

INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807TELEPHONE
800-782-2020

DATE: 01/09/14

POLICY: 504653232013001

CLAIM NUMBER: 20001981033

DATE OF LOSS: 06/12/13

INSURED NAME:

GUERRA, MARIO A

CLAIMANT NAME:

LEDUC

MARSHA

GEORGESON BELARDINELLI & NOYES
7060 N FRESNO ST STE 250

FRESNO CA 93720-2925

Please be advised that we are unable to conclude the pending bodily injury claim(s) of your client(s) due to the following reason(s):

() We have ordered and are awaiting all medical reports, notes and billing statements to properly evaluate your client's bodily injury claim.

(X) We are waiting for your office to forward all applicable medical reports, notes, and billing statements so that we can properly evaluate your client's bodily injury claim.

() We await your response to our request to take a recorded statement from your client concerning the facts of loss.

() We need the following records regarding your client's prior/subsequent loss/losses on :

() Medical Records

() Police Report

() Material Damage Records (vehicle damage estimates, photos, etc.)

() Please contact me with updated injury and treatment information.

() There are other claimants, and we are awaiting receipt of documentation from each claimant in order to determine the full exposure.

() Kindly advise of our recent settlement offer of \$ made on

() We need a copy of your client's policy declarations sheet showing what tort threshold your client was subject to on the above date of loss.

() We need an Affidavit of No Other Insurance from your client.

()

NF23B R0003 20001981033 005 BI 473 20140109 CLAI0001

LP0000539



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

If you have any questions about this matter, please feel free to
contact me at 205-803-8822

Sincerely,

JENNIFER CERAVOLO

Claims Adjuster

NF23B R0003 20001981033 005 BI 473 20140109 CLAI0001

LP0000540

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

GEORGESON BELLARDINELLI NOYES
7060 N FRESNO ST STE 250

FRESNO CA 93720-2925

DATE: 11/07/13
POLICY: 504653232013001
CLAIM NUMBER: 20001981033
DATE OF LOSS: 06/12/13
INSURED NAME:
GUERRA, MARIO A
CLAIMANT NAME:
LEDUC MARSHA

Please be advised that we are unable to conclude the pending bodily injury claim(s) of your client(s) due to the following reason(s):

() We have ordered and are awaiting all medical reports, notes and billing statements to properly evaluate your client's bodily injury claim.

() We are waiting for your office to forward all applicable medical reports, notes, and billing statements so that we can properly evaluate your client's bodily injury claim.

() We await your response to our request to take a recorded statement from your client concerning the facts of loss.

() We need the following records regarding your client's prior/subsequent loss/losses on :

- () Medical Records
- () Police Report
- () Material Damage Records (vehicle damage estimates, photos, etc.)

() Please contact me with updated injury and treatment information.

() There are other claimants, and we are awaiting receipt of documentation from each claimant in order to determine the full exposure.

() Kindly advise of our recent settlement offer of \$ made on

() We need a copy of your client's policy declarations sheet showing what tort threshold your client was subject to on the above date of loss.

() We need an Affidavit of No Other Insurance from your client.

()

NF23B R0003 20001981033 005- BI 473 20131107 CLAI0001

LP0000541



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

If you have any questions about this matter, please feel free to
contact me at 205-803-8822

Sincerely,

JENNIFER CERA VOLO

Claims Adjuster

NF23B R0003 20001981033 005 BI 473 20131107 CLAI0001

LP0000542



FINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807TELEPHONE
800-782-2020GEORGESON BELLARDINELLI NOYES
7060 N FRESNO ST STE 250

FRESNO CA 93720-2925

DATE: 11/07/13
POLICY: 504653232013001
CLAIM NUMBER: 20001981033
DATE OF LOSS: 06/12/13
INSURED NAME:
GUERRA, MARIO A
CLAIMANT NAME:
ABBY, TORI KAY

Please be advised that we are unable to conclude the pending bodily injury claim(s) of your client(s) due to the following reason(s):

() We have ordered and are awaiting all medical reports, notes and billing statements to properly evaluate your client's bodily injury claim.

(X) We are waiting for your office to forward all applicable medical reports, notes, and billing statements so that we can properly evaluate your client's bodily injury claim.

() We await your response to our request to take a recorded statement from your client concerning the facts of loss.

() We need the following records regarding your client's prior/subsequent loss/losses on :

- () Medical Records
- () Police Report
- () Material Damage Records (vehicle damage estimates, photos, etc.)

