already on

conference 3-19-08 638

OPENING LIEN.

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

STK0207071

NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

ID OR CASE NO STK0207071

(Print or type names and addresses; include ZIP Codes)

MEIDINGER, DONALD
Injured Worker

10/13/2006 -
Date of Claimed Injury

[redacted]
Social Security Number

[redacted]
Address

[redacted]
Date of Birth

RONALD STEIN, ESQ.
Attorney for Injured Worker

4521 QUAIL LAKES DR, STOCKTON, CA 95207
Address

SAN JOAQUIN COUNTY
Employer

24 S. HUNTER ST., STOCKTON, CA 95201
Address

AIMS
Insurance Carrier or, if Self-Insured, Certificate Name

P.O. BOX 28100, FRESNO, CA 93729
Address Where Claim Administered

RECEIVED
MAR 04 2008
DIVISION OF WORKERS' COMPENSATION STOCKTON OFFICE

STOCKWELL HARRIS WIDOM WOOLVERTON
Adjusting Agency, if Agency Administered

1545 RIVER PARK DR. #330, SACRAMENTO, CA 95815
Address

BLUE SHIELD OF CALIFORNIA
Attorney for Employer/Carrier

Boehm & Associates For:
Lien Claimant

1321 Harbor Bay Parkway, Suite 250, Alameda, CA 94502
Address & Telephone No.: Phone: 510-865-0544

Attorney for Lien Claimant

Address & Telephone No.:

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of Eight thousand five hundred forty four And 00/100 Dollars ($8,544.00) against any amount now due or which may hereafter become payable as compensation to the above named worker on account of the above claimed injury.

This request and claim for lien is for (Mark appropriate box):

- [x] The reasonable expense incurred by or on behalf of said worker for medical treatment to cure or relieve from the effects of said injury; or
- [ ] The reasonable medical expense incurred to prove a contested claim; or
- [ ] The reasonable value of living expenses of said worker or of his or her dependents, subsequent to the injury, or
- [ ] The reasonable living expenses of the spouse or minor children, or both, of said worker, subsequent to the date of injury, where such worker has deserted or is neglecting his or her family; or
- [ ] The reasonable fee for interpreter's services performed on _____, 19____.
- [ ] Group disability benefits (LC4903.1). Disability benefits are being paid on an on-going basis. Please allow us 15 days to update prior to any final disposition.

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

FOR INJURIES OCCURING ON OR AFTER JANUARY 1, 1990 FOR WHICH THE LIEN CLAIMANT DOES NOT HAVE A WCAB IDENTIFICATION NUMBER, the lien claimant declares under penalty of perjury that:

- [ ] a copy of the original completed Employee's Claim for Workers' Compensation Benefits (DWC Form 1) is attached, or
- [ ] the lien claimant does not have a copy of the claim form, but made the following efforts to secure one:

- [x] A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

Signature of Attorney for Lien Claimant

Signature of Lien Claimant

2/6/2007
Date

EMPLOYEE'S CONSENT TO ALLOWANCE TO LIEN

I consent to the requested allowance of a lien against my compensation.

Signature of Attorney for Injured Worker

Signature of Injured Worker

DWC WCAB Form (Rev 2/91)

DWC-6

Boehm & Associates

HEALTHCARE RECOVERY SPECIALISTS

Please Reply To:

☑ 1321 Harbor Bay Parkway #250
Alameda, CA 94502
(510) 865-0544 FAX (510) 814-8424

☐ 425 E. Colorado Street, Suite 420
Glendale, CA 91205
(818) 246-8380 FAX (818) 246-8161

February 6, 2007

Workers' Compensation Appeals Board
31 East Channel St., Rm. 344
Stockton, CA 95202-2314

RE: MEIDINGER vs. SAN JOAQUIN COUNTY
Our File #: W07MEI1011N
WCAB #: STK0207071, et at
Our Client: BLUE SHIELD OF CALIFORNIA

Gentlepersons:

We enclose for filing Notice and Request for Allowance of Lien for our client.

