THE CENTER FOR CHOLESTEROL MANAGEMENT
A Medical Corporation
1950 Sawtelle Blvd, Suite 150

NAME:

Christina Abell 12/31/08

CHIEF COMPLAINT:

56 yo w f c h/o PVD s/p ABF bypass
Presents for NMR LDL-P testing

HISTORY OF PRESENT ILLNESS:

pt denies chest pain but has intermittent SOB but smoked until Oct 2008. pt is extremely fatigued but does not get exercise. Her major c/o is extreme fatigue. She has a h/o Fibromyalgia and last LDL-C was 136. (Simvastatin) pt is currently taking 40mg. pt has generalized muscle pain and is very fatigued thallium stress before surgery

PMHX:

① PVD
② Hypercholesterol

PSHX:

① ABF bypass

MEDS:

Simvastatin 40mg po qd
Baby ASA 81mg po qd

ALLERGIES:

NKDA

SOCIAL HISTORY: smoked until 10/08 x 35 years

FAMILY HISTORY:

mother
high cholesterol

REVIEW OF SYSTEMS:

PHYSICAL EXAM

BP 120/77 P 78 RR 16 T

GENERAL: WDWN ♀ in NAD

HEENT: NC/AT

NECK: ⊖ carotid bruit

CHEST: clear

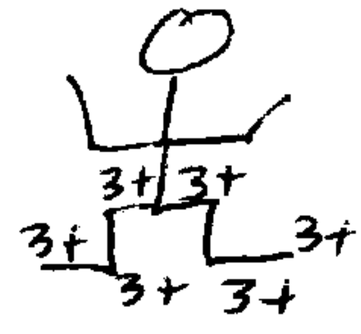
HEART: RRR

ABDOMEN: soft, ⊖ sided umbilical hernia

BACK:

EXTREMITIES: - ⊖ inguinal hernia

NEURO:



LABORATORIES:

PROBLEMS:

56yo w ♀ c h/o PVD: ⊖ carotid bruit and intolerance to zocor

PLAN:

⊖ initial labs
⊖ will call results
1/8/08 - talked to
pt regarding zocor stopped
unless symptoms resolve

NMR LIPOPROFILE®

LipoScience, Inc.
2500 Sumner Boulevard
Raleigh, NC 27616
877-547-6837
www.liposcience.com

Page 1

Patient Name	Sex	Age
ABELL,CHRISTINA	F	56

Patient ID	Birth Date	Accession Number
15714510	04/16/1952	T0375035

Clinician: RICHMAN,MICHAEL

Client Name and Address: Center for Cholesterol Mgmt 15057/
1950 Sawtelle Blvd Suite 150
Los Angeles, CA 90025
Phone: (310)481-3939
FAX: (310)481-3949

Date Collected	Date Received	Report Date and Time	Requisition Number	Fasting Status
12/31/2008	01/06/2009	01/06/2009 19:42	15714510	FASTING

LDL PARTICLE NUMBERS

	nmol/L	Optimal	Near or above optimal	Borderline-high	High	Very High
LDL-P (LDL Particle Number)	**1455**	<1000	1000-1299	1300-1599	1600-2000	>2000

	nmol/L	Low	Moderate	Borderline-high	High
Small LDL-P	**887**	<600	600-849	850-1200	>1200

PATIENT GOALS

High-Risk Patients
-primary goal: LDL-P<1000 nmol/L
-secondary goal: small LDL-P<850 nmol/L

Moderately High-Risk Patients
-primary goal: LDL-P<1300 nmol/L
-secondary goal: small LDL-P<850 nmol/L

LIPIDS

	mg/dL	Optimal	Near or above optimal	Borderline-high	High	Very High
LDL-C (calculated)	**100**	<100	100-129	130-159	160-189	>=190

HDL-C (by NMR) mg/dL: **68** — Desirable >=40

Triglycerides (by NMR) mg/dL: **50** — Desirable <150

Total Cholesterol mg/dL: **178** — Desirable <200

METABOLIC SYNDROME MARKERS

These markers increase the risk of developing Type 2 Diabetes Mellitus.

	nm	Large (Pattern A)	Small (Pattern B)
LDL Particle Size	**21.1**	23.0 - 20.6	20.5 - 18.0

	µmol/L	Low Risk	Intermediate	High Risk
Large HDL-P	**8.2**	>9.0	4.0 - 9.0	<4.0

	nmol/L	Low Risk	Intermediate	High Risk
Large VLDL-P	**0.5**	<0.5	0.5 - 5.0	>5.0

Small LDL Size (≤20.5 nm) ☐ Low Large HDL-P (<4.0 µmol/L) ☐ High Large VLDL-P (>5.0 nmol/L) ☐

** Continue **

NMR LIPOPROFILE®

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2500 Sumner Boulevard
Raleigh, NC 27616
877-547-6837
www.liposcience.com

