6232755

STATE OF CALIFORNIA

John Garamendi, Insurance Commissioner

DEPARTMENT OF INSURANCE
CONSUMER SERVICES AND MARKET CONDUCT BRANCH
CONSUMER SERVICES DIVISION
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013
www.insurance.ca.gov
CCB-012 P
Revised: 10/25/05

RECEIVED
DEPT. OF INSURANCE
LOS ANGELES
06 DEC 26 AM 10: 10

REQUEST FOR ASSISTANCE

[redacted]
Name

Work Phone: [redacted]

[redacted]
Address

Home Phone: [redacted]

[redacted]
City Zip

Before you file a complaint with the Department of Insurance, you should first contact the insurance company, agent or broker in an effort to resolve the issue(s). If you do not receive a satisfactory response, then complete this form, attach copies of any important papers that relate to your complaint and mail to address shown above.

Please be aware that a copy of this Request for Assistance and other documentation submitted by you may be provided to the insurance company, agent or broker unless you indicate that you do not want a copy of your correspondence forwarded by checking the box:

☐ **Do not forward a copy of the completed form and the documentation provided. However, please contact the insurance company and investigate the complaint on my behalf.**

1. Complete name of insurance company involved: PACIFICCARE - A UNITED HEALTH CARE COMPANY

2. Type of Insurance: Auto ☐ Home ☐ Life ☐ Health ☒ Other ☐

3. (a) Name of the policyholder if different from your name:

   (b) If a group policy, provide the group name: #90219335, SPORTS LEADERSHIP GROUP

4. Policy identification or certificate number: 074022400-01

5. Claim number (if applicable)

6. Date loss occurred or began (if applicable) 7/24/06 + 8/7/06 DATES OF SURGERY

7. Broker/Agent (if applicable) COSTCO Broker/Agent License number

   Street address City/State / Zip

8. Have you contacted the company, agent or broker? Yes ☑ No ☐

   If yes, state the date(s) and person(s) contacted MANY MANY TIMES - PACIFICCARE CUSTOMER SERVICE
   (Provide copies of all correspondence)

(COMPLETE REVERSE SIDE)

[redacted]

CDI00249535

9. Have you reported this to any other governmental agency? Yes ☐ No ☒
If yes, please give:

(1) Name of agency: _____

(2) File number, if known: _____

10. Have you previously written to the Department of Insurance about this matter?
Yes ☐ No ☒ File number (if available) _____ Date _____

11. Is there attorney representation in this matter? Yes ☐ No ☒ NOT YET!

12. Is a lawsuit currently on-going or pending? Yes ☐ No ☒ If yes, our ability to mediate this matter is limited, but we will investigate your inquiry for any regulatory issues. We may defer the regulatory investigation until the finality of the litigation. We ask that you still complete this form so we have a record of your issue. Once the matter is concluded, we would welcome any information regarding violations of law by the insurer that you or your attorney are willing to provide.

13. Briefly, describe your problem (use additional paper if needed):

DOCTORS DIAGNOS ME WITH SEVERE KERTAKONIS IN BOTH EYES. PRESCRIBE EITHER CORNEAL TRANSPLANTS OR INTACTS. PACIFIC CARE PRE AUTHORIZES INTACTS SURGURY FOR BOTH EYES. PACIFICCARE PAYS SURGEON. I PAY SURGERY CENTER FOR FACILITY USE $2245.00 ON 7/24/06 AND $1395.00 ON 8/7/06. I FILE REIMBURSMENT CLAIM FORMS. PACIFICCARE DENIES AND CHANGES REASON 3 TIMES 1ST "WE DON'T COVER CONTACTS" - THERE ARE NOT CONTACTS! 2ND "WE DONT COVER REFRACTIVE SURGURY" THIS IS NOT REFRACTIVE (AND THEY DID PAY SURGEON) 3RD "DATE OF SERVICE WAS OUT SIDE OF WINDOW" DATES OF SERVICE ARE INSIDE WINDOW - SEE PRE AUTHORIZATION FORM

14. What do you consider to be a fair resolution to your problem?

→ I DO NOT WANT THIS PUSHED TO 2007 AND HAVE PACIFICCARE PUT TOWARD DEDUCTABLE.
→ I WANT IMMEDIATE REIMBURSMENT
→ I WANT PACIFICCARE TO PAY PUNITIVE DAMAGES
WE HAVE SPENT MANY HOURS BECAUSE OF THEIR DELAY TACTICS. PLUS THEY NEVER RESPOND TO OUR REQUESTS FOR RETURN CALLS

[redacted] _____ 12-21-06
(Signature) (Date)

[redacted]

