#1-25

SOCIETY INSURANCE®

Small details. Big difference.℠

VIA CERTIFIED MAIL & REGULAR MAIL

April 25, 2025

FULL NAME
CLERK'S OFFICE
CITY OF SHEBOYGAN
828 CENTER AVE
STE 100
SHEBOYGAN WI 53081-4442

Claim Number:	WP2041358
Injured Worker:	Therese M Weaver
Date of Loss:	03/12/2025
Employer:	Reach Forward Inc

RE: NOTICE OF INJURY

FIRST REQUEST

Dear Clerk's Office,

Society Insurance is the Worker's Compensation carrier for the above Named Insured. We are paying WC benefits for Therese M Weaver and payments are not yet finalized.

This correspondence will serve as notice of our intent to seek recovery of our lien pursuant to section 102.29 of the Worker's Compensation Act. It is asked that you protect our interests and contact us prior to settlement with the Injured party, if applicable. We will provide you with our final lien amount, when available.

Enclosed is a completed Notice of Injury form along with supporting documents.

Please confirm receipt of this notice.

150 Camelot Drive
P.O. Box 1029
Fond du Lac, WI 54936-1029
888-576-2438
societyinsurance.com

If you have any questions or concerns, please contact me at the information listed below.

Kristy Huber
Workers Compensation Claims Department
Phone: 1-888-576-2438, ext. 5744
Department Fax: 920-922-1071
Email: khuber@societyinsurance.com

Enclosure(s)

DATE RECEIVED 4/29/25 RECEIVED BY NKC

CLAIM NO. 1-25

CITY OF SHEBOYGAN NOTICE OF DAMAGE OR INJURY

INSTRUCTIONS: TYPE OR PRINT IN BLACK INK

1. Notice of death, injury to persons or to property must be filed not later than 120 days after the occurrence.
2. Attach and sign additional supportive sheets, if necessary.
3. This notice form must be signed and filed with the Office of the City Clerk.

4. TWO ESTIMATES MUST BE ATTACHED IF YOU ARE CLAIMING DAMAGE TO A VEHICLE.

1. Name of Claimant: Therese M. Weaver / Society Insurance as Claimant's employer's WC carrier
2. Home address of Claimant: 3811 S. 17th Place, Sheboygan, WI 53081
3. Home phone number: 920-627-4097
4. Business address and phone number of Claimant: 920-453-0505 employer phone
   Employer: Reach Forward Inc, 1901 S. 8th St, Sheboygan, WI 53081
5. When did damage or injury occur? (date, time of day) 03/12/2025 1:30pm
6. Where did damage or injury occur? (give full description) On the Sidewalk leading into New York Ave Parking lot 4 behind the Mead Public Library
7. How did damage or injury occur? (give full description) Claimant was walking with a group of clients & Other Staff when she stepped in a hole in the Sidewalk causing her to ~~trip~~ twist her ankle then trip & fall.
8. If the basis of liability is alleged to be an act or omission of a City officer or employee, complete the following:

   (a) Name of such officer or employee, if known: _____

   (b) Claimant's statement of the basis of such liability: _____

9. If the basis of liability is alleged to be a dangerous condition of public property, complete the following:

   (a) Public property alleged to be dangerous: Hole in Sidewalk on New York Ave. leading into New York Ave Parking lot 4 behind the library

   (b) Claimant's statement of basis for such liability: This is a hole that should have been filled in years ago as it's a trip hazard. The hole has been in the sidewalk since at least 2019 and it looks to be created vs. simply damaged over time.

10. Give a description of the injury, property damage or loss, so far as is known at this time. (If there were no injuries, state "NO INJURIES").

Sprain/strain left ankle

11. Name and address of any other person injured: _____

12. Damage estimate: (You are not bound by the amounts provided here.)

Auto:	$_____
Property:	$_____
Personal injury:	$_____
Other: (Specify below	$ 1,949.43
TOTAL	$ 1,949.43 pd to date in medical

