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: Phillip Lopez		DOB: 02/17/1972	Gender: M F ✔
Street address: 92452 Rodriguez Divide Suite 33	City: East Matthewfort	State: Illinois	ZIP code: 79157
Member's plan ID number: 88588859053		Effective date: 04/05/2009	Phone: +15584400696

Service Information			
Referral requested by: Marquez, James and Robinson		Phone: +16491577467	FAX: +13259922825
Request date: 10/26/2005	Referred to (servicing provider): Ram Stam, MA	NPI/Tax ID: 1590567238	Specialty: Dermatology
Servicing provider's full address: 231 Sawyer Mountains Suite 810 Higginsberg, FL 29217		Phone: +18096740348	FAX: +19764896829
Facility name: Mikeport	NPI/Tax ID: 7180933328	Phone: +10247067579	FAX: +18724719111

Service(s) Requested:	
CPT/HCPC code(s): 90682	CPT/HCPC description: RIV4 vacc recombinant dna im
ICD-10 code(s): V31.0	Dx description: Occupant of three-wheeled motor veh
For modification/extension requests:	
Date last authorized: 09/08/2011	Previous Blue Shield Promise authorization number: 54647677944
MD/NP/PA justification for request: The RIV4 vaccine is a recombinant DNA-based vaccine used to protect against four strains of the respiratory syncytial virus (	
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.

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:
Tucker LLC	+19511113778	+18351315795	05/06/2002

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	ADdIuQQGNkNnKkjOruyLzOYkG	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-8451-2373-4	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Tiffany Morgan	+10418728116	01/19/1999	

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
John Davis	51834642117	978-0-560-66678-6

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Inda Laec, PA		Name: Pilot Kala, RN	
NPI #: 5649341700	Specialty: Physical Medicine	NPI #: 6098336630	Specialty: Neurology
Phone: +15332220344	Fax: +12141675143	Phone: +14088976680	Fax: +10845187015
Contact Name: Inda Laec, PA	Phone: +16928546413	Primary Care Provider Name (see instructions): Smith PLC	
Requesting Provider's Signature and Date (if required): 08/05/2000		Phone: +19986238190	Fax: +18217713268

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
Lung perf&ventilat diferentl		11/08/2006	07/21/2007	Chondrocostal junction syndrome [Ti -	M94.0
"Chemodenervation of muscle(s); muscle(s) innervated by facial nerve		08/27/1997	06/30/1998	Unspecified appendicitis -	K37
Pt eval high complex 45 min		02/27/2021	10/11/2021	Driver injured in collision with ot -	V29.4
X-ray exam of shoulder		05/08/2019	06/19/2019	Other disorders of brain in disease -	G94

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

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

Number of Sessions: 25 Duration: 120 minites Frequency: bimonthly Other: hsIvDwaXWCRaIKcpIqmC

☐ 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): _____ Duration: _____

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

A X-ray exam of the shoulder is clinically indicated to evaluate the anatomy and pathology of the shoulder joint and surrounding soft tissues. This is

An issuer needing more information may call the requesting provider directly at: +16928546413