Allstate
You're in good hands.
PO BOX 2874
CLINTON IA 52733

JOHN SOTELO
802 DILLON AVE
STERLING IL 610813141

Allstate Fire and Casualty Insurance Company
PO BOX 2874
CLINTON IA 52733

JOHN SOTELO
802 DILLON AVE
STERLING IL 610813141

August 22, 2023

INJURED PARTY: JOHN SOTELO
DATE OF LOSS: July 29, 2023
CLAIM NUMBER: 0726141641 VRJ

PHONE NUMBER: 205-981-3467
FAX NUMBER: 608-373-7383

Your Medical Payment Claim 0726141641

Dear JOHN SOTELO,

I'm very sorry to hear of your recent injury, and I wish you a speedy recovery.

I want you to know you may be owed benefits under your Medical Payments coverage. Please rest assured I will do my best to handle this for you as quickly as possible.

I know you may have questions about this process, so I've included some ***Helpful Hints for Your Medical Claim***, which offers additional information about the process along with answers to commonly asked questions. In addition, I've included other helpful information you can share with any medical providers who treat you for injuries related to this auto accident; this should help expedite the handling of any medical bills.

In case I need to refer to your medical records as I resolve your claim, I've included a "Medical Authorization" form. Please sign it and return it in the envelope I provided.

I also want to let you know Allstate Fire and Casualty Insurance Company makes available Voluntary Provider Networks, which include a variety of participating medical providers you can choose to treat your injuries. You are under no obligation to use a medical provider who is a member of one of these networks, and you are free to seek medical services from a provider of your choice. There is no penalty if you choose a provider outside the network. If you are injured and treated by a provider who is a member of one of the participating networks, we may review their bills for covered medical services for re-pricing based on the approved rate for that provider's network.

Please let me know if you would like contact information about the Allstate Fire and Casualty Insurance Company participating networks available in your state.

Please feel free to contact me for any questions or concerns you have about your claim.

Sincerely,

REGINA JOHNSON

REGINA JOHNSON
205-981-3467
Allstate Fire and Casualty Insurance Company
Enclosure(s)

Helpful hints for your medical claim

MEDICAL BILL QUESTIONS & ANSWERS

Where do I send bills/forms related to my medical claim?
Please send copies of documents related to treatment as a result of the motor vehicle accident on July 29, 2023 to:

Allstate Fire and Casualty Insurance Company
PO BOX 2874
Clinton, IA 52733
Or fax - 6083737383

Please write your claim number 0726141641 on each document so we can quickly identify it as being part of your claim. If you are submitting a prescription receipt for reimbursement, include fill date, quantity, prescribing doctor and prescription name.

How long will it take for my bills to be handled?
In general, we handle a bill within 30 days. If we need additional information, we will work with you and your provider.

What is a Voluntary Provider Network (VPN)? Voluntary Provider Networks, which include participating medical providers you can choose to treat your injuries may be available. You are under no obligation to use a medical provider who is a member of one of these networks and may seek medical services from a provider of your choice. There is no penalty if you choose a provider outside the network. If you are treated by a provider who is a member of one of the networks, we may review their bills for covered medical services for re-pricing based on the approved rate for that provider's network.

MEDICAL COVERAGE QUESTIONS & ANSWERS

What does my medical coverage cover?
In general, most policies cover reasonable and necessary medical expenses, subject to policy limits, incurred as a result of the accident.

Health care providers may bill more than the policy allows. Medical bill audit tools may be used to determine if the charged amount is within the general prevailing cost for the service within a geographic area (unless the charges are subject to fee schedule or other policy provisions).

In some states, a provider may bill you for the difference if the prevailing cost is less than their billed charges. Please contact us if you have questions regarding claim payments.

What if I have medical bills and charges that exceed the coverage limit under my policy?
All policies contain a limit that represents the most that we can pay. If you have medical bills that exceed the policy limit, the handling of those bills will have to be coordinated with any other insurance you may have available to you, such as a personal health policy.