PLEASE ENTER OUR NAME AND ADDRESS ON THE OFFICIAL ADDRESS RECORD AS AGENT OF RECORD FOR SERVICE OF ALL HEARINGS, FINDINGS, ORDERS, DECISIONS AND AWARDS PURSUANT TO WCAB RULE 10500.

By copy of this transmittal letter addressed as shown below we request all parties to serve copies of all medical reports in their possession or under their control in conformity with WCAB Rules 10601, 10608, 10615 and 10622 other than any such report which may be in the lien-supporting documentation filed and served herewith. To resolve this lien, please call the above-listed number and ask for Jessica Brown.

Please Note: Unless otherwise stated herein, this is not a final lien amount. Please request a final lien amount before settlement or final disposition of this case.

Thank you.

Very truly yours,

Boehm & Associates
IRS#: 94-2361175

NAME OF PARTIES	ADDRESS
RONALD STEIN, ESQ.	4521 QUAIL LAKES DR STOCKTON, CA 95207
STOCKWELL HARRIS WIDOM WOOLVERT	1545 RIVER PARK DR. #330 SACRAMENTO, CA 95815

PROOF OF SERVICE BY MAIL (1013a, 2015.5 C.C.P.)
STATE OF CALIFORNIA, COUNTY OF ALAMEDA

I am a resident of the county aforesaid; I am over the age of eighteen years and not a party to the within titled action; my business address is: 1321 Harbor Bay Parkway, Suite 250, Alameda, CA 94502

On 2/6/2007 I served the lien claim on the parties listed herein by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid in the United States mailed at Alameda, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on 2/6/2007 , at Alameda, California.

IRS#: 94-2361175

Boehm & Associates

HEALTHCARE RECOVERY SPECIALISTS

SUMMARY OF BENEFITS

New

CLM#

Patient: DONALD MEIDINGER

SSN: **Debtor No:**

D.O.B.

WCAB: STK0207071

Injury: CIRCULATORY SYSTEM, NERVOUS SYSTEM
D.O.I.: 10/13/06

Client: (BSCSFO) BLUE SHIELD OF CALIFORNIA

WC Insurance:

Group Insurance:

Group#

Other Coverage:

DRG: **Provider:**

Claim# - Provider of Service	Date(s) Of Service	Amount Billed	Benefits Paid	Diagnosis Code & Description
200629303853000 - LODI MEMORIAL HOSPIT	3/2006 - 10/15/2006	$18,748.80	$4,200.00	414.01 CORONARY ATHEROSCLEROSIS
200631803747000 - ST. JOSEPHS MED CENT	11/2/2006	$22,239.75	$4,344.00	414.01 CORONARY ATHEROSCLEROSIS
		$40,988.55	$8,544.00	

Total Additions: $8,544.00

Total Reductions: $0.00

Total This Summary: **$8,544.00** ☐

0

Previous Lien Amount: **$0.00**

New Lien Amount: **$8,544.00**

Last Update By: Norma Hartsfield

#1

BLUE SHIELD OF CALIFORNIA

EXPLANATION OF BENEFITS

P.O. BOX 272520, CHICO, CA 95927-2520

ISSUE DATE : 10 24 06
PAGE : 3

LODI MEMORIAL HOSP
FILE 73102 P O BOX 60000
SAN FRANCISCO CA 94160-3102

STATEMENT-NO : 803245574
CHECK NO : 019895012

PROVIDER NUMBER : ZZZC3903Z

PATIENT NAME I.D. NUMBER GROUP NUMBER	PATIENT ACCT. NUMBER CLAIM NUMBER	DATES OF SERVICE	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOTES	DEDUCTIBLE	CO-PAY AMOUNT	AMOUNT PAID
RECEIPT DATE : 10/20/06										
MEIDINGER DONAL VAD58199		101306-101506	00120	2	9100.00			0.00	0.00	
J01174629	20062930385300	101306-101506	00250	1	76.30			0.00	0.00	
000PH00010321		101306-101506	00259	11	212.50			0.00	0.00	
		101306-101506	00272	1	36.00			0.00	0.00	
		101306-101506	00300	3	69.00			0.00	0.00	
		101306-101506	00301	7	1884.00			0.00	0.00	
		101306-101506	00305	3	834.00			0.00	0.00	
		101306-101506	00324	1	541.00			0.00	0.00	
		101306-101506	00450	3	1513.00			0.00	0.00	
		101306-101506	00480	3	3496.00			0.00	0.00	
		101306-101506	00730	3	987.00			0.00	0.00	
TOTALS :					18748.80			0.00	0.00	

PAID
$4,200.00

CLAIM ELECTRONICALLY BILLED

NOTES :

YOUR CONTRACTUAL ADJUSTMENT IS $14548.80.