Itemized Bill
ATTACHED

PacifiCare

PPO/Indemnity Medical Claim Form

Instructions for Submitting Claims

1. Use a separate form for each family member, each different provider of service and each itemized bill.
2. Attach a fully itemized bill or ask the provider to complete the other side of this form.
   FULLY ITEMIZED BILLS MUST CONTAIN THE FOLLOWING INFORMATION: Date of service, diagnosis, type of service, procedure number, charge for each service, provider name, address, phone number, provider tax ID number.
3. A signature line for AUTHORIZATION TO PAY PROVIDER is given below. This directs PacifiCare to pay the provider. If you choose not to sign this authorization, benefits will be paid to you.
4. Please send claims to PacifiCare: P.O. Box 6099, Cypress, CA 90630
5. If you have questions regarding your claim or need additional claim forms or claim record envelopes, please call: 1-866-316-9776.
6. Reimbursement of pharmacy expense is outlined in your member materials. (Do not use this form for pharmacy claims.)

Employee Information (Complete for All Claims)

Employer Name: SPORTS LEADERSHIP GROUP	Group Number: 90219335
Employee's Name (Last, First M.I.): [redacted]	Employee's Street Address: [redacted]
Employee's Date of Birth: 11-16-1956 / Employee's SSN: [redacted]	City: [redacted] / State: [redacted] / Zip Code: [redacted]

This claim is for: ☒ Self ☐ Spouse ☐ Child ☐ Other - Please specify

Patient Information

Patient's Name (Last, First M.I.): [redacted]	Patient's Date of Birth: 11-16-1956 / PacifiCare ID#: 074022400-01

Patient is (Check if applicable): ☐ Female ☒ Married ☐ Disabled ☐ Retired ☒ Male ☐ Single ☐ On Medicare ☐ Student

If patient is disabled, give date of disability

Patient was treated for: ☒ Illness ☐ Pregnancy ☐ Injury at Work ☐ Accidental Injury ☐ Other - Please specify

If accident involved, give date, how and where accident occurred

Does patient have other health coverage? ☐ Yes ☒ No	If Yes, Name of Insurance Company	Group Number	Policy Number

Address of Insurance Company

Name of Policy Holder	Sex of Policy Holder ☐ Male ☐ Female	Policy Holder's Date of Birth
Name of Policy Holder's Employer	Policy Holder's Employer's Address	

Authorizations

RELEASE OF INFORMATION
I hereby authorize the release of any medical information necessary to process this claim.

[redacted] 7-26-06
Patient's or Authorized Person's Signature Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER
I hereby authorize benefits to be paid directly to the provider of service for this claim.

Patient's or Authorized Person's Signature Date

PLEASE ATTACH AN ITEMIZED BILL OR ASK THE PROVIDER OF SERVICE TO FILL OUT THE OTHER SIDE OF THIS CLAIM FORM

[redacted]

Itemized Bill Attached

PacifiCare®

PPO/Indemnity Medical Claim Form

Instructions for Submitting Claims

1. Use a separate form for each family member, each different provider of service and each itemized bill.
2. Attach a fully itemized bill or ask the provider to complete the other side of this form.
   FULLY ITEMIZED BILLS MUST CONTAIN THE FOLLOWING INFORMATION: Date of service, diagnosis, type of service, procedure number, charge for each service, provider name, address, phone number, provider tax ID number.
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5. If you have questions regarding your claim or need additional claim forms or claim record envelopes, please call: 1-866-316-9776.
6. Reimbursement of pharmacy expense is outlined in your member materials. (Do not use this form for pharmacy claims.)

Employee Information (Complete for All Claims)

Employer Name: Sports Leadership Group	Group Number: 90219335
Employee's Name (Last, First M.I.): [redacted]	Employee's Street Address: [redacted]
Employee's Date of Birth: 11-16-56 / Employee's SSN: [redacted]	City: [redacted] / State: [redacted] / Zip Code: [redacted]

This claim is for: ☒ Self ☐ Spouse ☐ Child ☐ Other - Please specify

Patient Information

Patient's Name (Last, First M.I.): [redacted]	Patient's Date of Birth: 11-16-56	PacifiCare ID#: 074022400 - 01

Patient is (Check if applicable): ☐ Female ☐ Married ☐ Disabled ☐ Retired ☒ Male ☐ Single ☐ On Medicare ☐ Student

If patient is disabled, give date of disability:

Patient was treated for: ☒ Illness ☐ Pregnancy ☐ Injury at Work ☐ Accidental Injury ☐ Other - Please specify

If accident involved, give date, how and where accident occurred:

Does patient have other health coverage? ☐ Yes ☒ No	If Yes, Name of Insurance Company: n/a	Group Number:	Policy Number:

Address of Insurance Company: n/a

Name of Policy Holder:	Sex of Policy Holder: ☐ Male ☐ Female	Policy Holder's Date of Birth:
Name of Policy Holder's Employer:	Policy Holder's Employer's Address:	

Authorizations

RELEASE OF INFORMATION
I hereby authorize the release of any medical information necessary to process this claim.