Will you reimburse me for my health insurance co-pay?
Yes. We will reimburse you for co-pays for reasonable medical expenses related to the accident within the policy limit. Just send us a copy of the bill.

GENERAL INFORMATION

What is a medical authorization and why do I have to sign it?
In order to expedite claim handling and properly evaluate your claim, we may need to obtain medical records and itemized billing. Due to HIPPA Privacy regulations, a signed release is required before your providers can release this information to us. This form will help ensure that we can obtain the bill(s) and medical records needed to process your claim.

Where can I check the status of my claim?

For 24/7 information visit MyClaim.com

Allstate
You're in good hands.

Authorization to Release Medical and Employer/Wage Information - This authorization contains the core elements outlined in the Health Insurance Portability Accountability Act (HIPAA). A property/casualty insurer is submitting this authorization.

Patient's Name: JOHN SOTELO	Claim Number: 0726141641
Address: 802 DILLON AVE, STERLING, IL, 61081-1314	Date of Loss: July 29, 2023
Date of Birth: March 14, 1974	Social Security Number:

Note: Please fill in the Social Security Number.

I authorize:

1. any medical, chiropractic physician, dentist, psychological, psychiatric, osteopathic, any other medical practitioner or healthcare provider, hospital, clinic, rehabilitation facility, nursing home, or any other healthcare facility to disclose information from the medical and healthcare records of the Injured Person. I understand that the specific type of information to be disclosed includes but is not limited to medical; and healthcare records and any other information including any history, treatment records, diagnosis, prognosis, narrative reports and billing records (which may include information indicating the presence of communicable or venereal diseases). This authorization also permits my medical providers to discuss in person, by telephone, electronically, or by mail, medical options, conclusions, treatment plans and other information: and
2. any firm, employer, or insurance company to furnish information about the earnings, loss of earnings, work history, workers compensation claim, and other medical information in its/their possession concerning the Insured Person, as well as, Event Data Recorder (EDR) Information, photographs and other information about the physical damage to the vehicle(s) involved in the accident and
3. any educational organization to furnish the school records or the Insured Person to; Allstate Fire and Casualty Insurance Company, its affiliates, its claims associates, and legal representatives (hereinafter referred to as "Allstate Fire and Casualty Insurance Company")

I authorize the use of the above information to permit Allstate Fire and Casualty Insurance Company to investigate, process, and determine the amount payable, if any, for all claims made under any Allstate Fire and Casualty Insurance Company policy that applies to the accident or occurrence on July 29, 2023.

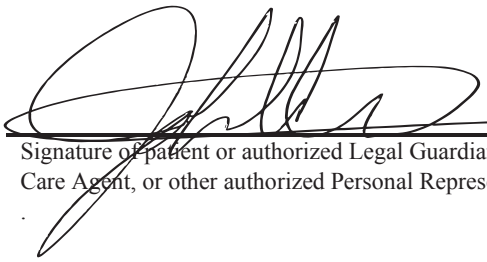
I understand that I can revoke this authorization at any time by notifying Allstate Fire and Casualty Insurance Company in writing. I understand that the revocation will not apply to information that has been released in response to this authorization.

This authorization is valid for the duration of the claim referenced above, and a photocopy is as valid as the original. This authorization specifically applies to records made before, during and after the date of signing this authorization for as long as the authorization is in effect.

I can request a copy of this signed authorization at any time from Allstate Fire and Casualty Insurance Company.

I understand that THIS IS NOT A RELEASE OF MY CLAIM. I understand the evaluation of my claim is based on the information available to Allstate Fire and Casualty Insurance Company. I understand that by signing this form does not mean I have settled my claim. I understand that the covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

Allstate Fire and Casualty Insurance Company and its representatives will use this information to verify and evaluate my claim in order to determine an appropriate resolution. In some instances, Allstate Fire and Casualty Insurance Company may also furnish the information to professional organizations whose purpose is to detect and deter insurance fraud. We may furnish it to other insurance companies to whom a claim has or may be submitted. We may disclose copies of the bills and or medical records to third parties as needed to seek reimbursement or repayment of benefits paid under the policy. I understand that if a person or entity receives this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.