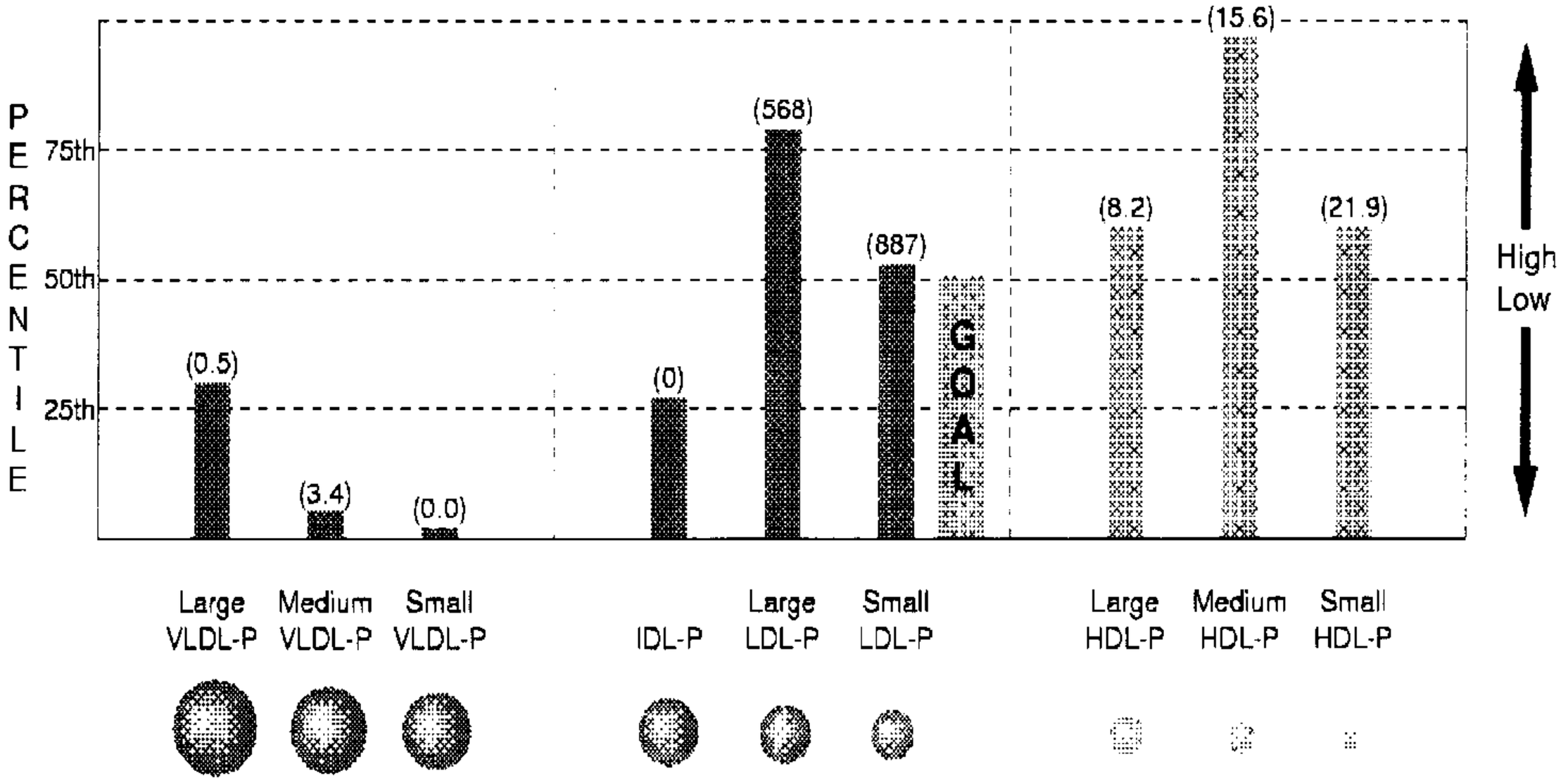
Patient Name	Accession Number	Requisition Number	Report Date and Time
ABELL,CHRISTINA	T0375035	15714510	01/06/2009 19:42

SUBCLASS PARTICLE NUMBERS

VLDL Subclasses (nmol/L)
Lower Values are Desirable

LDL Subclasses (nmol/L)
Lower Values are Desirable

HDL Subclasses (μmol/L)
Higher Values are Desirable



Lipoprotein subclass particle numbers are given in parentheses above each bar. The height of the bar is the percentile indicating if the value is "high" or "low" based on a reference population consisting of >6,900 subjects enrolled in the Multi-Ethnic Study of Atherosclerosis (MESA).