(X) Please contact me with updated injury and treatment information.

() There are other claimants, and we are awaiting receipt of documentation from each claimant in order to determine the full exposure.

() Kindly advise of our recent settlement offer of \$ made on

() We need a copy of your client's policy declarations sheet showing what tort threshold your client was subject to on the above date of loss.

() We need an Affidavit of No Other Insurance from your client.

()

NF23B R0003 20001981033 002 BI 473 20131107 CLAI0001

LP0000543



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

If you have any questions about this matter, please feel free to
contact me at 205-803-8822

Sincerely,

JENNIFER CERA VOLO

Claims Adjuster

NF23B R0003 20001981033 002 BI 473 20131107 CLAI0001

LP0000544



P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

GEORGESON BELLARDINELLI NOYES
7060 N FRESNO ST STE 250

FRESNO CA 93720-2925

DATE: 11/07/13
POLICY: 504653232013001
CLAIM NUMBER: 20001981033
DATE OF LOSS: 06/12/13
INSURED NAME:
GUERRA, MARIO A
CLAIMANT NAME:
ABBY MILEY

Please be advised that we are unable to conclude the pending bodily injury claim(s) of your client(s) due to the following reason(s):

() We have ordered and are awaiting all medical reports, notes and billing statements to properly evaluate your client's bodily injury claim.

(X) We are waiting for your office to forward all applicable medical reports, notes, and billing statements so that we can properly evaluate your client's bodily injury claim.

() We await your response to our request to take a recorded statement from your client concerning the facts of loss.

() We need the following records regarding your client's prior/subsequent loss/losses on :

- () Medical Records
- () Police Report
- () Material Damage Records (vehicle damage estimates, photos, etc.)

(X) Please contact me with updated injury and treatment information.

() There are other claimants, and we are awaiting receipt of documentation from each claimant in order to determine the full exposure.

() Kindly advise of our recent settlement offer of \$ made on

() We need a copy of your client's policy declarations sheet showing what tort threshold your client was subject to on the above date of loss.

() We need an Affidavit of No Other Insurance from your client.

()

NF23B R0003 20001981033 004 BI 473 20131107 CLAI0001

LP0000545



FINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

If you have any questions about this matter, please feel free to
contact me at 205-803-8822

Sincerely,

JENNIFER CERA VOLO

Claims Adjuster

NF23B R0003 20001981033 004 BI 473 20131107 CLAI0001

LP0000546

INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

GEORGESON BELLARDINELLI NOYES
7060 N FRESNO ST, STE 250

FRESNO CA 93720-

DATE: 08/08/13
POLICY: 504653232013001
CLAIM NUMBER: 20001981033
DATE OF LOSS: 06/12/13
INSURED NAME:
GUERRA, MARIO A
CLAIMANT NAME:
ABBY MILEY

Please be advised that we are unable to conclude the pending bodily injury claim(s) of your client(s) due to the following reason(s):

() We have ordered and are awaiting all medical reports, notes and billing statements to properly evaluate your client's bodily injury claim.

() We are waiting for your office to forward all applicable medical reports, notes, and billing statements so that we can properly evaluate your client's bodily injury claim.

() We await your response to our request to take a recorded statement from your client concerning the facts of loss.

() We need the following records regarding your client's prior/subsequent loss/losses on :

- () Medical Records
- () Police Report
- () Material Damage Records (vehicle damage estimates, photos, etc.)

() Please contact me with updated injury and treatment information.

() There are other claimants, and we are awaiting receipt of documentation from each claimant in order to determine the full exposure.

() Kindly advise of our recent settlement offer of \$ made on

() We need a copy of your client's policy declarations sheet showing what tort threshold your client was subject to on the above date of loss.

() We need an Affidavit of No Other Insurance from your client.

(X) WE ARE WORKING TO OBTAIN AUTHORIZATION TO RELEASE POLICY LIMIT INFORMATION.



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

If you have any questions about this matter, please feel free to
contact me at 800.782.2020 X38822 .