THE NEGOTIATED PAYMENT FOR THIS PER DIEM HOSPITALIZATION IS $4200.00.

THE PATIENT IS RESPONSIBLE FOR A DEDUCTIBLE OF $0.00, COINSURANCE OF $0.00, COPAYMENT OF $0.00, ADDITIONAL DEDUCTIBLE (SANCTIONS) OF $0.00 AND NON-COVERED SERVICES OR ITEMS OF $0.00. THE TOTAL PATIENT LIABILITY FOR THIS CLAIM IS $0.00.

FOR QUESTIONS REGARDING THE ABOVE CLAIM, PLEASE CALL (800) 334-5847

[redacted]

1214-1 EO (10/81)

CLAIM DETAIL INQUIRY

MNJ011746290000,200629303 00,542,ML,040

ICN	D	CT	PATIENT NAME	SR	DOB	D#	II	XI	XS	PC	TK
20062930385300	0	73	DONALD R MEIDINGER	M		00	N	N	N	J	00

SUB ID#	PROVIDER#	AI	WC	LOC/DATE/EXAM	MSG	SUSP	TFFSMMMLS	SI	CL	PI
J011746290000	54220ZZZC3903Z		N	082/102506/****	F574		111A1ZZI0	EF		

TOTCHG	DT-PD	RECD	AT	RSN	CSH	DOC#	AUTH#	LAST-P	LI	MA
001874880	102406	102006	00			E062930015383	0000000000	102306	11	

ML PAID 0420000 TOTINT 00000 CK# 019895012 RPLN 542 HPLN 542 CASE 3043352
PICKDT PCM P PICK# 000000000

LN	MSG	FDOS - LDOS	P	T	PROC	MODIFY	UNITS	DIAG	D	CG	PROVIDER	CHARGE
ALLOW	S1	S2	S3	S4	DDAM	CO-INS	NC	R&B	HCPCS	OI	OIDOL	OIALLOW	PAID
010	000	101306-101506	1	H	00120		00020	41401	B	41	54220ZZZC3903Z	0910000
0420000		0000000	0000000	0000000		U	000000000	000000000	0420000			
020	000	101306-101506	1	H	00250		00010	41401	B	41	54220ZZZC3903Z	0007630
0000000		0000000	0000000	0000000		U	000000000	000000000	0000000			
030	000	101306-101506	1	H	00259		00110	41401	B	41	54220ZZZC3903Z	0021250
0000000		0000000	0000000	0000000		U	000000000	000000000	0000000			