PRACTITIONER'S NOTES

Pure hypercholesterolemia

① P/C 2mm
② start crestor 10mg qd
+ zetia 10mg qd

7/4 Labs

** Continue **

NMR LIPOPROFILE®

LipoScience, Inc.
2500 Sumner Boulevard
Raleigh, NC 27616
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Patient Name	Sex	Age
ABELL,CHRISTINA	F	56

Patient ID	Birth Date	Accession Number
15714510	04/16/1952	T0375035

Clinician

RICHMAN,MICHAEL

Client Name and Address

Center for Cholesterol Mgmt 15057/
1950 Sawtelle Blvd Suite 150
Los Angeles, CA 90025
Phone: (310)481-3939
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Date Collected	Date Received	Report Date and Time	Requisition Number	Fasting Status
12/31/2008	01/06/2009	01/06/2009 19:42	15714510	FASTING

Test	Patient's Results		Reference Range	Units
	Within Range	Outside Range		
Homocysteine	8.5		<10.4	umol/L
hs-CRP	0.6		<=3.0	mg/L
	CRP, mg/L Risk Category --- <1.0 Low 1.0 - 3.0 Average >3.0 High Clinical decisions should be based on the average of 2 determinations made 2 weeks apart. Values >10 mg/L should be repeated and patient examined for sources of infection or inflammation.			
ALT	12		10-60	IU/L
AST	19		10-42	IU/L
Glycohemoglobin	5.3		4.6-6.2	%
CK, total	77		25-174	IU/L
TSH	0.74		0.4-4.0	uIU/mL

Via Facsimile 310-481-3949

January 4, 2009

Michael F. Richman, MD
The Center for Cholesterol Management
1950 Sawtelle Boulevard, Suite 150
Los Angeles, CA 90025

Re: Insurance/Christina Abell

Dear Dr. Richman:

A copy of my Blue Cross Blue Shield of Georgia insurance card follows. I will ask Dr. Paul Herd, Piedmont Atlanta, to forward relevant medical records to you as soon as possible.

I have just exhausted my supply of Simvastatin. Should I ask Dr. Herd to renew it, or can you prescribe something? (CVS Pharmacy 770/486-1639)

Thanks so much for taking time to see me on Thursday. I look forward to hearing from you.

Sincerely,

Christina Abell
100 Southern Trace Court
Peachtree City, GA 30269
770-631-9542
knoxasmus@aol.com

LIPOSCIENCE

2500 Sumner Blvd. • Raleigh, NC 27616
(919) 212-1999 • FAX: (919) 212-1954
CLIA #34D0952253

FACILITY

Center For Cholesterol Mgmt 15057
1950 Sawtelle Blvd
Suite 150
Los Angeles, CA 90025
(310)481-3939 Fax: 13104813949

Designate Requesting Clinician

X 1 1972554806 RICHMAN, MICHAEL F
1 1073557294 UYEDA, ROBERT Y

Additional Clinician: NPI

Collection Date 12/31/08 (mm dd yy) Collection Time

All information must be completed for sample to be processed

4 2 3 - 7 4 - 2 4 6 1
Social Security Number

Patient ID/Medical Record Number

Atwell Christina
Last Name First Name Middle

100 Southern Trace Ct
Address

Peachtree City, Ga 30269
City State Zip

Date of Birth 4/16/52 (mm/dd/yy) ☐ Male ☒ Female

770-631-9542
Telephone

IF PATIENT IS NONFASTING CHECK HERE ☐

Insurance (REQUIRED) Attach copy of insurance card front & back

☐ Medicare ☒ Insurance ☐ Client ☐ Patient

Medicare Number (including suffix) ___-___-____-___

BCBS ID Number (including prefix)

Insurance Company Name

Insured Name | Employer Name/Employer#

Member/Insured ID# | Group#

Claims Address

City State Zip

Patient Relation to Insured ☐ Self ☐ Spouse ☐ Dependent

Responsible Party Signature: I hereby authorize the release of medical information to LipoScience for services as described herein and authorize payment directly to LipoScience. I agree to assume responsibility for payment of charges for laboratory services that are not covered by the healthcare insurer.

X _____
Patient/Responsible Party Signature

12/31/08
Date

ICD-9 Code(s) (MANDATORY)

272.0				

CUSTOM PROFILES

X 1040 Dr Richman's Initial Panel

220 ☐	***NMR LipoProfile®*** (includes CPT codes 83704 + 80061)	P or S	180 ☐ Cholesterol, Total	P or S	100 ☐ Lp(a) P or S
375 ☐	***NMR LipoProfile®+Homocysteine+CRP*** (includes CPT codes 83704 + 80061 + 83090 + 86141)	P or S	245 ☐ Creatine Kinase (CK), Total	P or S	410 ☐ TSH S
			125 ☐ CRP-High Sensitivity	P or S	420 ☐ T-4, Free S
			178 ☐ Glucose	OX	430 ☐ T-4, Total S
			179 ☐ Glycohemoglobin (A1c)	L	185 ☐ Triglycerides P or S
540 ☐	***Lipoprotein Quantification by NMR with TC*** (includes CPT codes 83704 + 82465)	P or S	190 ☐ HDL Cholesterol	P or S	**COLLECTION**
			110 ☐ Homocysteine	P or S	P = 4 ml Plasma, Lavender Top Tube
	INDIVIDUAL		160 ☐ Insulin	S	S = 4 ml Serum, Red Top Tube or Greiner gel tubes* * No other gel tubes are acceptable
140 ☐	ALT	P or S	195 ☐ LDL Cholesterol, Direct Method	P or S	P or S = Plasma or Serum Acceptable
150 ☐	AST	P or S	210 ☐ Lipid Panel, Chemical Method	P or S	L = Whole Blood, Lavender Top Tube
170 ☐	C-Peptide	S	301 ☐ Lipoprotein Quantification by NMR	P or S	OX = Whole Blood, Gray Top (oxalate/fluoride) Tube

Please see the CMS policy for specific limits regarding the frequency of lipid testing.