10/10/23

Signature of patient or authorized Legal Guardian, Health Care Agent, or other authorized Personal Representative

Date

If signed by a Legal Representative relationship to patient

We will need to request copies of your medical records, itemized bills and wage verification in order to properly evaluate your injury claim. Providing the proper names and addresses of all providers who have treated you, as a result of this claim will help in expediting the handling of the claim.

Patient's Name : JOHN SOTELO
Date of Birth : March 14, 1974

Date of Loss : July 29, 2023
Claim: 0726141641

Providers:

Medical Provider (Hospital, Doctor, Ambulance, etc): OSF Saint Anthony Medical Center

Address: 5666 E. State St., Rockford IL 61107

Phone #: 815-226-2000

Fax #:

Dates of Treatment: 07/29/2023 - 09/13/2023

Medical Provider (Hospital, Doctor, Ambulance, etc): Dixon Community Fire Protection

Address: 1020 Palmyra St., Dixon IL 61021

Phone #: 815-284-6897

Fax #:

Dates of Treatment: 07/29/2023

Medical Provider (Hospital, Doctor, Ambulance, etc): CGH Home Nursing Services

Address: 3010 E Lynn Blvd., Sterling IL 61081

Phone #: 815-622-0836

Fax #:

Dates of Treatment:

Medical Provider (Hospital, Doctor, Ambulance, etc):

Address:

Phone #:

Fax #:

Dates of Treatment:

Other Medical Insurance applicable to loss:

Address:

Phone #:

Claim or Policy number:

Medicare: ☐ Yes ☒ No Medicare #:

Medicaid: ☐ Yes ☒ No Medicaid #:

Employers

Employer: Sotelo Media

Employer's Address: 412 E. 8th St., Rock Falls IL 61071

Employer's phone number: 815-908-7823

Occupation and Duties: Owner Operator

Supervisor or contact person: John R Sotelo (Self)

Pay Rate or Salary: NA

If hourly, please specify the number of hours worked per week: _____

Do you normally work overtime or have a shift differential? ☐ Yes ☒ No

If yes, please explain: _____

How much time did you lose from work? 07/29/2023 - Present

Please specify dates missed: Due to hand injuries unable for graphic design on computers

Which medical provider was involved in your medical leave from work? OSF Saint Anthony Medical Center
Veterans Affair Medical

Helpful Information for Providers

FOR PROVIDERS ONLY

- If you would like to enroll in electronic billing, please contact Jopari, Inc. at 866-269-0554 or you can enroll online at www.jopari.com/ebill-sign-up-form/. If you are already enrolled, you can submit bills at http://provider.jopari.net/. Please note that if you submit bills electronically, you will receive an electronic remittance notice (Explanation of Benefits) rather than a paper copy.

- If you intend to file a lien or have the insured party execute an assignment of benefits, please mail a copy to the address indicated above and provide a copy to our insured as well.

- To ensure quick response, please follow these guidelines:
  - Submit claims using standard HICFA forms
  - Include the (company) claim number
  - Specify diagnosis codes and CPT codes
  - Include a detailed description for any miscellaneous or unspecified procedure codes.
  - Include any and all medical records related to treatment (Records can also be submitted electronically once you have registered)

ALLSTATE GROUP-CLAIMS
Allstate Fire and Casualty Insurance Company
PO BOX 2874
Clinton IA 52733
UNITED STATES

Fold here: address must appear in return envelope window

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The office identified above provides claims handling services for the Allstate Group of Insurance Companies, including the underwriting company referenced on the documents accompanying this insert.