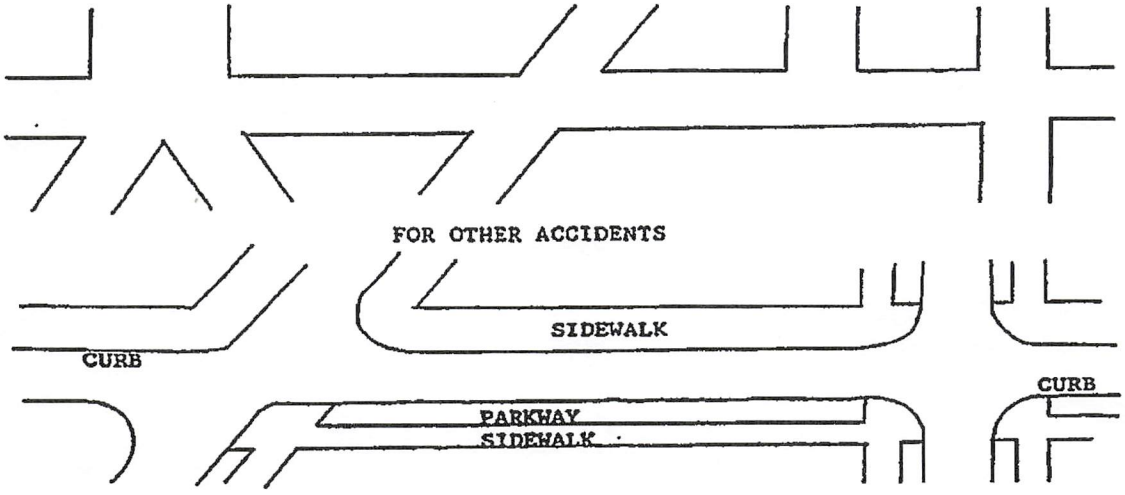
Damaged vehicle (if applicable)

Make: _____ Model: _____ Year: _____ Mileage: _____

Names and addresses of witnesses, doctors and hospitals: _____

FOR ALL ACCIDENT NOTICES, COMPLETE THE FOLLOWING DIAGRAM IN DETAIL. BE SURE TO INCLUDE NAMES OF ALL STREETS, HOUSE NUMBERS, LOCATION OF VEHICLES, INDICATING WHICH IS CITY VEHICLE (IF APPLICABLE), WHICH IS CLAIMANT VEHICLE, LOCATION OF INDIVIDUALS, ETC.

NOTE: If diagrams below do not fit the situation, attach proper diagram and sign.



SIGNATURE OF CLAIMANT _____ DATE _____

DATE RECEIVED _____ RECEIVED BY _____

CLAIM NO. _____

CLAIM

Claimant's Name: Society Insurance

Claimant's Address: 150 Camelot Drive
FDL, WI 54936

Claimant's Phone No. 920-933-5744
Kristy Huber

Auto	$ _____
Property	$ _____
Personal Injury	$ _____
Other (Specify below)	$ 1,949.43
TOTAL	$ 1,949.43

medical pd to date

PLEASE INCLUDE COPIES OF ALL BILLS, INVOICES, ESTIMATES, ETC.

WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM.
(WISCONSIN STATUTES 943.395)

The undersigned hereby makes a claim against the City of Sheboygan arising out of the circumstances described in the Notice of Damage or Injury. The claim is for relief in the form of money damages in the total amount of $ to be determined.

SIGNED Kristin Hall DATE: 04/25/2025

ADDRESS: 150 Camelot Drive, Fond du Lac, WI 54936

MAIL TO: CLERK'S OFFICE
828 CENTER AVE #100
SHEBOYGAN WI 53081


MEAD PUBLIC LIBRARY
LIBRARY PICKUP

SOCIETY INSURANCE.

Small details. Big difference.™
P.O. Box 1029, Fond du Lac, WI 54936-1029
Phone (888) 576-2438 • Fax (920) 922-1071

Received

MAR 28 2025

Society Insurance

Employee's Report of Injury

Claim Number
WP2041358

Claimant Information

Name (first, middle, last, suffix): Therese Marie Weaver			Date of birth: 3-11-73
Maiden name/ Alias/ or Other married names: Geilfuss			Phone: Same
Address: 3811 S. 17th Pl Sheboygan WI 53081			Cell phone: 920-627-4097
E-mail address: tweaver53105@gmail.com	Height: 5'6		Weight: 230
Marital status: ☒ Single ☐ Married ☐ Divorced ☐ Separated	Sex: ☐ Male ☒ Female	Number of dependent children and ages: 3 (27, 25, 22)	Are you a student? ☐ Yes ☒ No
Are you left or right-handed? ☐ Left ☒ Right	Are you on Medicare? ☐ Yes ☒ No	If yes, what is your Medicare number? (HICN)	
If a minor, give name and address of legal guardian: —			
Hobbies/ Sports/ Outside of work activities: spend time with family, diamond paint, watch movies			