Collection, Storage, and, Shipping Instructions on Back

ATTACH ABN IF NECESSARY

Specimen ID Labels

50

White Copy - LipoScience
Yellow Copy - Client

THE CENTER FOR CHOLESTEROL MANAGEMENT
A Medical Corporation
1950 Sawtelle Blvd. Suite 150
Los Angeles, CA 90025

Please complete all pages of this form

NAME: Christina A Abell **DATE:** 12-31-08

SEX: __M X F **DOB:** 04/16/52 **SSN:** 423 74 2461 **DL#:** GA

ADDRESS: 100 Southern Trace Court

CITY: Peachtree City **STATE:** GA **ZIP:** 30269

FAX: _____ **EMAIL:** knoxasmus@aol.com **PHONE:** 770-631-9542

EMERGENCY CONTACT: _____ **PHONE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMPLOYER: _____ **PHONE:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

Please list all of your medications, include non-prescription drugs, dietary supplements, and vitamins.

NAME OF DRUG:	DOSE:	No. TIMES DAILY:
Simvastatin	40mg/day	20mg x 2 @ bedtime
Baby Aspirin	81 mg/day	1 @ morning

Have you ever been diagnosed with?

High Blood Pressure	☐ Yes	☒ No	**How long ago?** _____
Diabetes	☐ Yes	☒ No	**How long ago?** _____
Stroke	☐ Yes	☒ No	**When did it occur?** _____
High Cholesterol	☐ Yes	☒ No	**What medications do you take for this, if any?** _____
Lung Disease	☐ Yes	☒ No	**What type?** _____

Heart Disease ☐ Yes ☒ No **How long ago?** _____

Other Vascular Disease ☒ Yes ☐ No **How long ago?** April 08

List other medical problems you have had. These would include problems for which you have taken medications or been hospitalized. Please include the dates these problems occurred.

_____

_____

_____

_____

Are you allergic to any medications? ☐ Yes ☒ No

List those medications? _____

Are you allergic to X-Ray dye? ☐ Yes ☒ No

List all surgeries, both major and minor, you have had:

SURGERY	DATE	HOSPITAL
arterial femoral bypass	6-26-08	Piedmont Atlanta

Have you ever smoked? ☒ Yes ☐ No **How many cigarettes per day?** 40

How long (have) did you smoke (d)? 35 years

If you quit, when did you quit? April 08

How many glasses per week do you consume of? WINE 3/4 **BEER** — **COCKTAILS** 4/4

Has anyone in your family had any of the following illnesses?

	WHICH FAMILY MEMBER	HOW OLD WERE THEY
Cancer		
Heart Attack		
Angina or clogged arteries	mother	62
Sudden death		
Hypertension		
Other heart disease	mother	

High cholesterol LDL = 138 Total HDL 220 HDL Tri 61

Stroke ~~/~~

Diabetes _____

Are you having or have you ever had? (check all for which the answer is "yes").

- ☒ Increasing Breathlessness With Your Usual Activities
- ☐ Unexpected weight gain of more than 5 lbs in the last weeks or months
- ☐ Pain, pressure/discomfort in the chest
- ☐ Shortness of breath at rest, laying down
- ☐ Any neck, jaw, left arm discomfort
- ☐ Pain or cramps in leg(s) with walking
- ☐ A stroke or temporary stroke
- ☐ Spells of rapid irregular heartbeat
- ☐ Urination at night
- ☐ Abnormal EKG
- ☐ Recent Cough
- ☐ Passed (ing) out-fainting
- ☒ worsening fatigue
- ☐ Swelling of the ankles
- ☒ Dizzy spells
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Rheumatic fever
- ☐ Varicose veins

☐ **Have you ever been hospitalized for your heart, or what they thought was your heart?** _____

☐ **Any other cardiac diagnosis?** _____

☐ **Any tests done for your heart? What tests?** thalium stress, u/s carotid, vein imaging
$6500 $1500 $13000

When where they done? May/June 08

After any problems you wish to address at this visit?

