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: Donald Camacho		DOB: 07/30/1949	Gender: M F
Street address: 523 Scott Plains Apt. 110	City: Port Michael	State: South Carolina	ZIP code: 90507
Member's plan ID number: 37911467934		Effective date: 05/27/2017	Phone: +14303477225

Service Information			
Referral requested by: Shah, Bradley and Foster		Phone: +14787806662	FAX: +13310911314
Request date: 04/02/2008	Referred to (servicing provider): Pilot Kala, RN	NPI/Tax ID: 4255848722	Specialty: Family Medicine
Servicing provider's full address: 339 Kimberly Views Suite 710 Thompsonfurt, AS 94795		Phone: +10973711912	FAX: +17189817388
Facility name: South Rebeccaside	NPI/Tax ID: 8499149104	Phone: +17344752614	FAX: +14369556424

Service(s) Requested:	
CPT/HCPC code(s): 97597	CPT/HCPC description: RMVL devital tis 20cm/<
ICD-10 code(s): M76.1	Dx description: Psoas tendinitis
For modification/extension requests:	
Date last authorized: 01/12/2017	Previous Blue Shield Promise authorization number: 38976015421
MD/NP/PA justification for request: Clinical justification for a removal of devital tissue (RMVL devital tis) measuring 20 cm is necessary due to the presence of	
Requesting provider's name (please print): Dr. Peter Pan, MD	Provider's signature: Dr. Pe

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:
Adams Inc	+17761818814	+12671627229	07/09/2006

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	eYUZQhjCbmwOhMSseUHZvCtJn
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	1-355-18308-1

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Christina Lambert	+15799796249	10/16/1951	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Michael Morales	73463905330	978-0-87204-827-0	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Almy Shaw, MD		Name: Calk Barnks, NP	
NPI #: 5383684481	Specialty: Pediatrics	NPI #: 4293145205	Specialty: Neurological Surgery
Phone: +14391512660	Fax: +10051819344	Phone: +19655769489	Fax: +18441629669
Contact Name: Dr. Kareen Sharm, MD	Phone: +18942154919	Primary Care Provider Name (see instructions): Williams, Kerr and King	
Requesting Provider's Signature and Date (if required): 03/28/2001		Phone: +12323252475	Fax: +17226993738

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
Sodium fluoride F-18		04/24/2007	06/11/2007	Person injured in unspecified motor -	V89.0
Assay of lipoprotein [only when billed with ICD-10-CM code Z13.6]		09/25/2000	11/24/2000	Certain conditions originating in t -	XVI
Bone imaging limited area		04/03/2004	04/08/2004	Unspecified abortion : incomplete, -	O06.0
ELISA HIV-1/HIV-2 screen		04/28/1996	05/28/1996	Injuries to unspecified part of tru -	T08-T14

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

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

Number of Sessions: 3 Duration: 30 minutes Frequency: 3 times a month Other: uFLUweLLpJNQszEJFoLD

☐ 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)

The ELISA HIV-1/HIV-2 screen is a vital test to detect the presence of the Human Immunodeficiency Virus

An issuer needing more information may call the requesting provider directly at: +18942154919