Injury Information

Date of injury/illness: 3-12-25	Time of incident (include a.m. or p.m.): 1:15 pm	Date employer notified: 3-12-25	Time employer notified (include a.m. or p.m.): 1:30 pm
Name of the person you reported your injury to: Tracy Wolff	Title: Program Director	Phone:	
Address where injury occurred: 900th block of New York Ave sheboygan WI 53081			
Work being done when injury occurred: Took clients to library after we went for a walk around			
Whose payroll were you on when injured? Reach forward	What body parts did you injure? left ankle		
In detail, explain how the injury occurred? (Use back if needed) While walking with the Clients around the library, my left foot twisting in some sort of Circle on the sidewalk. This cause me to fall to the cement on my right side.			
What was the cause of your injury? Was anyone else at fault? (Please provide names and/or model numbers of machine or tool.) The sidewalk it wasn't completly level and when I step on it my foot rolled causing the rest of me to follow.			
Did this injury cause you to lose any time from work? ☐ Yes ☒ No	If so, please give dates: 3-17-25 Just time that I went to dr.	If so, please give expected date of return: —	

SOCIETY INSURANCE.
Small details. Big difference.®
P.O. Box 1029, Fond du Lac, WI 54936-1029
Phone (888) 576-2438 • Fax (920) 922-1071

Witness Statement Form

Injured worker's information

Injured worker's name	Claim number
Therese M Weaver	WP2041358

Your information

Name	Address
Dawn Gleason	936 1/2 Eastern Ave. Plymouth, WI 53073
Home phone	Cell phone: 920 316 2320
Employer: Reach Forward	Job title: Caregiver

Incident information

Date of incident	Time of incident	What is your relationship to the injured worker?	Did you see the incident?
3-12-25	1:40 Pm	Coworker	☒ Yes ☐ No

What work was being performed when the incident occurred?
Client outing; walking on sidewalk outside of mead Public library

Please explain what you saw.
Staff was walking with clients when Foot got caught in hole on sidewalk. Her ankle twisted and caused her to fall forward hitting knees and right side of body on sidewalk.

Where were you in relation to the injured employee when the incident occurred? Did you have a clear view of the incident?
Walking on other side of client and Therese. (Side by side) yes I had a clear view

Incident information continued

How did the injured employee act after the incident? Did they say anything to you?
Refused my assistance in standing; Stood up on own and brushed herself off. She said ow and told me she was okay but sore. Proceeded to walk with a limp and slower pace.

Did the injured employee show you where they were hurt?
No but I seen her ankle twist and her hit her knees and right side of body on sidewalk

Did you see anyone else who may have seen what happened? If yes, please include names and phone numbers.
No

Was anything said to you by anyone other than the injured employee? If yes, who said something? When did they say it? What did they say?
N/A

Did you discuss anything regarding the injury with anyone? If yes, who did you discuss it with? When did you discuss it? What did you discuss?
Program manager Tracy Wolff; with Tracy on 3-12-25 Shortly after Therese fell at program. I filled out an incident report with what I saw

Did the injured employee ever mention any prior problems with the injured area to you? If yes, when did they mention it?
No

Witness signature	Date
[signature]	3/14/2025

SOCIETY INSURANCE

SOCIETY INSURANCE

Diagnostic Paid Detail for Therese M Weaver - 746

RUN DATE 4/25/25

RUN TIME 2:02 PM

REPORT CRITERIA

Claim Number: WP2041358 **Loss Date:** 03/12/2025 **Status:** Open

Claimant: Therese M Weaver **Insured:** Reach Forward Inc **Adjuster:** Renae Seth

Date	Payee	Service Facility	Draft Reason	Draft #	Payment Status	Billed Amount	Check Amount
4/8/2025	Aurora Medical Group Inc	Aurora Health Care	03/12/2025 SVCS For T. Weaver ACCT G1501859050 Per Bill Review	0000601100	Complete	$90.00	$76.50

TOTALS

Loss Reserve	Loss Paid	Loss Recoverable	Loss Recovery	Loss Incurred	Expense Reserve	Expense Paid	Expense Recoverable	Expense Recovery	Expense Incurred
$173.50	$76.50	$0.00	$0.00	$250.00	$0.00	$0.00	$0.00	$0.00	$0.00