Sincerely,

JENNIFER CERAVOLO

Claims Adjuster

NF23B R0003 20001981033 004 BI RCH 20130808 CLAI0001

LP0000548



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807TELEPHONE
800-782-2020GEORGESON BELLARDINELLI NOYES
7060 N FRESNO ST, STE 250

FRESNO CA 93720-

DATE: 08/08/13
POLICY: 504653232013001
CLAIM NUMBER: 20001981033
DATE OF LOSS: 06/12/13
INSURED NAME:
GUERRA, MARIO A
CLAIMANT NAME:
LEDUC MARSHA

Please be advised that we are unable to conclude the pending bodily injury claim(s) of your client(s) due to the following reason(s):

() We have ordered and are awaiting all medical reports, notes and billing statements to properly evaluate your client's bodily injury claim.

() We are waiting for your office to forward all applicable medical reports, notes, and billing statements so that we can properly evaluate your client's bodily injury claim.

() We await your response to our request to take a recorded statement from your client concerning the facts of loss.

() We need the following records regarding your client's prior/subsequent loss/losses on :

() Medical Records

() Police Report

() Material Damage Records (vehicle damage estimates, photos, etc.)

() Please contact me with updated injury and treatment information.

() There are other claimants, and we are awaiting receipt of documentation from each claimant in order to determine the full exposure.

() Kindly advise of our recent settlement offer of \$ made on

() We need a copy of your client's policy declarations sheet showing what tort threshold your client was subject to on the above date of loss.

() We need an Affidavit of No Other Insurance from your client.

(X) WE ARE WORKING TO OBTAIN AUTHORIZATION TO RELEASE POLICY LIMIT INFORMATION.

NF23B R0003 20001981033 005 BI RCH 20130808 CLAI0001

LP0000549



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

If you have any questions about this matter, please feel free to
contact me at 800.782.2020 X38822

Sincerely,

JENNIFER CERA VOLO

Claims Adjuster

NF23B R0003 20001981033 005 BI RCH 20130808 CLAI0001

LP0000550



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807TELEPHONE
800-782-2020GEORGESON BELLARDINELLI NOYES
7060 N FRESNO ST, STE 250

FRESNO CA 93720-

DATE: 08/08/13
POLICY: 504653232013001
CLAIM NUMBER: 20001981033
DATE OF LOSS: 06/12/13
INSURED NAME:
GUERRA, MARIO A
CLAIMANT NAME:
ABBY, TORI KAY

Please be advised that we are unable to conclude the pending bodily injury claim(s) of your client(s) due to the following reason(s):

() We have ordered and are awaiting all medical reports, notes and billing statements to properly evaluate your client's bodily injury claim.

() We are waiting for your office to forward all applicable medical reports, notes, and billing statements so that we can properly evaluate your client's bodily injury claim.

() We await your response to our request to take a recorded statement from your client concerning the facts of loss.

() We need the following records regarding your client's prior/subsequent loss/losses on :

- () Medical Records
- () Police Report
- () Material Damage Records (vehicle damage estimates, photos, etc.)

() Please contact me with updated injury and treatment information.

() There are other claimants, and we are awaiting receipt of documentation from each claimant in order to determine the full exposure.

() Kindly advise of our recent settlement offer of \$ made on .

() We need a copy of your client's policy declarations sheet showing what tort threshold your client was subject to on the above date of loss.

() We need an Affidavit of No Other Insurance from your client.

(X) WE ARE WORKING TO OBTAIN AUTHORIZATION TO RELEASE POLICY LIMIT INFORMATION.

NF23B R0003 20001981033 002 BI RCH 20130808 CLAI0001

LP0000551



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

If you have any questions about this matter, please feel free to
contact me at 800.782.2020 X38822

Sincerely,

JENNIFER CERAVOLO

Claims Adjuster

NF23B R0003 20001981033 002 BI RCH 20130808 CLAI0001

LP0000552



P O BOX 830807
Birmingham, AL 35283

July 29, 2013

Georgeson Belardinelli and Noyes
Fax #: 559-447-0747

RE:	Claim number:	20001981033
	Date of Loss:	06/12/2013
	Insureds:	Mario Guerra, Maria Guerra & Daniel Canchola
	Your Clients:	Tori Abby, Miley Abby, Mandy Jobe Cal LeDuc, Lukus LeDuc and Jay LeDuc

Dear Richard A. Belardinelli:

This letter confirms I am in receipt of your representation letter and signed Designations of Counsel for your above mentioned clients. I am in the process of obtaining written permission to disclose the policy limits from our insured. Once I have received his written permission I will contact you and provide you with that information.

In the meantime, should you have any questions or wish to discuss this matter, please do not hesitate to contact me at 205-803-8822.

