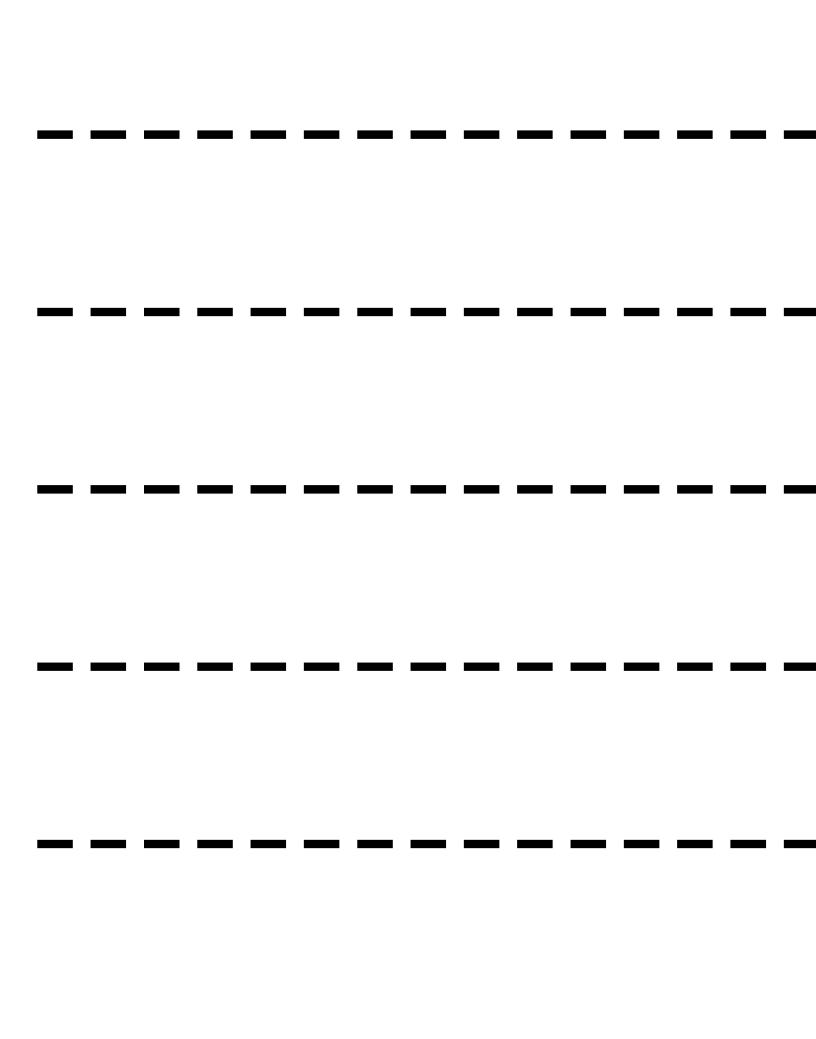
## TREATMENT AUTHORIZAT ON REQUEST

### State of California -DEPARTMENT OF HEALTH SERVICES

#### Date Time Printed: 10-Mar-2025 12:11:48

#### TREATMENT AUTHORIZAT ON REQUEST CONTROL

#### NUMBER (TCN): 0539476744



#### PROVIDER

#### INFORMATIO N

### Provider ID: 00A088470

# As submitted on TAR: Name:

Prescribing