WCSOCIETY INSURANCE

100209160615
Claim Nbr: WP2041358
Vendor Nbr: 391678306

Pay Code: MED

Recv Date: 20250327

Page 1 of 1

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

Image was generated electronically by Jopari

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 392845333
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WEAVER, THERESE, M				3. PATIENT'S BIRTH DATE MM DD YY: 03 11 1973	SEX: M	F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial): REACH FORWARD
5. PATIENT'S ADDRESS (No., Street): 3811 S 17TH PLACE				6. PATIENT RELATIONSHIP TO INSURED: Self	Spouse	Child	Other X	7. INSURED'S ADDRESS (No., Street)
CITY: SHEBOYGAN	STATE: WI			8. RESERVED FOR NUCC USE			CITY	STATE
ZIP CODE: 53081	TELEPHONE (Include Area Code): ( )						ZIP CODE	TELEPHONE (Include Area Code): ( )
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
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) X YES NO			a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? YES X NO PLACE (State) WI			b. OTHER CLAIM ID (Designated by NUCC): Y4 WP2041358
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? YES X NO			c. INSURANCE PLAN NAME OR PROGRAM NAME: WC221
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes*, complete items 9, 9a, and 9d.

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

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, INJURY, or PREGNANCY (LMP) MM DD YY: 03 12 2025 QUAL. 431	15. OTHER DATE QUAL. 439 MM DD YY: 03 12 2025	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNALEX ZABEL	17a. 17b. NPI 1659029510	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 03 12 25 TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): PWKM1ELAC10254047101		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M25572 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 X-RAY EXAM OF ANKLE										ZZ	2085R0202X
03 12 25	03 12 25	23		73610	26 LT	A	9000	1		NPI	1770014847
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. Rsvd for NUCC Use
391678306	G1501859050	X YES NO	$ 9000	$	

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 # (800) 326-2250
SYED HUSSAINI 2085R0202X SIGNED 03/27/2025 DATE	AURORA MEDICAL CENTER SHEBOYGAN COU 3400 UNION AVE SHEBOYGAN, WI 530818426 a. 1922053107 b.	AURORA MEDICAL GROUP INC PO BOX 735044 CHICAGO, IL 606735044 a. 1427271378 b. ZZ193200000X

Optum

Society 3030

Process Date: 04/07/2025
Control Number: 381511
EOR Page 1 of 2
Rev/Aud: AA/RS

Claim Number:	WP2041358	PPO/OSR ID:	ExternalReview Procura
Claimant:	Weaver, Therese M	NPI Number:	1770014847
Provider Tax ID:	391678306 Vendor: 391678306-5029	Payment Code:	diagnostic
Provider Ref:	G1501859050 Geo Zip: 53081	DOI:	03/12/2025
		Jurisdiction State:	WI
		Adjuster Name:	Renae Seth
		Claim Received:	03/27/2025
		BR Received:	03/27/2025

AURORA MEDICAL GROUP INC
PO BOX 735044
CHICAGO, IL 60673

ICD-DX1: M25.572 Pain in left ankle and joints of left foot

Region: G4

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
03/12/25	23	73610	26,LT	RADEX ANKLE CO	1.000	90.00	3.10	10.40	0.00	76.50	298,4101
			TOTALS:			90.00	3.10	10.40	0.00	76.50	
			TOTAL RECOMMENDED ALLOWANCE:							76.50	

Services performed by: HUSSAINI, SYED

Reason Code Reimbursement Description:

298	-THE RECOMMENDED ALLOWANCE IS BASED ON THE VALUE FOR THE PROFESSIONAL COMPONENT OF THE SER VICE PERFORMED.
4101	-THE REIMBURSEMENT RATE FOR THE TREATMENT PROVIDED IS BASED ON AN OPTUM CPT, HCPCS DATABASE AMO UNT CERTIFIED BY THE DEPARTMENT OF WORKFORCE DEVELOPMENT.

