WEST ANAHEIM MEDICAL CENTER

3033 W. ORANGE AVENUE
ANAHEIM, CA 92804

TO: Blue Shield PPO FAX: 844-295-4637 PHONE:	FROM: **EMERGENCY DEPARTMENT** FAX: **714-229-4059** PHONE: **714-229-4088**

MESSAGE:

REGARDS,

WAMC ER

ATTENTION

Thank you for your cooperation.

blue california

Promise Health Plan

Durable Medical Equipment Treatment Authorization Request

	Routine Request		Modification/ Extension		Retroactive Request		Urgent Request
FAX: (323) 889-6504		FAX: (323)889-6504		FAX (323)889-6504		FAX: (323) 889-5403	

Important: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee.

Patient Information		**Language spoken:** English	
Member's name: Ryan Jarvis		DOB: 06/26/2006	Gender: M F ✔
Street address: 93749 Brittany Views Apt. 816	City: Shepherdborough	State: Indiana	ZIP code: 64472
Member's plan ID number: 45845872231		Effective date: 03/27/2016	Phone: +13424183925

Service Information			
Referral requested by: Shaw-Smith		Phone: +14951594066	FAX: +18738146542
Request date: 12/20/1998	Referred to (servicing provider): Ram Stam, MA	NPI/Tax ID: 3665097499	Specialty: Neurology
Servicing provider's full address: 57495 Amanda Course Christinamouth, NH 25036		Phone: +17490676946	FAX: +13190426397
Facility name: Lake Mario	NPI/Tax ID: 3454311663	Phone: +19070666702	FAX: +17199288652

Service(s) Requested:	
CPT/HCPC code(s): 92132	CPT/HCPC description: Cpmtr ophth dx img ant segmt
ICD-10 code(s): Q17.2	Dx description: Microtia
For modification/extension requests:	
Date last authorized: 10/09/2008	Previous Blue Shield Promise authorization number: 61160929542
MD/NP/PA justification for request: Cpmtr ophth dx img ant segmt is a clinically-proven imaging tool that provides detailed information on the anatomy and pathology	
Requesting provider's name (please print): Bob Faylor, PA	Provider's signature: Bob Fa

Accident?	If yes, where did he accident occur?
Yes No ✔	Home Work Auto Other:

IPA responsibility? Check box, if yes	IPA authorization number:
	Dates of service authorized (from/to): -

PLEASE ATTACH THE LATEST AVAILABLE MEDICAL RECORDS AND PROGRESS NOTES. THIS REFERRAL DOES NOT GUARANTEE ELIGIBILITY. PLEASE CHECK ELIGIBILITY BEFORE RENDERING SERVICE. Payment will not be made for unauthorized services. All lab and x-rays must be ordered/performed by contracted providers. If you are unsure whether the provider is contracted with Blue Shield of California Promise Health Plan, contact Blue Shield Promise's Utilization Management Department at **(800) 468-9935**. Specialist findings must be sent to the member's primary care physician.

CVSHealth

Formulary Exception/Prior Authorization Request Form

Patient Information		Prescriber Information		
Patient Name: Test Patient		Prescriber Name: Dr. Smith RN		
Patient ID#: 12345653				
Address: 34126 Bear Drive		ProviderAddress: 1234 Mamu St.		
City: San Ramon	State: CA	City: San Ramon		State: CA
Home Phone: 925-123-1212	ZIP: 94582	Office Phone #:	Office Fax #:	ZIP: 94582
Gender: F	DOB: 01/01/1973	Contact Person at Doctor's Office: Sandy Millx		

Diagnosis and Medical Information			
Medication: amlodipine	Strength: 10 mg	Frequency: once daily	
Expected Length of Therapy: 6 months	Qty: 1	Day Supply: 30	If this is a continuation of therapy, how long has the patient been on the medication?
Diagnosis: High Blood pressure		Diagnosis (ICD) Code(s): I10-I16	

FORM CANNOT BE EVALUATED WITHOUT REQUIRED CLINICAL INFORMATION

What condition is the drug being prescribed for? _____

Please list all medications the patient has tried specific to the diagnosis and specify below:
Therapeutic failure, including length of therapy for each drug: _____

Drug(s) contraindicated: _____

Adverse event (e.g. toxicity, allergy) for each drug: _____

Is the request for a patient with one or more chronic conditions (e.g., psychiatric condition, diabetes) who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change? Specify anticipated significant adverse event:
_____

Does that patient have a chronic condition confirmed by diagnostic testing? If so, please provide diagnostic test and date: _____

Does the patient have a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature? If so, please provide documentation: _____

Does the patient require a specific dosage form (e.g., suspension, solution, injection)? If so, please provide dosage form: _____

Are additional risk factors (e.g., GI risk, cardiovascular risk, age) present? If so, please provide risk factors: _____

Other: Please provide additional relevant information: _____

REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION.