### Test Provider Fax:

Medicare
Certified
Provider: Yes

#### Contact Name: Contact Phone: Contact Ext:

## TAR Completed By Suresh

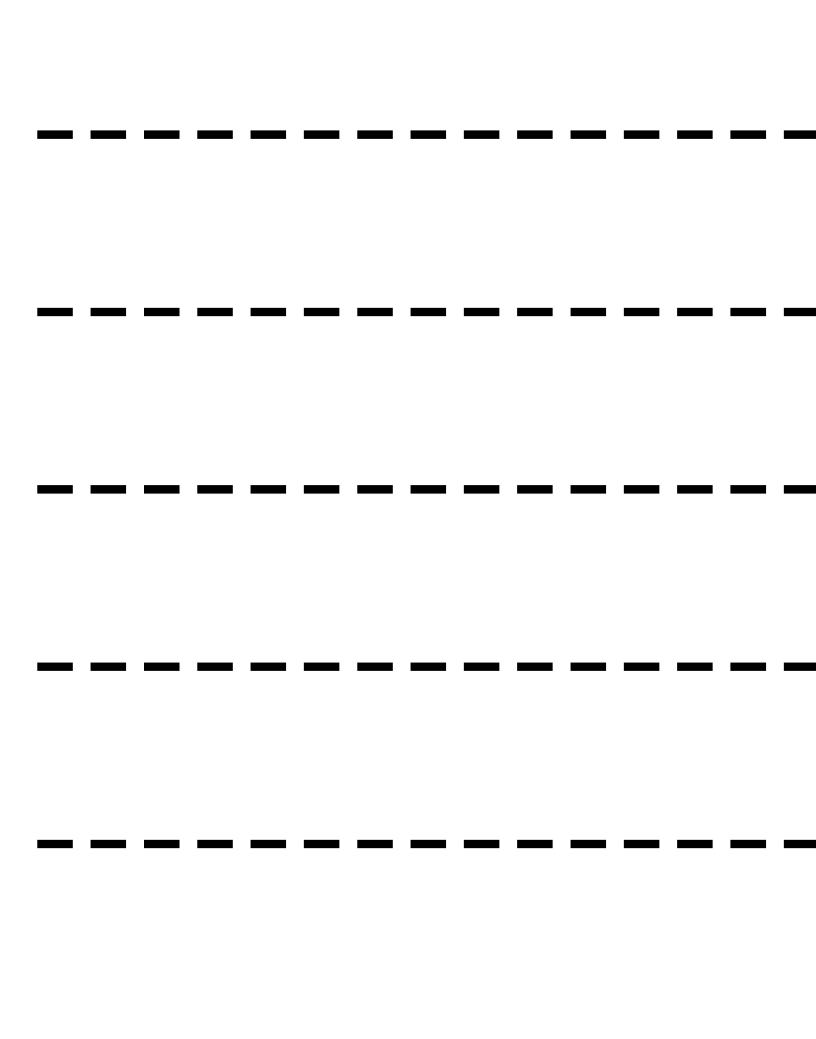
As contained

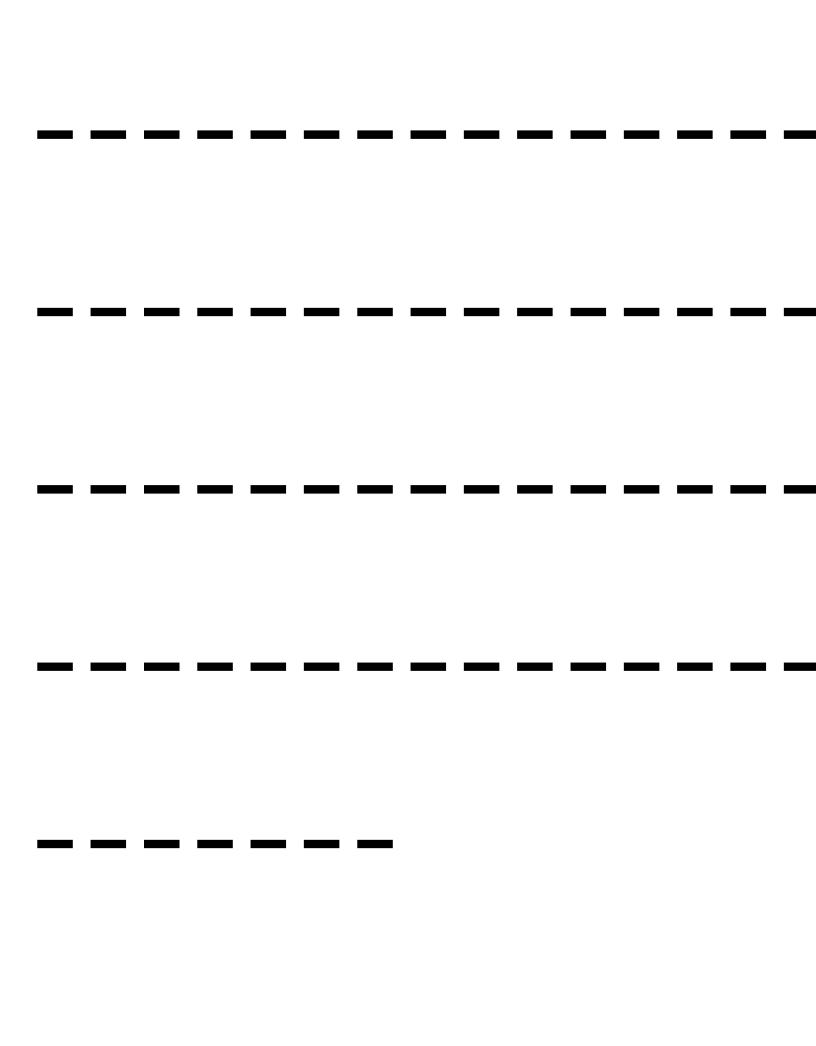
#### on Provider Master File: Name: Prescribing Test Provider