Procura/Trilogy Work Comp:QUESTIONS REGARDING PPO/NETWORK REDUCTIONS CONTACT PROCURA: (877) 461-3750 OR EMAIL OptumWC.ProPPO@optum.com

Carrier/Insurer: Society Insurance, PO Box 1029, Fond Du Lac, WI 54936

1.) The Equian DRG, ASC, HOSF, CPT/HCPCS, Anesthesia, ER, and Hospital Radiology databases are certified by the State of Wisconsin (DWD). Equian may use other databases certified by DWD, and these will be identified as such. 2.) This EOR should be received 30 days after the insurance carrier or self-insured employer (collectively payor) has received a completed bill which clearly identifies your name; address and phone number; the patient-employee; the date of service; the health service procedure; and the amount charged for each procedure, along with supporting documentation. 3.) The provider's obligation under par. (c), if the fee is beyond the formula amount, to provide the insurer or self-insurer with a written justification for the higher fee, at least 20 days prior to submitting the dispute to the department. The notice must clearly explain that the only justification for a fee more than the formula amount is that the service provided in this particular case is more difficult or more complicated than in the usual case; and 4.) The insurer's or self-insurer's obligation under par. (d) to respond within 15 days of receiving the provider's written justification for charging a fee beyond the formula amount. 5.) That pursuant to s. 102.16 (2) (b), Stats., once the notice required by this subsection is received by a provider, a health service provider may not collect the disputed fee from, or bring an action for collection of the disputed fee against, the employee who received the services for which the fee was charged. 6.) If you believe a factual error has been made (e.g., coding error) you must notify the payor of this error at least 20 days prior to submitting a dispute to the department. If it is accepted that an error has been made, payment (or partial payment) will be issued in 30 days. 7.) DWD certified databases do not provide certified data (more than 25 occurrences of a code in a region) on every code. If the recommended payment is based on less than 25 occurrences, or other calculation, it will be so described in the explanation. Equian has determined that the alternative reimbursement amount(s) is reasonable and reliable based on prevailing industry practices in the absence of a fee schedule or certified database amount (e.g., usual and customary).

If you have any questions regarding the contents of this review, please call Optum at 866-271-6317 *toll free*. For reconsideration of denied or reduced payment, please respond either by e-mail at reconappeals@optum.com or by fax at 1-800-218-6580. Please include 1) A narrative explanation of why each item should be paid, 2) A copy of this Review Analysis, and 3) Supporting documentation.

EFFECTIVE IMMEDIATELY, all medical bills submitted for Society Insurance claims must be submitted with associated claimant medical records and are to be forwarded to the following address or sent electronically:

Society, PO Box 14832, Lexington, KY 40512, Attn: Mailroom

E-bill payer ID for electronic billing:
WCEDI - Primary ID LS253, Secondary ID CB039 via WorkComp EDI
Jopari - J2139

Optum

Society 3030

Process Date: 04/07/2025
Control Number: 381511

Rev/Aud: AA/RS

Claim Number:	WP2041358	PPO/OSR ID:	ExternalReview Procura
Claimant:	Weaver, Therese M	NPI Number:	1770014847
Provider Tax ID:	391678306 Vendor: 391678306-5029	Payment Code:	diagnostic
Provider Ref:	G1501859050 Geo Zip: 53081	DOI:	03/12/2025
		Jurisdiction State:	WI
		Adjuster Name:	Renae Seth
		Claim Received:	03/27/2025
		BR Received:	03/27/2025

AURORA MEDICAL GROUP INC
PO BOX 735044
CHICAGO, IL 60673

ICD-DX1: M25.572 Pain in left ankle and joints of left foot

Region: G4

* Workers' Compensation *

SOCIETY INSURANCE

SOCIETY INSURANCE

Clinic/Doctor Paid Detail for Therese M Weaver - 743

RUN DATE 4/25/25

RUN TIME 2:02 PM

REPORT CRITERIA

Claim Number: WP2041358 **Loss Date:** 03/12/2025 **Status:** Open

Claimant: Therese M Weaver **Insured:** Reach Forward Inc **Adjuster:** Renae Seth

Date	Payee	Service Facility	Draft Reason	Draft #	Payment Status	Billed Amount	Check Amount
4/8/2025	Aurora Medical Group Inc		03/17/2025 SVCS For T. Weaver ACCT G1501859040 Per Bill Review	0000601108	Complete	$370.00	$300.43

TOTALS

Loss Reserve	Loss Paid	Loss Recoverable	Loss Recovery	Loss Incurred	Expense Reserve	Expense Paid	Expense Recoverable	Expense Recovery	Expense Incurred
$499.57	$300.43	$0.00	$0.00	$800.00	$0.00	$0.00	$0.00	$0.00	$0.00