Sincerely

A handwritten signature in black ink, appearing to read 'Jennifer Ceravolo'.

Jennifer Ceravolo
Continuing Action Adjuster
Infinity Select Insurance Company

GEORGESON BELARDINELLI AND NOYES

ATTORNEYS AT LAW

7060 NORTH FRESNO STREET, SUITE 250
FRESNO, CALIFORNIA 93720

TELEPHONE
(559) 447-8800

TELECOPIER
(559) 447-0747

July 18, 2013

VIA U.S. MAIL ONLY

Infinity Select Insurance Company
P.O. Box 830807
Birmingham, AL 35283-0807

Re: Claim Number: 20001981033
Date of Loss: June 12, 2013
Our clients: *Tori Abby, Miley Abby, Mandy Jobe*
Cal LeDuc, Lukus LeDuc and Jay LeDuc

Dear Adjuster:

As you know we have been retained by *Tori Abby, Miley Abby, Mandy Jobe, Cal LeDuc, Lukus LeDuc and Jay LeDuc* to represent their interests as they relate to the accident of June 12, 2013 with your insured. Additional signed Designations of Counsel are enclosed herein.

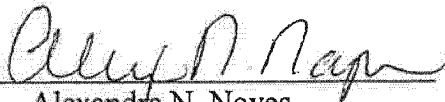
You are requested to direct all future communications herein to this firm and to cease all direct communication with our clients. Further, please allow this letter to revoke any and all authorizations, oral or written, which have been given to you previously by our clients.

Again, we request you provide us with written confirmation of coverage for the above-referenced accident and information regarding the limits of your applicable policy.

Thank you for your courtesy and cooperation.

Very Truly Yours,

GEORGESON, BELARDINELLI AND NOYES

By 
Alexandra N. Noyes
Richard A. Belardinelli

AN/ck
Enclosures

LP0000554

DESIGNATION OF COUNSEL

I, Jay LeDuc, the undersigned, hereby designate the law firm of GEORGESON, BELARDINELLI AND NOYES, 7060 N. Fresno Street, Suite 250, Fresno, CA 93720, as my attorneys of record to represent my interests with respect to that certain accident which occurred on or about June 12, 2013. My said attorneys are specifically authorized to handle my claim, and all matters related thereto, arising from the above-referenced occurrence.

A copy of this form shall have the same effect as the original.

DATED: 7-9-13


Jay LeDuc

DESIGNATION OF COUNSEL

I, Lukus LeDuc, the undersigned, hereby designate the law firm of GEORGESON, BELARDINELLI AND NOYES, 7060 N. Fresno Street, Suite 250, Fresno, CA 93720, as my attorneys of record to represent my interests with respect to that certain accident which occurred on or about June 12, 2013. My said attorneys are specifically authorized to handle my claim, and all matters related thereto, arising from the above-referenced occurrence.

A copy of this form shall have the same effect as the original.

DATED: 7/2/13

Lukas LeDuc
Lukas LeDuc

GEORGESON BELARDINELLI AND NOYES

ATTORNEYS AT LAW
7060 NORTH FRESNO STREET, SUITE 250
FRESNO, CALIFORNIA 93720

TELEPHONE
(559) 447-8800

TELECOPIER
(559) 447-0747

July 8, 2013

VIA U.S. MAIL ONLY

Infinity Select Insurance Company
P.O. Box 830807
Birmingham, AL 35283-0807

Re: Claim Number: 20001981033
Date of Loss: June 12, 2013
Our clients: *Tori Abby, Miley Abby, Mandy Jobe*
Cal LeDuc, Lukus LeDuc and Jay LeDuc

Dear Adjuster:

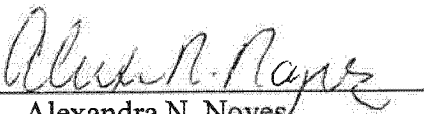
Please be advised that we have been retained by Tori Abby, Miley Abby, Mandy Jobe, Cal LeDuc, Lukus LeDuc and Jay LeDuc to represent their interests as they relate to the accident of June 12, 2013 with your insured. Enclosed herein are signed Designations of Counsel. You are requested to direct all future communications herein to this firm and to cease all direct communication with our clients. Further, please allow this letter to revoke any and all authorizations, oral or written, which have been given to you previously by our clients.

In addition, we request you provide us with written confirmation of coverage for the above-referenced accident and information regarding the limits of your applicable policy.