### Phone: (000) 000-000Attention Line INC Address Line

### 1:840 Stillwater Road Address Line

### City: West Sacramento State: CA Zip: 95605





### PATIENT INFORMATIO N

## Incoming Recipient ID: 00000111

As submitted

#### on TAR: First Name: Y Last Name: Dale Date o Birth:

#### 12/22/1966 Gender: Male

### As contained on Eligibility

### File (FAME / MEDS): First Name: Dale Last Name: Yi

#### Date of Birth: 12/22/1966 Gender: Male

Patient's

### authorized representative (if any): Name: SWAROOP

#### REDDY YANDAPAIII Address: test123@soft City: ol.com

# HYDERABAD State: CA Zip: 50203

Recipient

#### providing Medi-Cal eligibility (if not patient) First Name:

#### Jim Last Name: Barns Date of Birth: 09/09/1987 Gender: Male

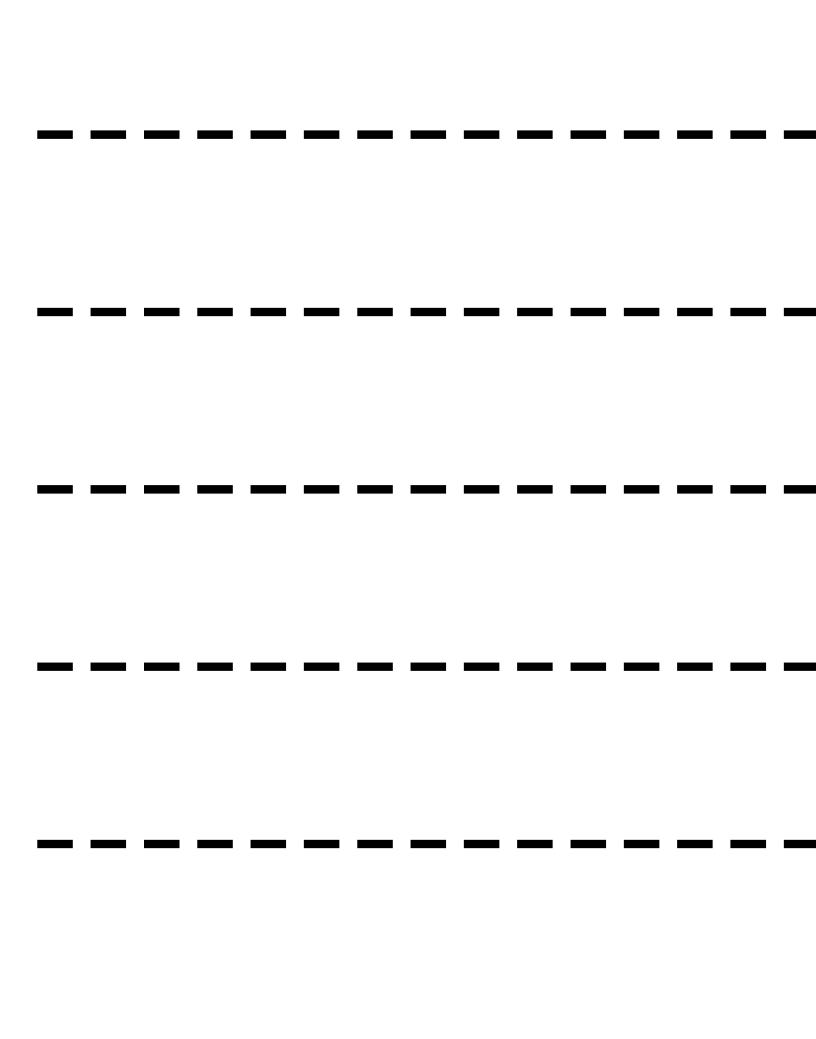
#### Contact Phone: (123) 456-2345 Residence