WCSOCIETY INSURANCE

100209159851
Claim Nbr: WP2041358
Vendor Nbr: 391678306

Pay Code: MED

Recv Date: 20250327

Page 1 of 1

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

Image was generated electronically by Jopari

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#) X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 392845333

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

3. PATIENT'S BIRTH DATE (MM DD YY): 03 11 1973 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REACH FORWARD

5. PATIENT'S ADDRESS (No., Street): 3811 S 17TH PLACE

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

7. INSURED'S ADDRESS (No., Street):

CITY: SHEBOYGAN STATE: WI

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 53081 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (Include Area Code): ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. RESERVED FOR NUCC USE:

c. RESERVED FOR NUCC USE:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

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

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

c. OTHER ACCIDENT? [ ] YES [X] NO

10d. CLAIM CODES (Designated by NUCC):

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. INSURED'S DATE OF BIRTH (MM DD YY): SEX M [ ] F [ ]

b. OTHER CLAIM ID (Designated by NUCC): Y4 WP2041358

c. INSURANCE PLAN NAME OR PROGRAM NAME: WC221

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, complete items 9, 9a, and 9d.

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

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, INJURY, or PREGNANCY (LMP) (MM DD YY): 03 12 2025 QUAL. 431

15. OTHER DATE QUAL. 439 (MM DD YY): 03 12 2025

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNPAUL KNAPP

17a.

17b. NPI 1447563200

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): SPEC84

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S93402A B. S96912A C. W010XXA D. Y990

E. F. G. H.

I. J. K. L.

22. 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 OFFICE O/P NEW SF 15 MIN										ZZ	363A00000X
03 17 25	03 17 25	11		99202		ABCD	37000	1		NPI	1518924497
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 391678306

26. PATIENT'S ACCOUNT NO.: G1501859040

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

28. TOTAL CHARGE: $ 37000

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

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.)

DAVID OSTERWIND 363A00000X

SIGNED 03/27/2025 DATE

32. SERVICE FACILITY LOCATION INFORMATION

AURORA MEDICAL GROUP PLYMOUTH CLINI
2600 KILEY WAY

PLYMOUTH, WI 530735020

a. NPI b.

33. BILLING PROVIDER INFO & PH # (800) 326-2250

AURORA MEDICAL GROUP INC
PO BOX 735044

CHICAGO, IL 606735044

a. 1427271378 b. ZZ193200000X

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Optum

Society 3030

Process Date: 04/07/2025
Control Number: 381516
EOR Page 1 of 1
Rev/Aud: AA/RS

Claim Number:	WP2041358	PPO/OSR ID:	ExternalReview Procura
Claimant:	Weaver, Therese M	NPI Number:	1518924497
Provider Tax ID:	391678306 Vendor: 391678306-5029	Payment Code:	Clinic/doctor
Provider Ref:	G1501859040 Geo Zip: 53073	DOI:	03/12/2025
		Jurisdiction State:	WI
		Adjuster Name:	Renae Seth
		Claim Received:	03/27/2025
		BR Received:	03/27/2025

AURORA MEDICAL GROUP INC
PO BOX 735044
CHICAGO, IL 60673

ICD-DX1: S93.402A Sprain of unspecified ligament of left
ICD-DX2: S96.912A Strain of unsp msl/tnd at ank/ft level, left
ICD-DX3: W01.0XXA Fall same lev from slip/trip w/o strike
ICD-DX4: Y99.0 Civilian activity done for income or pay

Region: G4

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
03/17/25	11	99202		OFFICE/OUTPATIE	1.000	370.00	69.57	0.00	0.00	300.43	4101
				TOTALS:		370.00	69.57	0.00	0.00	300.43	
				TOTAL RECOMMENDED ALLOWANCE:						300.43	

Services performed by: OSTERWIND, DAVID

Reason Code Reimbursement Description:

4101 -THE REIMBURSEMENT RATE FOR THE TREATMENT PROVIDED IS BASED ON AN OPTUM CPT, HCPCS DATABASE AMO UNT CERTIFIED BY THE DEPARTMENT OF WORKFORCE DEVELOPMENT.