Victoria Reed 12-31-08

Patient name (sign) **Date**

_____ _____

Witness **Date**

INSURANCE INFORMATION

Please provide us with your medical insurance information:

PRIMARY INSURANCE POLICY:

Company: BCBS Georgia Phone: _____

Policy #: _____ Group: _____

Name and SS# of Insured: Christina Abell 423 74 2461

SECONDARY INSURANCE POLICY:

Company: — Phone: _____

Policy #: _____ Group: _____

Name and SS# of Insured: ~~Christina Abell~~ 423 74

OTHER INSURANCE:

company: _____ Phone: _____

Policy #: _____ Group: _____

Name and SS# of Insured: _____

ASSIGNMENT BENEFITS

I HEREBY ASSIGN TO MICHAEL RICHMAN M.D., MY RIGHT TO AND INTEREST IN ANY AND ALL HEALTH CARE AND /OR SURGICAL BENEFITS, OTHERWISE PAYABLE TO ME , FOR MEDICAL AND/OR SURGICAL TREATMENT RENDERED BY ANY OF THE ASSIGNEES. I HEREBY DIRECT MY INSURANCE COMPANY TO MAKE PAYMENTS DDIECTLY TO THE ASSIGNEE AT 1950 SAWTELLE BLVD # 145A LOS ANGELES, CA 90025.
IN UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COMPANY(DZS), UNLESS SUCH CHARGES ARE LIMITED BY EXISTING CONTRACT AGREEMENTS BETWEEN THE ASSIGNEE AN MY MEDICAL CARRIER, AND THAT FINANCE CHARGES WDLL BE ADDED TO ANY OUTSTANDING BALANCE, STARTING THIRTY DAYS FROM THE DATE A BILL IS SUBMITTED TO MY INSURANCE COMPANY, OR FROM THE DATE OF MY FIRST STATEMENT, IF CHARGES ARE NOT COVERED BY MY INSURANCE COMPANY, I AUTHORIZE THE PHYSICIAN LISTED ABOVE TO RELEASE TO MY INSURANCE COMPANY/OR ITS REPRESENTATIVES OR AGENTS, ANY MEDICAL INFORMATION RELATIVE TO THE SERVICES RENDERED TO ME. I ACKNOWLEDGE THAT A PHOTOCOPY OR FAX OF THIS ORIGINAL IS AS VALID AS THE ORIGINAL.

Christina Abell 12-31-08

Your signature here Today's date

The Center for Cholesterol Management

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

With my consent, The Center for Cholesterol Management may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to The Center for Cholesterol Management's Notice of Privacy Practices (NOPP) for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices (NOPP) prior to signing this consent. The Center for Cholesterol Management reserves the right to revise its Notice of Privacy Practices (NOPP) at anytime. A revised NOPP may be obtained by forwarding a written request to The Center for Cholesterol Management at the address above.

With my consent, The Center for Cholesterol Management may call my home, office, and/or other locations and leave a message on voicemail, answering machine and/or directly reference me and/or any items that assist The Center for Cholesterol Management in carrying out TPO, such as appointment reminders, insurance items, lab reports, hospital reports, etc.. I agree that any such call or message pertaining to my clinical care, including laboratory results may reference me personally by name.

With my consent The Center for Cholesterol Management may mail to my home and/or other locations, items that assist The Center for Cholesterol Management to carry out TPO, such as appointment reminder cards, practice marketing brochures, patient statements, etc., as long as they are marked personal and/or confidential.

With my consent, The Center for Cholesterol Management may e-mail to my home and/or other locations as per the patient data sheet. I have the right to request that The Center for Cholesterol Management restrict how it uses or discloses my PHI to carry out TPO. However, The Center for Cholesterol Management is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the aforementioned uses as well as The Center for Cholesterol Management's use and disclosure of my PHI to carry out TPO. I have received a copy of The Center for Cholesterol Management's Privacy Practices Policy (NOPP). I may revoke my consent in writing except to the extent that The Center for Cholesterol Management has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, he Center for Cholesterol Management may decline to provide treatment to me

Signature of patient or legal guardian: Christina Abell
Date: 12-31-08
Patient's Name: same Christina Abell
Witness:

PRIVACY OF MEDICAL RECORDS

Our physicians and staff are fully and acutely aware of the potentially sensitive nature of the information contained in your medical record. Therefore, we ask that you provide us below with a list of those individuals or parties whom you intend to have access to such information in your medical records, and those whom you do not. Unless you request otherwise, it is our policy to share such information with the following individuals or parties:

1. Your next of kin, usually identified as the emergency contact and/or the person(s) who accompanies you during your office visit(s), spouse, child(ren), and/or parent(s);
2. Your medical insurance carrier and its agents;
3. Your referring physician and his/her staff;
4. The physicians and professionals to whom we make referrals, including the pathologist, radiologist, and anesthesiologist, and their staff.

We CANNOT bill your insurance company and/or collect any money from them on your behalf unless we have your permission to disclose such information to them. Also, the quality of your medical care might be compromised if our physicians do not have your permission to consider your case fully and frankly with other physicians and professionals who are involved in your medical care.
Please acknowledge below that you permit the foregoing individuals or parties to have access to the information contained in your medical records by signing below, and list additional individuals or parties that you permit access to such information.