PLEASE COMPLETE CORRESPONDING SECTION ON PAGE 2 FOR THE SPECIFIC DRUGS/CLASSES LISTED.

FOR ANY DRUG/CLASS NOT LISTED ON PAGE 2, PLEASE ATTACH ADDITIONAL INFORMATION, BUT CANNOT EXCEED TWO PAGES.

PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS.

PLEASE FAX COMPLETED FORM TO 1-888-836-0730.

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark®, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.

Prescriber Signature: _____ **Date**: 02/10/2022

FakeDoc M.D.

HEALTH INTAKE FORM

Please fill out the questionnaire carefully. The information you provide will be used to complete your health profile and will be kept confidential.

Date: 9/14/19

Name: Sally Walker DOB: 09/04/1986

Address: 24 Barney Lane City: Towaco State: NJ Zip: 07082

Email: sally.walker@cmail.com Phone #: (906) 917-3486

Gender: F Marital Status: Single Occupation: Software Engineer

Referred By: None

Emergency Contact: Eva Walker Emergency Contact Phone: (906) 334-8926

Describe your medical concerns (symptoms, diagnoses, etc):

runny nose, mucas in throat, weakness, aches, chills, tired

Are you currently taking any medication? (If yes, please describe):

Vyvanse (25mg) daily for attention

Texas Standard Prior Authorization Request Form for Health Care Services

Clear Form | Print

Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Gibbs, Gonzalez and Finley	+15788887536	+13262961433	08/12/2021

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	JXGVqXPeGNQFLEWqyItNWJfPv	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	0-599-65681-6	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
Linda Ortiz	+12239853999	02/21/1957	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Joshua Willis	6487018291	978-0-514-33819-6	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Ltoen Klak, MD		Name: Calk Banks, NP	
NPI #: 8989641566	Specialty: OBGYN	NPI #: 2371877675	Specialty: Pathology
Phone: +13510080449	Fax: +13680799831	Phone: +13387970154	Fax: +15669146342
Contact Name: Stooj Blake, RN	Phone: +13219745333	Primary Care Provider Name (see instructions): Carter, Contreras and Hill	
Requesting Provider's Signature and Date (if required): 03/03/2021		Phone: +19192897061	Fax: +13806966552

Section V — Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD Code)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code
Place po breast cath for rad - 19296		04/22/2006	07/29/2006	Relapsing polychondritis - M94.1	
X-ray exam knee 4 or more - 73564		07/28/2010	09/27/2010	Maternal care for signs of fetal hy - O36.3	
GI protein loss exam - 78282		05/27/2008	11/19/2008	Other bursitis of elbow - M70.3	
Cath place cardio brachytx - 92974		06/12/1997	08/02/1997	Other rosacea - L71.8	

☐ Inpatient ☐ Outpatient ☑ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other: _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☑ Mental Health/Substance Abuse

Number of Sessions: 19 Duration: 60 minites Frequency: daily Other: shBLWQfzZcrjKchsztxy

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____

☑ DME (MD Signed Order Attached? ☑ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☑ Yes ☐ No)

Equipment/Supplies (include any HCPCS Codes): E0570 - Nebulizer with compressio Duration: 45 minutes

Section VI — Clinical Documentation (See Instructions Page, Section VI)

KUHyLZNZBWZqbIcqMvKluBeHPMxkouCRkkqMZBspyFFtdACWEluBxVoeFjDusauEXFdHpODlKPiNEKckmGWHiS
ElCjJrpHIftMciasiuzvOyNJLWlaWdtJBiamCavMomKQEZsktpjHXJYnCgDPIcecyQpVyfmLaRcjyKkCGccWryPkzgEgDO
wowKnatcArumLsaLIPiy

An issuer needing more information may call the requesting provider directly at: +13219745333