Carrier/Insurer: Society Insurance, PO Box 1029, Fond Du Lac, WI 54936

1.) The Equian DRG, ASC, HOSF, CPT/HCPCS, Anesthesia, ER, and Hospital Radiology databases are certified by the State of Wisconsin (DWD). Equian may use other databases certified by DWD, and these will be identified as such. 2.) This EOR should be received 30 days after the insurance carrier or self-insured employer (collectively payor) has received a completed bill which clearly identifies your name; address and phone number; the patient-employee; the date of service; the health service procedure; and the amount charged for each procedure, along with supporting documentation. 3.) The provider's obligation under par. (c), if the fee is beyond the formula amount, to provide the insurer or self-insurer with a written justification for the higher fee, at least 20 days prior to submitting the dispute to the department. The notice must clearly explain that the only justification for a fee more than the formula amount is that the service provided in this particular case is more difficult or more complicated than in the usual case; and 4.) The insurer's or self-insurer's obligation under par. (d) to respond within 15 days of receiving the provider's written justification for charging a fee beyond the formula amount. 5.) That pursuant to s. 102.16 (2) (b), Stats., once the notice required by this subsection is received by a provider, a health service provider may not collect the disputed fee from, or bring an action for collection of the disputed fee against, the employee who received the services for which the fee was charged. 6.) If you believe a factual error has been made (e.g., coding error) you must notify the payor of this error at least 20 days prior to submitting a dispute to the department. If it is accepted that an error has been made, payment (or partial payment) will be issued in 30 days. 7.) DWD certified databases do not provide certified data (more than 25 occurrences of a code in a region) on every code. If the recommended payment is based on less than 25 occurrences, or other calculation, it will be so described in the explanation. Equian has determined that the alternative reimbursement amount(s) is reasonable and reliable based on prevailing industry practices in the absence of a fee schedule or certified database amount (e.g., usual and customary).

If you have any questions regarding the contents of this review, please call Optum at 866-271-6317 *toll free*. For reconsideration of denied or reduced payment, please respond either by e-mail at reconappeals@optum.com or by fax at 1-800-218-6580. Please include 1) A narrative explanation of why each item should be paid, 2) A copy of this Review Analysis, and 3) Supporting documentation.

EFFECTIVE IMMEDIATELY, all medical bills submitted for Society Insurance claims must be submitted with associated claimant medical records and are to be forwarded to the following address or sent electronically:

Society, PO Box 14832, Lexington, KY 40512, Attn: Mailroom

E-bill payer ID for electronic billing:
WCEDI - Primary ID LS253, Secondary ID CB039 via WorkComp EDI
Jopari - J2139

SOCIETY INSURANCE

Hospital/Surgery Paid Detail for Therese M Weaver - 742

RUN DATE 4/25/25

RUN TIME 2:01 PM

REPORT CRITERIA

Claim Number: WP2041358 **Loss Date:** 03/12/2025 **Status:** Open

Claimant: Therese M Weaver **Insured:** Reach Forward Inc **Adjuster:** Renae Seth

Date	Payee	Service Facility	Draft Reason	Draft #	Payment Status	Billed Amount	Check Amount
4/10/2025	Aurora Med Ctr Sheboygan Coun	Aurora Health Care	03/12/2025 SVCS For T. Weaver ACCT H65888777801 Per Bill Review	0000601147	Complete	$1,850.00	$1,572.50

TOTALS

Loss Reserve	Loss Paid	Loss Recoverable	Loss Recovery	Loss Incurred	Expense Reserve	Expense Paid	Expense Recoverable	Expense Recovery	Expense Incurred
$1,077.50	$1,572.50	$0.00	$0.00	$2,650.00	$0.00	$0.00	$0.00	$0.00	$0.00

Image was generated electronically by Jopari

Claim Number: WP2041358 100209050912
Vendor Number: 390930748 Recv Date: 20250326

1 AURORA MED CTR SHEBOYGAN COUN 3400 UNION AVENUE SHEBOYGAN, WI 530818426 (800)326-2250	2 AURORA MED CTR SHEBOYGAN COUN PO BOX 735041 CHICAGO, IL 606735041	3a PAT. CNTL # H65888777801 b. MED. REC. # 376302 5 FED. TAX NO. 390930748 6 STATEMENT COVERS PERIOD FROM 031225 THROUGH 031225	4 TYPE OF BILL 0131 7 MED