THE FOLLOWING IS A LIST OF ADDITIONAL INDIVIDUALS OR PARTIES WHO HAVE MY PERMISSION TO ACCESS THE INFORMATION CONTAINED IN MY MEDICAL RECORD (IF THERE ARE NONE, WRITE IN "NONE"):

Your signature (required): Cristina Ruiz Date: 12.31.08

Please acknowledge below any individuals or parties that you DO NOT authorize access to the information contained in your medical record by signing below.

THE FOLLOWING IS A LIST OF INDIVIDUALS OR PARTIES WHO DO NOT HAVE MY PERMISSION TO ACCESS THE INFORMATION CONTAINED IN MY MEDICAL RECORD (IF THERE ARE NONE, WRITE IN "NONE"):

None

Your signature (required): J. Ruiz Date: 12.31.08

THE CENTER FOR CHOLESTEROL MANAGEMENT
A Medical Corporation

BILLING POLICY

We would like to prevent any misunderstanding about our billing financial policies. Please let the office administration know of you would like to discuss any of the following policies in more detail.

If you belong to an HMO, or any other restricted insurance plan, you MUST let us know before you are treated. Some of these plans limit your choice of doctor or hospital, and some exclude particular medical conditions. If you need surgery, we will try to select the hospital and doctors from your plan, although this might not always be possible or practical, particularly with the pathologist and the radiologist. Please provide our business office with all of your insurance information before you are treated, and we will help you fulfill the terms of your policy so that you can obtain maximum and timely reimbursement.

We will send you monthly statements until your insurance company has paid, regardless of our provider status. This allows you to verify that your insurance company was billed correctly, and to see how long they take to pay. If you have more than one insurance policy and the benefits are not coordinated, each company will determine benefits separately. In this situation, it might happen that we have different agreements with different companies. We will then collect benefits from each company and reimburse you any amount above billed charges.

Starting January 2001, you will also need to complete a separate form, "Privacy of Medical Records," so that we have a clear understanding of those individuals and parties whom you intend to have access to information contained in your medical record, and those whom you do not.

We accept Visa, MasterCard, and Diner's. There is a $25 charge for all checks returned by the bank. If you would like us to bill your insurance company on your behalf, please complete the Assignment of Benefits sections below. Please sign below once you have had a chance to review our billing policies.

I AUTHORIZE MICHAEL RICHMAN M.D., AND STAFF TO PROVIDE ME WITH REASONABLE AND PROPER MEDICAL CARE. I UNDERSTAND THAT I WILL HAVE AN OPPORTUNITY TO ASK QUESTIONS AND TO HAVE MY QUESTIONS ANSWERED, BEFORE I DECIDE TO PROCEED.

Your signature (required): Sharon Richman Date: 12/3/04

03/03/2006

Georgia

DRIVER'S LICENSE

NUMBER 061682102 EXPIRES 04-16-2009

ABELL, CHRISTINA A
100 SOUTHERN TRACE CT
PEACHTREE CTY, GA 30269-1312

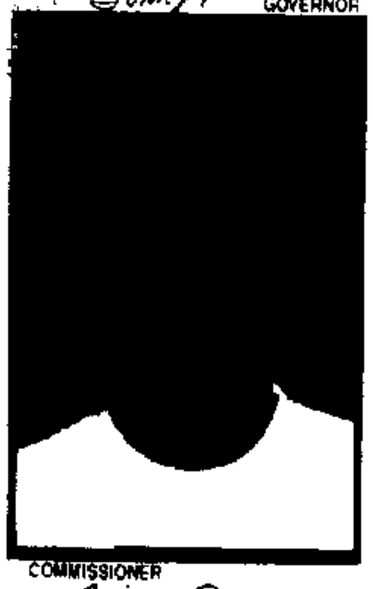
SEX	BIRTHDATE	EXAM DATE	COUNTY
F	04-16-1952	02-28-2005	056

HEIGHT	WEIGHT	CSC	FEE	RESTRICTIONS
5-08	130	2 100	15.00	

CLASS	ENDORSEMENTS	TYPE
C		REG

Christina Abell

Sonny Perdue GOVERNOR



COMMISSIONER
Jim Davis

SS#
423-74-2461

PPO

Member Name *CHRISTINA A ABELL*
Member ID *XKC328A16085-01*
Group Number *IPK03K1001*
Group Name *TONIK 3000*

Benefits Effective as of *04/01/2008*

Co-Pays	*30 OV*	*30 SP OV*	*100 ER*
	10 G-RX	*30 B-RX*	*50 NON PREP*

Coinsurance *100%IN 70%OUT*
Deductibles *3,000 CAL YR*
Dental Co-Ins *80 % BASIC* *DEDUCT 25*

Customer Service 1-800-441-2273

PROVIDERS FILE ALL CLAIMS DIRECTLY WITH YOUR LOCAL BLUE CROSS BLUE SHIELD PLAN. PLEASE SUBMIT ALL CLAIMS WITH THE 3-DIGIT ALPHA PREFIX THAT PRECEDES THE MEMBER ID ON THE FRONT OF THE CARD

Hospital providers should submit all claims directly to: **Blue Cross and Blue Shield of Georgia, P.O. Box 9907, Columbus, GA 31908-9907**

This product is underwritten by Blue Cross and Blue Shield of Georgia, an independent licensee of the Blue Cross Blue Shield Association. This card is for identification only; does not automatically guarantee eligibility for benefits and is not transferable.

