosacral region

Electronically Signed
Michael Breneman DC 10/11/2024 02:53 PM

ITEM 2

noridian
Healthcare Solutions

November 9, 2024

[redacted]

Xref: 2308549138

Dear [redacted]

Enclosed is your documentation regarding services provided to you.

In order to process your claim properly, the following information is required along with the CMS 1490S Form: a copy of the original documentation, and the following information below:

Date of each service (when did you see the provider)

An itemized bill from the Rendering Provider

Charge for EACH service rendered (cannot be one total charge for multiple services and must show the actual charge of each service if a discount is applied to the total bill)

Procedure Code(s) and any appropriate modifiers

Rendering Provider's NPI (National Provider Identifier number).

Please send the requested document(s) with a copy of this letter to:

Noridian Healthcare Solutions LLC
PO Box 6700
Fargo, ND 58108 – 6700

All data submitted must be LEGIBLE and must be resent to the Medicare carrier within 6 months of the date of this letter or within 1 year of the date of the service, whichever is later.

For services received on or after September 1, 1990, you do not have to submit your Medicare Part B claims. Providers or suppliers are required by law to enroll in the Medicare program and to submit claims to Medicare for you. Please advise your provider of care to submit this claim to our office. Notice will be sent upon completion of processing.

We suggest for non-emergency care to always seek services from a doctor or supplier that is enrolled in the Medicare program.

If you receive services from a doctor or supplier that refuses to submit a claim to the Medicare carrier on your behalf for services that otherwise would be payable by Medicare, you should:

Send notification to the contractor in writing that the doctor or supplier refused to submit a claim to Medicare, along with a complete Form CMS-1490S with all supporting documentation.

If you have any questions regarding this request, please call 1-800-MEDICARE (1-800-633-4227).

Sincerely,

Claims Processing
Noridian Healthcare Solutions LLC
Medicare Part B

Cascadia Chiropractic and Massage
1507 172nd ST NE Suite A
Marysville, WA 98271
Phone: (360) 652-7246 Fax: (360) 654-0611

Itemized Statement

Statement Date: Friday, June 27, 2025 [redacted]

For Activity: 09/20/2024 thru 06/27/2025
Cell: [redacted]

[redacted] **7864-Patient Options**

Date	Code	Description	Uts	Charge	Pri Paid	Sec Paid	Pat Paid	WOff	DISC	Misc CHG	Tax	Ins Amount	Pat Owes
9/20/24	NPXRAYCERV	NP XRAY CERVICAL	1	78.00				-78.00				0.00	0.00
9/20/24	NPXRAYLUMB	NP XRAY LUMBAR	1	84.00				-84.00				0.00	0.00
9/20/24	NPCHIRO	NP CHIRO VISITS 1-3	1	27.00				-27.00				0.00	0.00
9/20/24	NPEXAM	NP Problem Focused Exam	1	56.00				-56.00				0.00	0.00
9/20/24	A9273	6x20 Cervical Hot/Cold	1	19.00			-20.79				1.79	0.00	0.00
9/20/24		Payment-Credit Card (Payment $20.79)											0.00
9/24/24	S8990	Wellness Visit Chiropractic	1	70.00			-70.00					0.00	0.00
9/24/24		Payment-Credit Card (Payment $70.00)											0.00
9/25/24	S8990	Wellness Visit Chiropractic	1	70.00			-70.00					0.00	0.00
9/25/24		Payment-Credit Card (Payment $70.00)											0.00
9/27/24	S8990	Wellness Visit Chiropractic	1	70.00			-70.00					0.00	0.00
9/27/24		Payment-Credit Card (Payment $70.00)											0.00
10/04/24	S8990	Wellness Visit Chiropractic	1	70.00			-70.00					0.00	0.00
10/04/24		Payment-Credit Card (Payment $70.00)											0.00
10/08/24	S8990	Wellness Visit Chiropractic	1	70.00			-70.00					0.00	0.00
10/08/24		Payment-Credit Card (Payment $70.00)											0.00
10/11/24	S8990	Wellness Visit Chiropractic	1	70.00			-70.00					0.00	0.00
10/11/24		Payment-Credit Card (Payment $70.00)											0.00
Total				**$684.00**		**$0.00**		**($245.00)**		**$0.00**		**$0.00**	
					$0.00		**($440.79)**		**$0.00**		**$1.79**		**$0.00**