

**WEST ANAHEIM  
MEDICAL CENTER**

3033 W. ORANGE AVENUE  
ANAHEIM, CA 92804

TO: Blue Shield FPO  
FAX: 844-295-4637  
PHONE: \_\_\_\_\_

FROM: EMERGENCY DEPARTMENT

FAX: 714-229-4059

PHONE: 714-229-4088

MESSAGE:

REGARDS,

**WAMC ER**

**ATTENTION**

*Confidentiality Notice: This facsimile message, including any attachments is the property of West Anaheim Medical Center and is for the sole use of the intended recipient (s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by telephone and return the documents to the sender.*

*Thank you for your cooperation.*

## 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.

<b>Patient Information</b>		<b>Language spoken:</b> English	
Member's name:	Edward Hernandez MD	DOB:	04/05/1990
Street address:	55118 Victoria Cliff Suite 350	City:	Washington
Member's plan ID number:	91023308562	Effective date:	06/07/2005
		Gender:	M F <input checked="" type="checkbox"/>
		State:	Hawaii
		ZIP code:	88044
		Phone:	+15792194435

<b>Service Information</b>			
Referral requested by:	Salazar PLC	Phone:	+19090285514 FAX: +11341603172
Request date:	12/12/1994	Referred to (servicing provider):	Dr. Kareen Sharm, MD
		NPI/Tax ID:	147474183
		Specialty:	OBGYN
Servicing provider's full address:	495 Erica Cove Suite 345 New Olivia, OK 68807		
Facility name:	North Joel	Phone:	+14823617563
	NPI/Tax ID:	2259587695	FAX: +18452670577
		Phone:	+14877892764
		FAX:	+12696131459

<b>Service(s) Requested:</b>	
CPT/HCPC code(s):	G0120
CPT/HCPC description:	Colon ca scrn; barium enema
ICD-10 code(s):	J70.1
Dx description:	Chronic and other pulmonary manifes

<b>For modification/extension requests:</b>	
Date last authorized:	08/05/2007
Previous Blue Shield Promise authorization number:	68377970180
MD/NP/PA justification for request:	Colon cancer is one of the most common cancers in the United States, with an estimated 95,520 new cases in 2020. Early detection
Requesting provider's name (please print):	Calk Barns, NP
Provider's signature:	Calk B

Accident?	If yes, where did he accident occur?
Yes No <input checked="" type="checkbox"/>	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.

## 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@gmail.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, mucus 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

SECTION I — SUBMISSION

Clear Form Print

Issuer Name: White-Wells	Phone: +10087851189	Fax: +16448498552	Date: 03/01/2009
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SECTION II — GENERAL INFORMATION

Review Type: <input type="checkbox"/> Non-Urgent <input checked="" type="checkbox"/> Urgent	Clinical Reason for Urgency: hHGrEqnHAQRupHADVTXJCJHFo
Request Type: <input type="checkbox"/> Initial Request <input checked="" type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #: 0-8206-3204-X

SECTION III — PATIENT INFORMATION

Name: Joseph Brock	Phone: +13591178828	DOB: 02/15/1930	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Subscriber Name (if different): Jordan Carson	Member or Medicaid ID #: 86913220046	Group #: 978-0-05-540904-1	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name: Pilot Kala, RN		Name: Calk Barnks, NP	
NPI #: 2228180533	Specialty: Pediatrics	NPI #: 2765424528	Specialty: Immunology
Phone: +19429125559	Fax: +19888569811	Phone: +18756445186	Fax: +12665946052
Contact Name: Ram Stam, MA	Phone: +17239976575	Primary Care Provider Name (see instructions): Lane-Price	
Requesting Provider's Signature and Date (if required): 03/27/2010		Phone: +13441254424	Fax: +18459541426

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
Lwr xtr vasc stdy bilat		05/01/2006	02/25/2007	Obstetric and gynaecological device - Y76.3	
Joint survey single view		01/04/2008	04/10/2008	Iniiencephaly - Q00.2	
Copper cu 64 dotatate diag		06/27/1993	09/22/1993	Malignant neoplasm: Cardia - C16.0	
Tomosynthesis, mammo screen		05/16/2004	06/16/2004	Haemorrhagic disorder due to circul - D68.3	
<input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Provider Office <input type="checkbox"/> Observation <input type="checkbox"/> Home <input type="checkbox"/> Day Surgery <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Physical Therapy <input checked="" type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Mental Health/Substance Abuse					
Number of Sessions: 22 Duration: 120 minites Frequency: yearly Other: SdBUZfRSTtaKiEDEZcer					
<input type="checkbox"/> Home Health (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (Nursing Assessment Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No)					
Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____					
<input type="checkbox"/> DME (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (Medicaid Only: Title 19 Certification Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No)					
Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____					

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

Tomosynthesis, also referred to as 3D mammography, is a type of breast imaging that provides an additional level of detail when compared

An issuer needing more information may call the requesting provider directly at: +17239976575