BLUE SHIELD
OF CALIFORNIA

EXPLANATION OF BENEFITS

#2

P.O. BOX 272520, CHICO, CA 95927-2520

ST JOSEPHS MED CENTER OF
STOCKTON
FILE 73436 P O BOX 60000
SAN FRANCISCO CA 94160

ISSUE DATE : 11 28 06
PAGE : 6

STATEMENT-NO : 817173047
CHECK NO : 020190181

PROVIDER NUMBER : ZZZA3902Z

PATIENT NAME I.D. NUMBER GROUP NUMBER	PATIENT ACCT. NUMBER CLAIM NUMBER	DATES OF SERVICE	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOTES	DEDUCTIBLE	CO-PAY AMOUNT	AMOUNT PAID
RECEIPT DATE : 11/14/06										
MEIDINGER DONAL 1010648911		110206-110206	00250	5	143.75			0.00	0.00	
J01174629	20063180374700	110206-110206	00272	1	1842.00			0.00	0.00	
000PH00010321		110206-110206	00272	1	1.00			0.00	0.00	
		103106-103106	00301	1	390.00			0.00	0.00	
		103106-103106	00301	1	9.00			0.00	0.00	
		103106-103106	00305	1	253.00			0.00	0.00	
		103106-103106	00324	1	616.00			0.00	0.00	
		110206-110206	00361	6	15131.00			0.00	0.00	
		103106-103106	00390	1	522.00			0.00	0.00	
		110206-110206	00710	200	2994.00			0.00	0.00	
		103106-103106	00730	1	338.00			0.00	0.00	
TOTALS :					22239.75			0.00	0.00	

PAID
$4,344.00

CLAIM ELECTRONICALLY BILLED

NOTES :

THIS CLAIM WAS PROCESSED ACCORDING TO YOUR NEGOTIATED CARDIAC CATHETERIZATION RATE.

YOUR CONTRACTUAL ADJUSTMENT IS $17895.75.

THE NEGOTIATED PAYMENT FOR THIS CASE RATE HOSPITALIZATION IS $4344.00.

THE PATIENT IS RESPONSIBLE FOR A DEDUCTIBLE OF $0.00, COINSURANCE OF $0.00, COPAYMENT OF $0.00, ADDITIONAL DEDUCTIBLE (SANCTIONS) OF $0.00 AND NON-COVERED SERVICES OR ITEMS OF $0.00. THE TOTAL PATIENT LIABILITY FOR THIS CLAIM IS $0.00.

THE ALPHA PREFIX AND/OR SUBSCRIBER IDENTIFICATION NUMBER SUBMITTED FOR THIS DATE OF SERVICE WAS INCORRECT. WE HAVE PROCESSED THIS CLAIM WITH THE IDENTIFICATION NUMBER SUBMITTED THAT CORRESPONDS WITH OUR RECORDS. PLEASE REFER TO THE PATIENT'S CURRENT IDENTIFICATION CARD AND USE THE CORRECT INFORMATION FOR EACH DATE OF SERVICE TO ENSURE THAT FUTURE CLAIMS ARE PROCESSED PROMPTLY.

FOR QUESTIONS REGARDING THE ABOVE CLAIM, PLEASE CALL (800) 334-5847

CONTINUED

CLAIM DETAIL INQUIRY

MNJ011746290000,2006318037 00,542,ML,040

ICN	D	CT	PATIENT NAME	SR	DOB	D#	II	XI	XS	PC	TK
20063180374700	5	73	DONALD R MEIDINGER	M1	[illegible]	00	N	N	N	J	00

SUB ID#	PROVIDER#	AI	WC	LOC/DATE/EXAM	MSG	SUSP	TFFSMMMLS	SI	CL	PI
J011746290000	54220ZZZA3902Z		N	082/112906/****	I684		111A1ZZI0	EF		

TOTCHG	DT-PD	RECD	AT	RSN	CSH	DOC#	AUTH#	LAST-P	LI	MA
002223975	112806	111406	00			E063180017654	0000000000	112806	11	

ML PAID 0434400 TOTINT 00000 CK# 020190181 RPLN 542 HPLN 542 CASE 3052455
PICKDT PCM P PICK# 000000000

LN	MSG	FDOS - LDOS	P	T	PROC	MODIFY	UNITS	DIAG	D	CG	PROVIDER	CHARGE
ALLOW	S1	S2	S3	S4	DDAM	CO-INS	NC	R&B	HCPCS	OI	OIDOL	OIALLOW	PAID
010	000	110206-110206	2	H	00250		00050	41401	2	41	54220ZZZA3902Z	0014375
0434400		0000000	0000000	0000000	J3010	U	000000000	000000000	0434400			
020	000	110206-110206	2	H	00272		00010	41401	2	41	54220ZZZA3902Z	0184200
0000000		0000000	0000000	0000000		U	000000000	000000000	0000000			
030	000	110206-110206	2	H	00272		00010	41401	2	41	54220ZZZA3902Z	0000100
0000000		0000000	0000000	0000000	C1769	U	000000000	000000000	0000000			