Thank you for your courtesy and cooperation.

Very Truly Yours,

GEORGESON, BELARDINELLI AND NOYES

By 
Alexandra N. Noyes
Richard A. Belardinelli

AN/ck
Enclosures

LP0000557

DESIGNATION OF COUNSEL

I, Tori Abby, the undersigned, hereby designate the law firm of GEORGESON, BELARDINELLI AND NOYES, 7060 N. Fresno Street, Suite 250, Fresno, CA 93720, as my attorneys of record to represent my interests with respect to that certain accident which occurred on or about June 12, 2013. My said attorneys are specifically authorized to handle my claim, and all matters related thereto, arising from the above-referenced occurrence.

A copy of this form shall have the same effect as the original.

DATED: 7-3-13

Tori Abby
Tori Abby

DESIGNATION OF COUNSEL

I, Tori Abby, as guardian for Miley Abby, the undersigned, hereby designate the law firm of GEORGESON, BELARDINELLI AND NOYES, 7060 N. Fresno Street, Suite 250, Fresno, CA 93720, as my attorneys of record to represent my interests with respect to that certain accident which occurred on or about June 12, 2013. My said attorneys are specifically authorized to handle my claim, and all matters related thereto, arising from the above-referenced occurrence.

A copy of this form shall have the same effect as the original.

DATED: 7-3-13

Tori Abby
Tori Abby, as Guardian for Miley Abby

DESIGNATION OF COUNSEL

I, Cal LeDuc, the undersigned, hereby designate the law firm of GEORGESON, BELARDINELLI AND NOYES, 7060 N. Fresno Street, Suite 250, Fresno, CA 93720, as my attorneys of record to represent my interests with respect to that certain accident which occurred on or about June 12, 2013. My said attorneys are specifically authorized to handle my claim, and all matters related thereto, arising from the above-referenced occurrence.

A copy of this form shall have the same effect as the original.

DATED: 7-3-13


Cal LeDuc

DESIGNATION OF COUNSEL

I, Mandy Jobe, the undersigned, hereby designate the law firm of GEORGESON, BELARDINELLI AND NOYES, 7060 N. Fresno Street, Suite 250, Fresno, CA 93720, as my attorneys of record to represent my interests with respect to that certain accident which occurred on or about June 12, 2013. My said attorneys are specifically authorized to handle my claim, and all matters related thereto, arising from the above-referenced occurrence.

A copy of this form shall have the same effect as the original.

DATED:

July 2, 2013

Mandy Jobe
Mandy Jobe

INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

CAL LEDUC
RE: MARSHA LEDUC
5795 S CRAWFORD AVE
REEDLEY CA 93654-

DATE: 06/24/13
POLICY: 504653232013001
CLAIM NUMBER: 20001981033
DATE OF LOSS: 06/12/13
INSURED NAME:
GUERRA, MARIO A
CLAIMANT NAME:
LEDUC MARSHA

The above claim has been transferred to me for future handling.
Please refer all future correspondence and phone calls to my
attention. When communicating with me be sure to reference the
correct claim number.

Mail and phone calls to the proper Claim Adjuster identified with the
correct claim number, will facilitate quicker handling of your
claim.

If you have any questions, please do not hesitate to call me at
205-803-8822

Sincerely,

JENNIFER CERAVOLO

Claims Adjuster

Warning: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING
TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR
FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND
MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

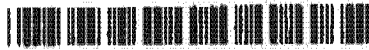
D9133 R0002 20001981033 005 BI 473 20130624 CLAI0001

LP0000562

Community Regional Anes Med Grp (3)
PO BOX 7096
Stockton CA 95267-0096

IF PAYING BY MASTERCARD, DISCOVER, OR AMERICAN EXPRESS, FILL OUT BELOW.	
CHECK CARD USING FOR PAYMENT	
<input type="checkbox"/> MASTERCARD <input type="checkbox"/> VISA <input type="checkbox"/> DISCOVER <input type="checkbox"/> AMERICAN EXPRESS	CARD NUMBER SIGNATURE STATEMENT DATE 6/25/2013
AMOUNT EXP. DATE ACCT. # 1106366	PAY THIS AMOUNT 2400.00
SHOW AMOUNT PAID HERE \$	
REMIT TO	