[redacted] 8-7-06
Patient's or Authorized Person's Signature — Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER
I hereby authorize benefits to be paid directly to the provider of service for this claim.

X
Patient's or Authorized Person's Signature — Date

PLEASE ATTACH AN ITEMIZED BILL OR ASK THE PROVIDER OF SERVICE TO FILL OUT THE OTHER SIDE OF THIS CLAIM FORM

[redacted]

HORIZON VISION CENTERS

14895 East 14th Street, Suite 360
San Leandro, CA 94578

PATIENT RECEIPT

Patient: [redacted]

Address: _____

Home # _____ Surgery Date: 8/7/06

Work # _____ Surgeon: Turner

Type of Surgery:

Procedure	Eyes
• PRK/LASEK	Right Eye
• EPI-LASEK	Left Eye
• LASIK	Both Eyes
• WAVEFRONT	
• INTRALASE	
• INTACS	
• AK	
• RETREAT	Original Surgery Date: _____

Place of Surgery: Horizon Vision Centers

- ✓ San Leandro
- San Jose
- Concord
- Petaluma
- San Francisco
- Sacramento
- Roseville

Diagnosis Code: Myopia (367.1) Hyperopia (367.0) Keratoconus (371.61) (circle one)

Procedure Code: Corneal Refractive Surgery – Conventional (65760) Custom (66999) INTACS (00997) (circle one)

Total Amount Received: $1395.00

Check # Discover American Express Visa MasterCard

Corporate Office: (510) 297-5050 Fax: 297-5057
TAX ID # 30-0097822

14895 East 14th Street, Suite 360
San Leandro, CA 94578

PATIENT RECEIPT

Patient: [redacted]

Address: _____

_____

Home # _____ Surgery Date: 7/24/06

Work # _____ Surgeon: Turner

Type of Surgery:

Procedure	Eyes
• PRK/LASEK	(Right Eye)
• EPI-LASEK	Left Eye
• LASIK	Both Eyes
• WAVEFRONT	
• INTRALASE	
• (INTACS)	
• AK	
• RETREAT	Original Surgery Date: _____

Place of Surgery: Horizon Vision Centers

- ✓ San Leandro
- o San Jose
- o Concord
- o Petaluma
- o San Francisco
- o Sacramento
- o Roseville

Diagnosis Code: Myopia (367.1) Hyperopia (367.0) [Keratoconus (371.61)] (circle one)

Procedure Code: Corneal Refractive Surgery – Conventional (65760) Custom (66999) [INTACS (00997)] (circle one)

Total Amount Received: $2245.00

Check # Discover American Express [Visa] MasterCard

Corporate Office: (510) 297-5050 Fax: 297-5057
TAX ID # 30-0007822

[redacted]

PacifiCare®

ed Healthcare Company

P.O. Box 6099
Cypress, CA 90630
www.pacificare.com

Date: 07/24/2006

[redacted]

Insured Name:	[redacted]
Subscriber Name:	
ID Number:	074022400
Procedure:	IMPLT INTRASTOM CRNEAL RN
Facility:	HORIZON VISION CENTER MED GROU
Type of Treatment:	OUTPATIENT
Services Approved From:	06/24/2006
Services Approved Through:	08/23/2006
Authorization #:	a0125961

Dear [redacted] :

PacifiCare Life and Health Insurance Company ("PacifiCare") received a request to authorize the above named service. We have pre-authorized the named service, based solely on the information submitted.

Pre-authorization is a determination of medical necessity only. Payment will be based on the terms of your benefit coverage and enrollment or eligibility at the time service(s) are rendered.
If additional services or procedures are needed you or your physician should contact Pacificare at 1-866-863-9776. If additional services or procedures are performed without further authorization, the payment of your health plan benefits may be decreased or result in non-payment.

If you should have any questions please contact PacifiCare's Customer Service Department at 1-866-316-9776, 6:00 a.m. to 9:00 p.m. PST, Monday through Friday.

Sincerely,
PacifiCare Medical Management

This letter not in company's claim file.

cc: STEPHEN G TURNER MD
HORIZON VISION CENTER MED GROU

[redacted]

[redacted]

DEPT. OF INSURANCE
CONSUMER SERVICES AND MARKET CONDUCT BRANCH
CONSUMER SERVICES DIVISION
300 SOUTH SPRING ST. SOUTH TOWER
LOS ANGELES, CA 90013

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