TONIK CUSTOMER SERVICE NUMBER
1-800-441-2273

NOTICE TO MEMBERS Present this identification card when receiving health care services. If your plan contains a copay feature, the copay is due at the time services are rendered. Your portion of coinsurance may also be due at that time. To locate PPO providers outside the state of Georgia, call Network Access at **1-800-810-2583**, or you may visit us at **www.bcbsga.com**

Notice to Pharmacy Please submit to Wellpoint NextRx using the following data: Plan code: 100 BIN number: 610053. For assistance call **1-800-962-7378**

Pre-Certification Procedures Pre-certification is required for all hospital admissions and certain outpatient procedures. For services outside the state of Georgia, you are responsible for obtaining pre-certification under this plan. For pre-certification, you or your physician or hospital may call **1-800-722-5614**. Failure to pre-certify may result in the denial of a claim.

Dental Claims Procedure Claims must be filed directly to: Blue Cross Dental Customer Service, P.O. Box 9056, Oxnard, CA 93031-9060. Reference Payor Number: **SB601**. Customer Service Telephone Number: **1-800-209-7852**. Dental TDD Number: **1-800-759-0084**

FONB

The Abells 770-631-8018 P.2

2357 WARM SPRING ROAD
COLUMBUS, GA 31908

Anthem

RICHMAN, MITCHELL MD

spoke to pharmacist - DON - 1-13-09 @ 9:40 AM.

Date: 1/13/2009
Member Name: CHRISTINA ABELL
Member Number: 328A16085
Case Number: 2041314
Provider Name: RICHMAN, MITCHELL MD
Provider Fax: 3104813949

Classification	Start Date	Drug Name
Pharmaceutical	1/13/2009	CRESTOR

Review Outcome: Certification
Place of service: Pharmacy

The requested medication(s) has been certified as listed above based on medical necessity. The authorization(s) has been approved from 1/13/2009 to 1/13/2010 .

This determination is a recommendation regarding the medical necessity of the services listed above. The decision regarding what treatment is best remains with the patient and the healthcare provider.

This letter and the associated review do not guarantee claims payment. No benefit determination has been made at this time. Payment of benefits could be limited or denied if the information submitted with claims differs from that given by telephone, and is subject to all policy exclusions, limitations, waivers, pre-existing conditions and coverage eligibility when the services listed above are provided.

* Dr. The chart for Christina Abell was faxed to us by Dr. Lichman's office. We have been trying to get the information from the patient's insurance company.

WELLPOINT nextRx

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Non Preferred Statins

Complete form in its entirety and fax to:

Prior Authorization of Benefits (PAB) Center at (888) 831- 2243

1. PATIENT INFORMATION

Patient Name: Christina ABELL

Patient ID #: 320A160085

Patient DOB: 04/16/1952.

Date of Rx: 01-9-09

Patient Phone #: 770-631-9542

Patient Email Address: _____

2. PHYSICIAN INFORMATION

Prescribing Physician: Michael Lichman MD.

Physician Address: 1950 Sawtelle Blvd #150 LA CA 90025

Physician Phone #: 310-481-3939

Physician Fax #: 310-481-3949.

Physician Specialty: Cardiothoracic Surgeon & general

Physician DEA: BR3315567

Physician NPI #: 1972554806

Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
☐ Crestor (rosuvastatin) ☐ Vytorin (ezetimibe/simvastatin)	10mg	1 po qd	#30

7. DIAGNOSIS: Pure Hypercholesterolemia ; PVD

8. CLINICAL INFORMATION

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

List trial of statins (excluding samples) - Please include the following information:

DRUG NAME	DOSE	SIG	TRIAL DATE(s) AND DURATION	OUTCOME
1. Simvastatin	40mg	1 tab po qd		2008
2.				
3.				

9. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request

☐ Yes ☒ No Has the patient been on the requested statin in the previous 180 days? (Please provide documentation) **Documentation MUST be provided:** Should include, but is not limited to, chart notes, prescription claims records, prescription receipts, laboratory data, reason for failure of medications tried (e.g. symptoms, frequency)

☐ Yes ☒ No Did the patient achieve the LDL cholesterol goal on a 30 day trial of Lipitor 40mg, 80mg *or* simvastatin 80mg?

☒ Yes ☐ No Is the patient intolerant* to **BOTH** simvastatin AND Lipitor?