0102256 SP 0128 -001-P02258-1



MARSHA K LEDUC
6246 CRAWFORD AVE
REEDLEY CA 93654



Community Regional Anes Med Grp (3)
PO BOX 7096
Stockton CA 95267-0096

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

Patient Name		Insurance Balance	Patient Balance	Statement Date	Page	
MARSHA K LEDUC		0.00	2400.00	6/25/2013	1/1	
Service Date	BIN Number	Provider Name	Total Charge	Payments Adjustments	Insurance Balance	Patient Balance
06/12/2013	2121343	Jakkarin J Sareerak	2400.00	0.00	0.00	2400.00
Total Charges: 2400.00 Amount Paid by Insurance: 0.00 Amount Due from Insurance: 0.00 Please Pay This Amount: 2400.00						
Current	30-60 Days	61-90 Days	91-120 Days	120+ Days	Total Balance	Insurance Due
2400.00	0.00	0.00	0.00	0.00	2400.00	0.00
					Patient Due	2400.00

Please be advised that the Patient Balance above is now your responsibility

Kindly make your check payable to Community Regional Anes Med Grp (3) and mail to the above address.
Si necesita ayuda en español Por Favor llame al: (877) 866-9877

SERVICES WERE RENDERED AT:
FRESNO COMMUNITY HOSPITAL

Billing Questions: (877) 866-9877
Office Hours: Monday - Friday 8:00 AM - 4:30 PM PST

678

LP0000563

CENTRAL CALIF FACULTY MED GRP
PO BOX 8036
FOUNTAIN VALLEY, CA 92728-8036



004672 0101

RETURN SERVICE REQUESTED

DATE OF SERVICE: 06/12/13
PATIENT NAME: MARSHA
ACCOUNT #: CCF 228946060
INSURANCE: CASH

Page 1 of 1

MARSHA K LEDUC
6246 CRAWFORD AVE
REEDLEY, CA 93654-9546

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, CHECK AND FILL OUT BELOW.		
<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> VISA
<input type="checkbox"/> AMERICAN EXPRESS		
CARD NUMBER		IDENTIFICATION CODE *
SIGNATURE		EXP. DATE
STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
07/02/13	528.00	CCF 228946060
* LAST THREE DIGITS ON BACK OF CREDIT CARD. REQUIRED FOR PAYMENT PROCESSING		SHOW AMOUNT PAID HERE \$

CENTRAL CALIF FACULTY MED GRP
PO BOX 8036
FOUNTAIN VALLEY, CA 92728-8036

5867 ST *STM173G1D000904

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

ACCOUNT NUMBER: CCF 228946060 PATIENT: MARSHA

STATEMENT DATE: 07/02/13

DATE	DESCRIPTION	AMOUNT
06/12/13	COMPREHENSIVE EXAM	528.00
	Primary CASH billed 06/28/13 SECONDARY INSUR:	
<p>This bill is for the services provided by the physicians in the emergency department of the hospital. The hospital requires the physicians to bill patients separately for their services. These charges are not included in your hospital bill.</p> <p>Esta factura cubre el servicio medico que recibio en la sala de emergencia. El hospital requiere que los servicios del doctor se cobren por separado. Este servicio no esta incluido en los cargos que aparecen en la factura del hospital.</p> <p>For billing questions, you may contact us at toll free 877 552-1475 or via email at ccf@attglobal.net Medicare patients are only responsible for co-pays and deductibles.</p>		BALANCE DUE
		528.00

COMMENTS:

FOR SERVICES RENDERED AT OP-CENTRAL CALIF FAC ME
CENTRAL CALIF FACULTY MED GRP

BUSINESS OFFICE HOURS:

9:00 AM to 5:00 PM (MON-FRI)

PHONE NUMBER: toll free 877 552-1475

MESSAGE:

YOU MAY ACCESS YOUR ACCOUNT INFORMATION AT ANY TIME THROUGH OUR AUTOMATED SYSTEM AT toll free 877 552-1475.

LP0000564

10388060003623010100

INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

ABBY, TORI KAY
795 S CRAWFORD AVE

REEDLEY CA 93654-

DATE: 06/24/13
POLICY: 504653232013001
CLAIM NUMBER: 20001981033
DATE OF LOSS: 06/12/13
INSURED NAME:
GUERRA, MARIO A
CLAIMANT NAME:
ABBY, TORI KAY

The above claim has been transferred to me for future handling. Please refer all future correspondence and phone calls to my attention. When communicating with me be sure to reference the correct claim number.