#### Status: Worker's Comp: No OHC Status: No Other

### Health Coverage Medicare Status: Under 65, does not

### have Medicar Coverage Med/OHC Date: 10/10/2020

#### Patient Record No: 345



#### GENERAL TAF

#### INFORMATIO N

Receipt Date: 10-Mar-2025

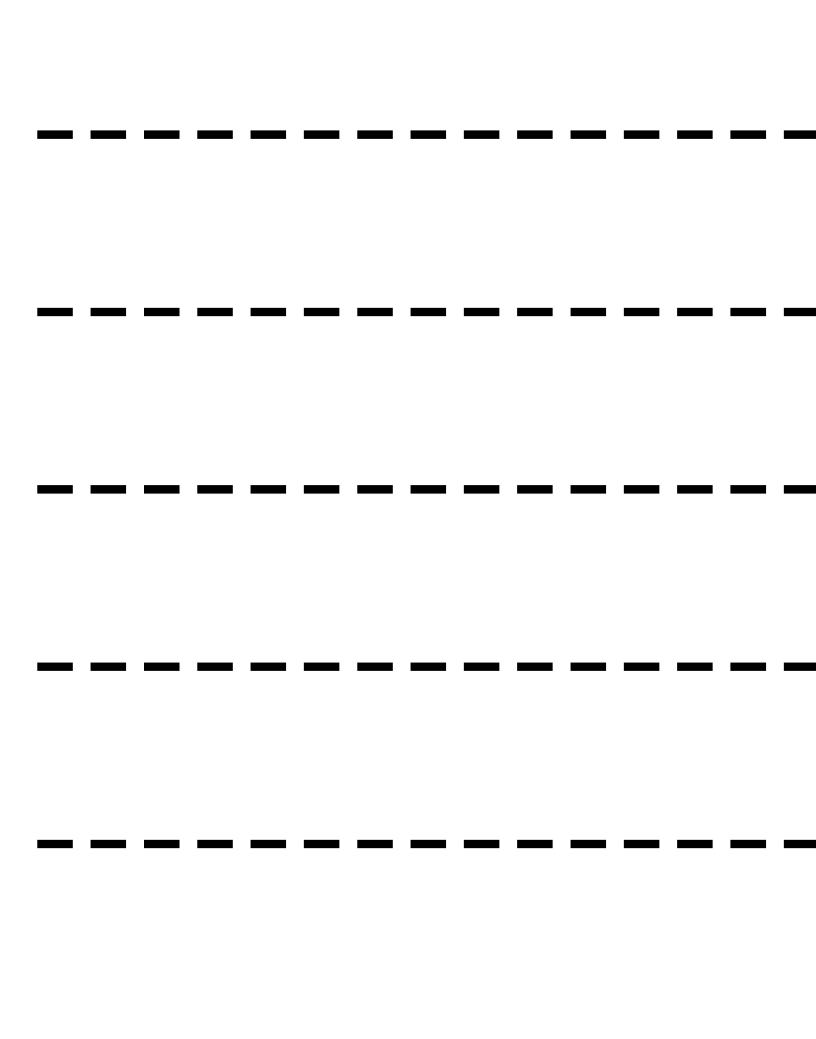
#### 10:07:52 Update Reason: Retroactive Reason:

#### Retroactive Date: Special Handling Reason:

# Exceeded Code 1 Restrictions

Miscellaneous

### TAR Information:



#### SERVICE

#### INFORMATIO N

### TCN#: 0539476744

#### TAR Service Num: 1 Pric Indicator: 0 No special conditions

#### Service Cd: F8000 Modifiers: NU Service Desc:

### POSTERIOR GAIT TRAINER Service Indicator Description:

#### DME - Other Status: Approved Status Date: 03/10/2025

#### Units: 5 Used: 0 Quantity: 1 Day Side: L From Date:

#### 02/02/2010 Thru Date: 02/10/2010 Admit Date: 02/02/2010

#### Admit From: Home Anticipated -Length Needed: 1

#### Day Schedule: Frequency: 1 per Day Discharge

#### Date: 02/11/2010 Discharge: Place Home of Service:

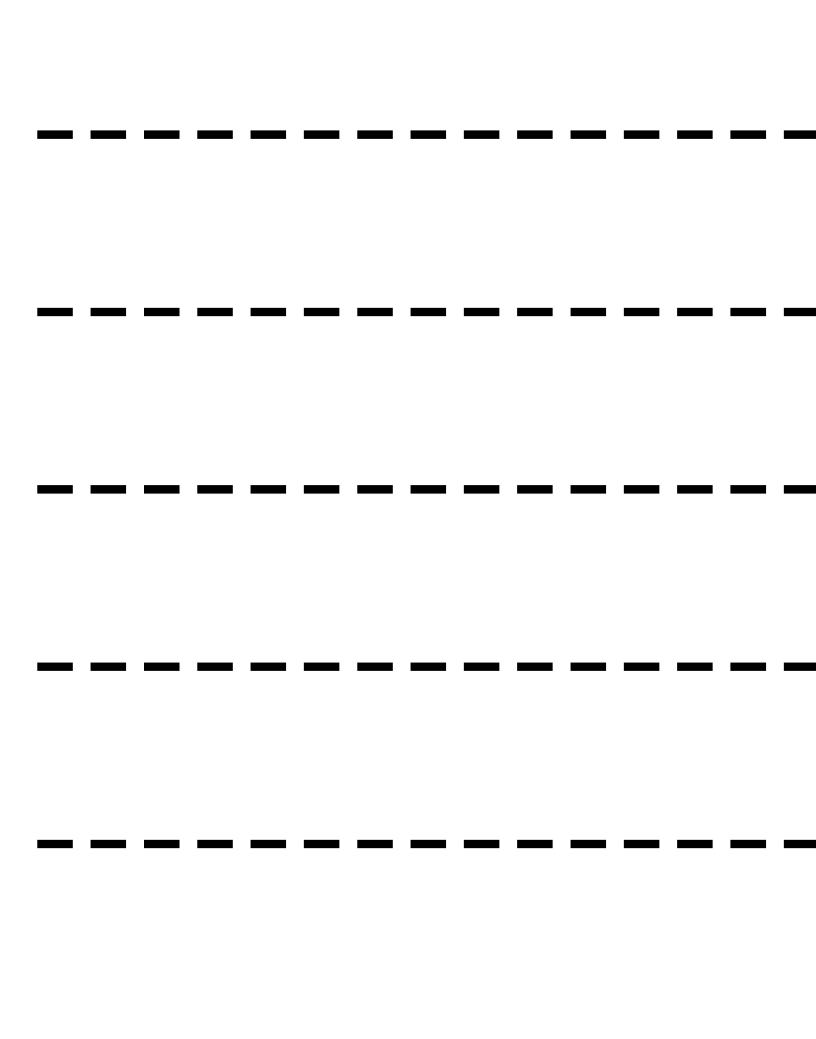
### Home Diag: ICD-10: A92.8 Desc: Other specified

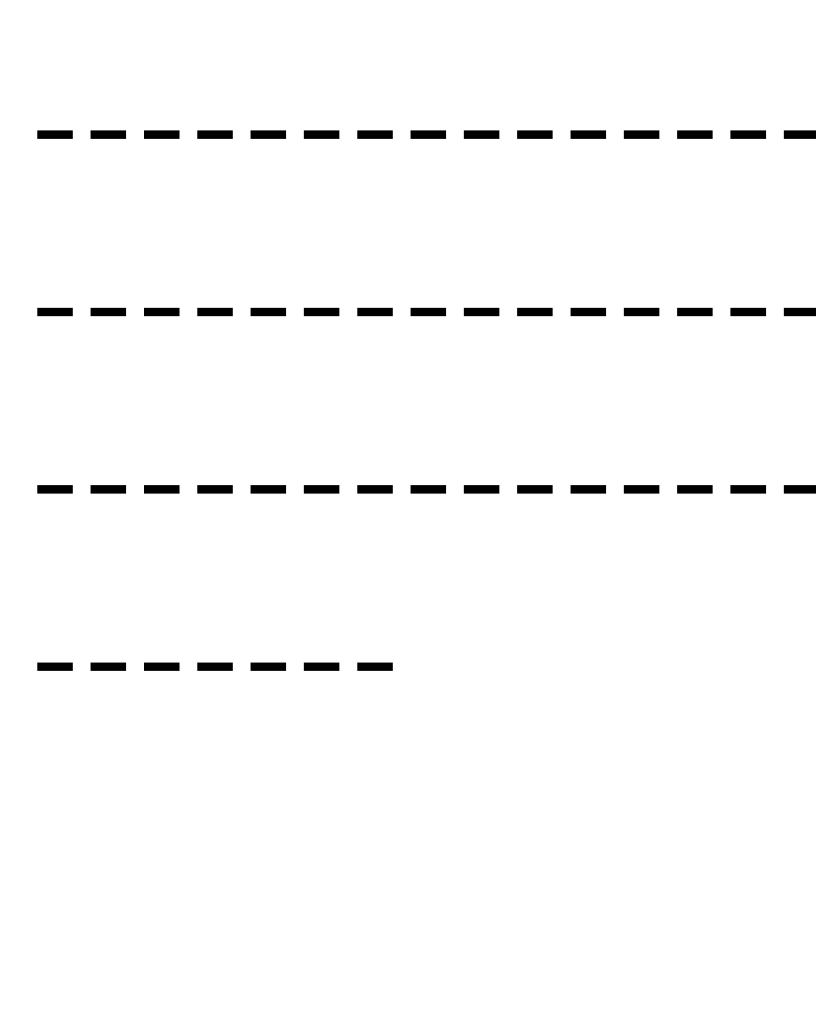
#### mosquitoborne viral fevers Date of Onset: 10/10/2009