Please specify intolerance: pt is intolerant of lipophyllic statins

Note: If patient had elevated liver function tests (LFTs) they must be ≥ 3x the upper normal limit and should return to normal limits prior to initiation of therapy with another statin.

☐ Yes ☒ No Is the patient currently on a product that interacts with **BOTH** simvastatin AND Lipitor?

Please specify product: _____

What is the patient's current LDL? _____

☒ Yes ☐ No Patient requires more than 50% reduction in LDL?

☐ Yes ☐ No Patient requires less than 50% reduction in LDL?

it has severe allergic reaction to insulin therapy

10. PHYSICIAN SIGNATURE

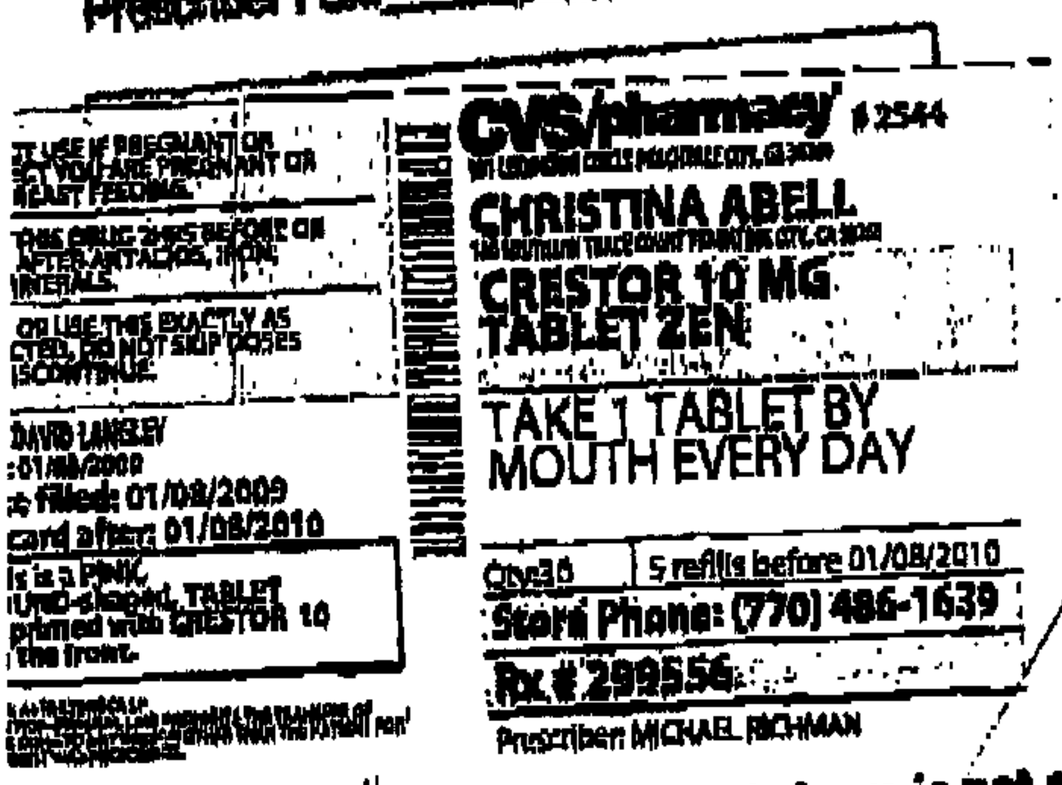
Prescriber or Authorized Signature _____ Date 1/12/09

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions

Pharmacy Name: CVS Pharmacy
Location: 101 Lexington Circle Peachtree City GA
Direct Line: 770 486 1639 Fax: 770 486 1674

MEDICATION NOT COVERED - FOLLOW UP REQUEST

DATE - 1st Request: 1/8/09 2nd Request: Dr. Richman 3rd/Final Request: (310) 481-3939
Prescriber Fax: (310)575-4250 (310)575-4050 Prescriber Phone: 3105754050 (310)575-4050



Patient DOB: 4/16/52
Patient Phone: 7163 9542
Insurance: wellpoint
Insurance ID: 328A16085

NOT on PT

The medication as prescribed above is not covered by the insurance because:

- [ ] It is not on their formulary.
- [ ] Dosing and/or quantity as prescribed exceeds plan limits:
- [ ] Length of therapy has been exceeded:
- [ ] Medication is covered but non-formulary with a high copay: $
- [ ] Insurance is MediCal and the medication requires a TAR.
- [ ] Other:

To ensure uninterrupted therapy for the patient, please:

- [ ] Submit a Prior Authorization request. You may call the insurance at: 1-800-962-7378
- [ ] Change the medication to:
- [ ] Change the dose or directions to:
- [ ] Complete the following form and fax to:
- [ ] Provide us with a Diagnosis (ICD-9 Code) and Medical Justification including past medications tried and failed so that we may contact the insurance:
- [ ] Other:

If you are applying for a Prior Authorization, would you please contact us when this medication is approved or denied? Thank you for your prompt attention to this matter!