Mail and phone calls to the proper Claim Adjuster identified with the correct claim number, will facilitate quicker handling of your claim.

If you have any questions, please do not hesitate to call me at 205-803-8822

Sincerely,

JENNIFER CERAVOLO

Claims Adjuster

Warning: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

D9133 R0002 20001981033 002 BI 473 20130624 CLAI0001

10388060003624010100



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

DATE: 06/24/13
POLICY: 504653232013001
CLAIM NUMBER: 20001981033
DATE OF LOSS: 06/12/13
INSURED NAME:
GUERRA, MARIO A
CLAIMANT NAME:
ABBY MILEY

PARENTS OF MILEY ABBY
5795 CRAWFORD AVE

REEDLEY CA 93654-9433

The above claim has been transferred to me for future handling. Please refer all future correspondence and phone calls to my attention. When communicating with me be sure to reference the correct claim number.

Mail and phone calls to the proper Claim Adjuster identified with the correct claim number, will facilitate quicker handling of your claim.

If you have any questions, please do not hesitate to call me at 205-803-8822

Sincerely,

JENNIFER CERAVOLO

Claims Adjuster

Warning: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

D9133 R0002 20001981033 004 BI 473 20130624 CLAI0001

INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807TELEPHONE
800-782-2020

DATE: 06/24/13

POLICY: 504653232013001

CLAIM NUMBER: 20001981033

DATE OF LOSS: 06/12/13

INSURED NAME:

GUERRA, MARIO A

CLAIMANT NAME:

ABBY, TORI KAY

ABBY, TORI KAY
795 S CRAWFORD AVE

REEDLEY CA 93654-

In order to properly evaluate your injury claim, it will be necessary to obtain copies of your medical bills, medical records, your doctors' treatment notes, and your doctors' recommendations for future medical treatment. Please send this information to us as it becomes available, and include the claim number so that we may identify and route the information correctly.

In order to expedite our evaluation of your claim, we ask that you complete and sign the enclosed form entitled Authorization to Disclose Health Information. We can utilize this form to obtain the medical bills and records from your providers. Please return the completed form to us at your earliest opportunity.

On the additional form entitled Names of Treating Physicians, please include the names and addresses to each of the facilities where you have received medical treatment. Also include the names of each treating physician.

If you have any questions, after your review of this authorization form, please do not hesitate to contact me at
205-803-8822

Sincerely,

JENNIFER CERAVOLO

Claims Adjuster

Warning: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

D9083 R0005 20001981033 002 BI 473 20130624 CLAI0001



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION FORM

Patient Name : _____
Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized and directed to make the disclosure: _____

Address _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

___ Problem list
___ Medication list
___ List of allergies
___ Immunization record
___ Most recent history & physical
___ Most recent discharge summary
___ Laboratory results from _____ to _____
___ X-ray & imaging reports from _____ to _____
___ Consultation reports from _____ to _____
___ Entire record
___ Other _____

4. I understand that the information in my health record may include information relating to sexual transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization: _____
For the purpose of: _____

Authorization To Disclose Health Information Form Continues on Next Page

D9083 R0005 20001981033 002 BI 473 20130624 CLAI0001



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

Authorization To Disclose Health Information Form Page 2

6. I understand I have the right to revoke the authorization at any time. I understand if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to the authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ If I fail to specify an expiration date, event or condition, this authorization will be valid for the duration of the claim.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

8. A photostatic or photographic copy of this authorization shall be considered as effective and valid as the original.

9. The individual signing this form or their authorized representative is entitled to receive a copy of the authorized form.

10. If receiving Medicare benefits, your Medicare Health Insurance Claim Number (HICN #): _____

Signature of Patient or
Legal Representative

Date

If Signed by Legal Representative,
Relationship to Patient

Witness

D9083 R0005 20001981033 002 BI 473 20130624 CLAI0001



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

NAMES OF TREATING PHYSICIANS FORM

Instructions: Please list the names of your treating doctor(s) you have seen in connection with your automobile accident. It is important to keep a copy of your medical expenses, however, we would appreciate being provided with copies of any bills you may already have received.

Thank you for your assistance in the handling of your claim.