8 PATIENT NAME	9 PATIENT ADDRESS
a 392845333	a 3811 S 17TH PLACE
b WEAVER, THERESE M	b SHEBOYGAN c WI d 53081 e

10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
03111973	F			1	1		01		WI	

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
04	031225	11	031225											

38 WCSOCIETY INSURANCE

39–41 VALUE CODES: (none)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0320	X-RAY EXAM OF ANKLE	73610-LT	031225	1.00	630.00		
0450	EMERGENCY DEPT VISIT LOW MDM	99283	031225	1.00	1220.00		
	PAGE 1 OF 1	CREATION DATE	032625	TOTALS	1850.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A WCSOCIETY INSURANCE		Y	Y			1922053107

57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A REACH FORWARD	20	392845333	WC221	

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
		REACH FORWARD

66 DX S93402A

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73
	S99912A		W010XXA	

74 PRINCIPAL PROCEDURE CODE DATE / a.–e. OTHER PROCEDURE CODE DATE: (none)

75

76 ATTENDING	NPI 1447563200	QUAL	
LAST KNAPP		FIRST PAUL	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS

81CC		
a	B3	207P00000X
b	B3	282N00000X
c		
d		

Aurora Medical Center Sheboygan County

Aurora Health Care
PO BOX 343918
Milwaukee, WI 53234-3918
Ph:(800) 326-2250

Detailed Bill Date: 03/25/25

Account ID
400391718

Guarantor Name & Address
Tw03122025other
Reach Forward
1901 S 8th St
Sheboygan, WI 53081

Visit ID
658887778

Detailed Bill For

Patient Name: Weaver, Therese M
Account Class: Emergency
Attending Physician: Knapp, Paul A

Total Charges: 1,850.00
Service Date:
03/12/2025

Hospital Charges

Date	Rev Code	Procedure Code	Description	Qty	Amount
03/12/25	0450	10002637	ED Level 3	1	1,220.00
03/12/25	0320	10000437	XR Ankle Complete	1	630.00

Total hospital charges: **1,850.00**
Total hospital payments and adjustments:

Total Balance: 1,850.00

Printed by: HBBCKGRND

Optum

Society 3030

Process Date: 04/09/2025
Control Number: 381469

Rev/Aud: AA/RS

Claim Number:	WP2041358	PPO/OSR ID:	ExternalReview Procura
Claimant:	Weaver, Therese M	NPI Number:	1922053107
Provider Tax ID:	390930748 Vendor: 390930748-0026	Payment Code:	Hospital/surgery
Provider Ref:	H65888777801 Geo Zip: 53081	DOI:	03/12/2025
		Jurisdiction State:	WI
		Adjuster Name:	Renae Seth
		Claim Received:	03/26/2025
		BR Received:	03/27/2025

AURORA MED CTR SHEBOYGAN COUN
PO BOX 735041
CHICAGO, IL 60673

ICD-DX1: S93.402A Sprain of unspecified ligament of left

Admitted: 03/12/2025 Discharged: 03/12/2025
Region: G4 Medicare: 520035

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
03/12/25	23	73610	LT,TC	RADEX ANKLE CO	1.000	630.00	66.10	66.82	0.00	497.08	4104
03/12/25	23	99283		EMERGENCY DEP	1.000	1,220.00	0.00	144.58	0.00	1,075.42	5141
			TOTALS:			**1,850.00**	**66.10**	**211.40**	**0.00**	**1,572.50**	
			TOTAL RECOMMENDED ALLOWANCE:							**1,572.50**	

Services performed by: AURORA MED CTR SHEBOYGAN COUNTY

Reason Code Reimbursement Description:

4104 -THE REIMBURSEMENT RATE FOR THE TREATMENT PROVIDED IS BASED ON THE DEPARTMENT OF WORKFORCE D EVELOPMENT AMOUNTS SHOWN IN THE RADIOLOGY DATABASE WHICH ONLY REFLECT THE TECHNICAL COMPONE NT OF THE SERVICE.

5141 -REVIEWED BY TRUE COURSE. NO REDUCTIONS.

Procura/Trilogy Work Comp:QUESTIONS REGARDING PPO/NETWORK REDUCTIONS CONTACT PROCURA: (877) 461-3750 OR EMAIL OptumWC.ProPPO@optum.com

Carrier/Insurer: Society Insurance, PO Box 1029, Fond Du Lac, WI 54936

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Optum

Society 3030

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EOR Page 2 of 2
Rev/Aud: AA/RS

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AURORA MED CTR SHEBOYGAN COUN
PO BOX 735041
CHICAGO, IL 60673

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Admitted: 03/12/2025 Discharged: 03/12/2025
Region: G4 Medicare: 520035

* Workers' Compensation *