AMBULANCE
NAME and
ADDRESS

AMOUNT OF
BILL\$

AMOUNT OF
BILLHOSPITAL
OR DOCTOR
NAME and
ADDRESS

\$

STILL BEING TREATED? YES ☐ NO ☐HOSPITAL
OR DOCTOR
NAME and
ADDRESS

AMOUNT OF
BILL\$

STILL BEING TREATED? YES ☐ NO ☐

IF YOU ARE MISSING WORK, PLEASE COMPLETE:

EMPLOYER
NAME and
ADDRESS

PHONE

()

RATE OF PAY: \$

 / PER

SUPERVISOR:

YOUR POSITION:

D9083 R0005 20001981033 002 BI 473 20130624 CLAI0001

10388060000118040110



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

PARENTS OF MILEY ABBY
5795 CRAWFORD AVE

REEDLEY

CA 93654-9433

DATE: 06/24/13

POLICY: 504653232013001

CLAIM NUMBER: 20001981033

DATE OF LOSS: 06/12/13

INSURED NAME:

GUERRA, MARIO A

CLAIMANT NAME:

ABBY

MILEY

In order to properly evaluate your injury claim, it will be necessary to obtain copies of your medical bills, medical records, your doctors' treatment notes, and your doctors' recommendations for future medical treatment. Please send this information to us as it becomes available, and include the claim number so that we may identify and route the information correctly.

In order to expedite our evaluation of your claim, we ask that you complete and sign the enclosed form entitled Authorization to Disclose Health Information. We can utilize this form to obtain the medical bills and records from your providers. Please return the completed form to us at your earliest opportunity.

On the additional form entitled Names of Treating Physicians, please include the names and addresses to each of the facilities where you have received medical treatment. Also include the names of each treating physician.

If you have any questions, after your review of this authorization form, please do not hesitate to contact me at 205-803-8822

Sincerely,

JENNIFER CERAVOLO

Claims Adjuster

Warning: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

D9083 R0005 20001981033 004 BI 473 20130624 CLAI0001



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION FORM

Patient Name : _____
Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized and directed to make the disclosure: _____

Address _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

___ Problem list
___ Medication list
___ List of allergies
___ Immunization record
___ Most recent history & physical
___ Most recent discharge summary
___ Laboratory results from _____ to _____
___ X-ray & imaging reports from _____ to _____
___ Consultation reports from _____ to _____
___ Entire record
___ Other _____

4. I understand that the information in my health record may include information relating to sexual transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization: _____
For the purpose of: _____

Authorization To Disclose Health Information Form Continues on Next Page

D9083 R0005 20001981033 004 BI 473 20130624 CLAI0001



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807

TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

Authorization To Disclose Health Information Form Page 2

6. I understand I have the right to revoke the authorization at any time. I understand if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to the authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ If I fail to specify an expiration date, event or condition, this authorization will be valid for the duration of the claim.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

8. A photostatic or photographic copy of this authorization shall be considered as effective and valid as the original.

9. The individual signing this form or their authorized representative is entitled to receive a copy of the authorized form.

10. If receiving Medicare benefits, your Medicare Health Insurance Claim Number (HICN #): _____

Signature of Patient or
Legal Representative

Date

If Signed by Legal Representative,
Relationship to Patient

Witness

D9083 R0005 20001981033 004 BI 473 20130624 CLAI0001



INFINITY SELECT INSURANCE COMPANY

P.O. BOX 830807
BIRMINGHAM, AL 35283-0807TELEPHONE
800-782-2020

POLICY NUMBER: 504653232013001

CLAIM NUMBER: 20001981033

NAMES OF TREATING PHYSICIANS FORM

Instructions: Please list the names of your treating doctor(s) you have seen in connection with your automobile accident. It is important to keep a copy of your medical expenses, however, we would appreciate being provided with copies of any bills you may already have received.

Thank you for your assistance in the handling of your claim.

AMBULANCE
NAME and
ADDRESS

AMOUNT OF
BILL\$ _____
AMOUNT OF
BILLHOSPITAL
OR DOCTOR
NAME and
ADDRESS

\$ _____

STILL BEING TREATED? YES _____ NO _____

HOSPITAL
OR DOCTOR
NAME and
ADDRESS

AMOUNT OF
BILL

\$ _____

STILL BEING TREATED? YES _____ NO _____

IF YOU ARE MISSING WORK, PLEASE COMPLETE:

EMPLOYER
NAME and
ADDRESS

PHONE

() _____

RATE OF PAY: \$ _____ / PER _____

SUPERVISOR: _____

YOUR POSITION: _____

D9083 R0005 20001981033 004 BI 473 20130624 CLAI0001