#### Rendering / Prescribing ID 1982756425 Price: 123 MSRP / Inv:

#### 456 Adjudication Reason(s): Approved as submitted

## Field Office: ACS/PSD ONSITE





## SERVICE INFORMATIO N

TCN #:

### 0539476744 TAR Service Num: 2 Pric Indicator: 0 -No special

#### conditions

Service Cd: 11
Service Desc:
Subacute

#### Service Indicator Description: Subacute Status:

#### Approved Status Date: 03/10/2025 Units: 5 Used: 0

#### Quantity: 1 Day From Date: 02/02/2025 Thru Date:

#### 02/10/2025 Admit Date: 02/02/2025 Admit From: Home

### Anticipated Length Needed: 1 Day Frequency: 1

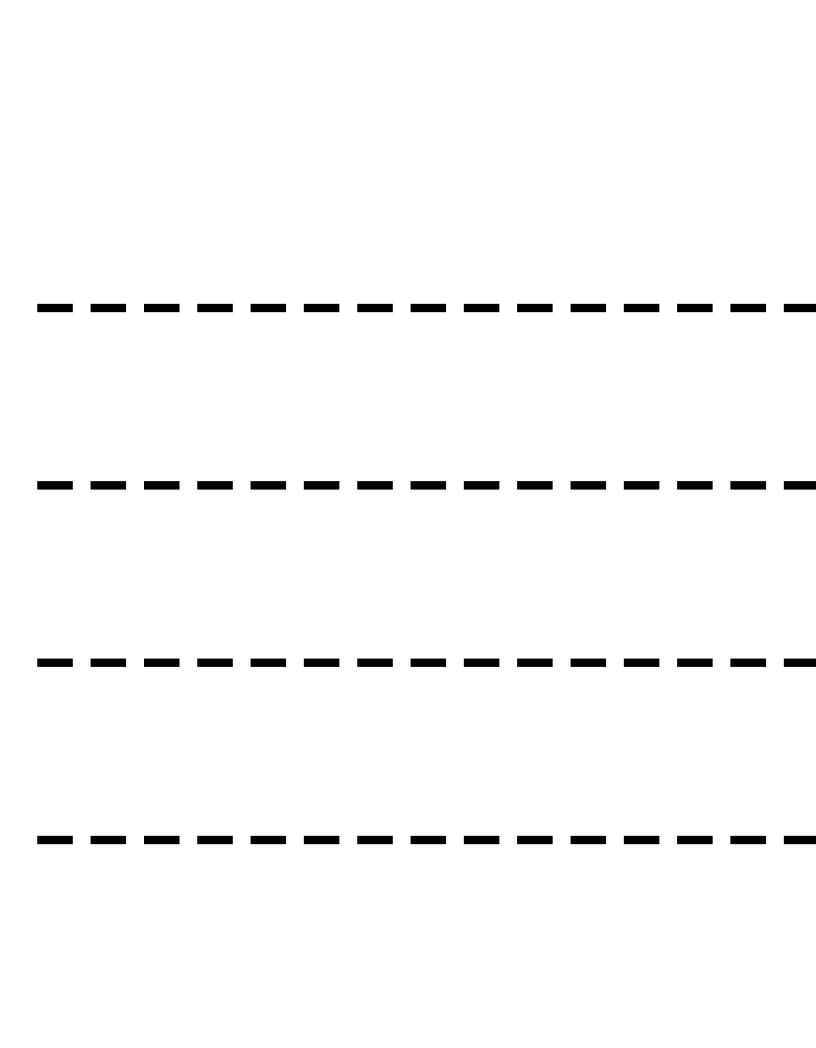
#### Day Discharge Date: 02/11/2025 Discharge:

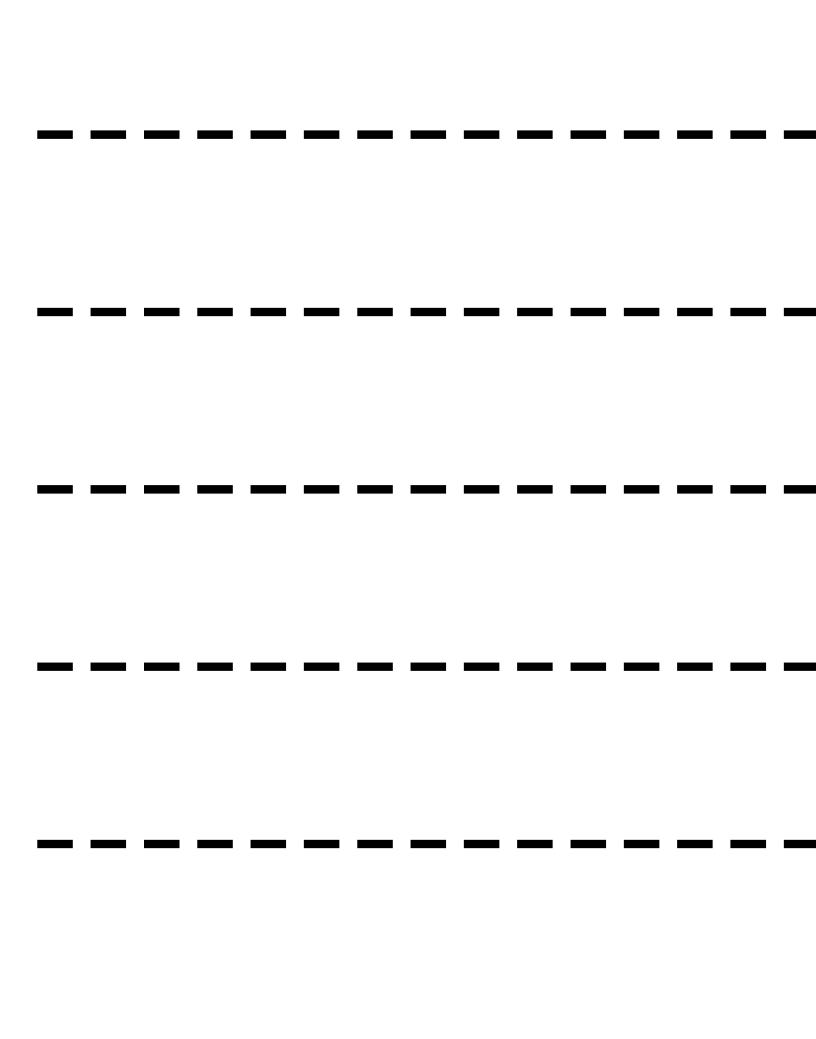
#### Home Diag: ICD-10: A92.5 Desc: Zika virus disease Dat

### of Onset: 10/10/2024 Place of Service: Rendering /

#### Prescribing ID 1982756425 Price: Adjudication Reason(s):

#### Approved as submitted Field Office: ACS/PSD ONSITE





# SERVICE INFORMATIO N

#### TCN #: 0539476744 TAR Service Pric Num: 3

# Indicator: 0 - No special conditions

Service Cd:

#### V2799 Modifiers: NU Service Desc: MISCELLANE( US VISION

#### SERVICE Service Indicator Description: Vision

#### Contact Lens Status: Rejected Status Date: 03/10/2025

#### Units: 5 Used: 0 Quantity: Side: From Date:

#### 02/02/2025 Thru Date: 02/10/2025 Admit Date: Admit From:

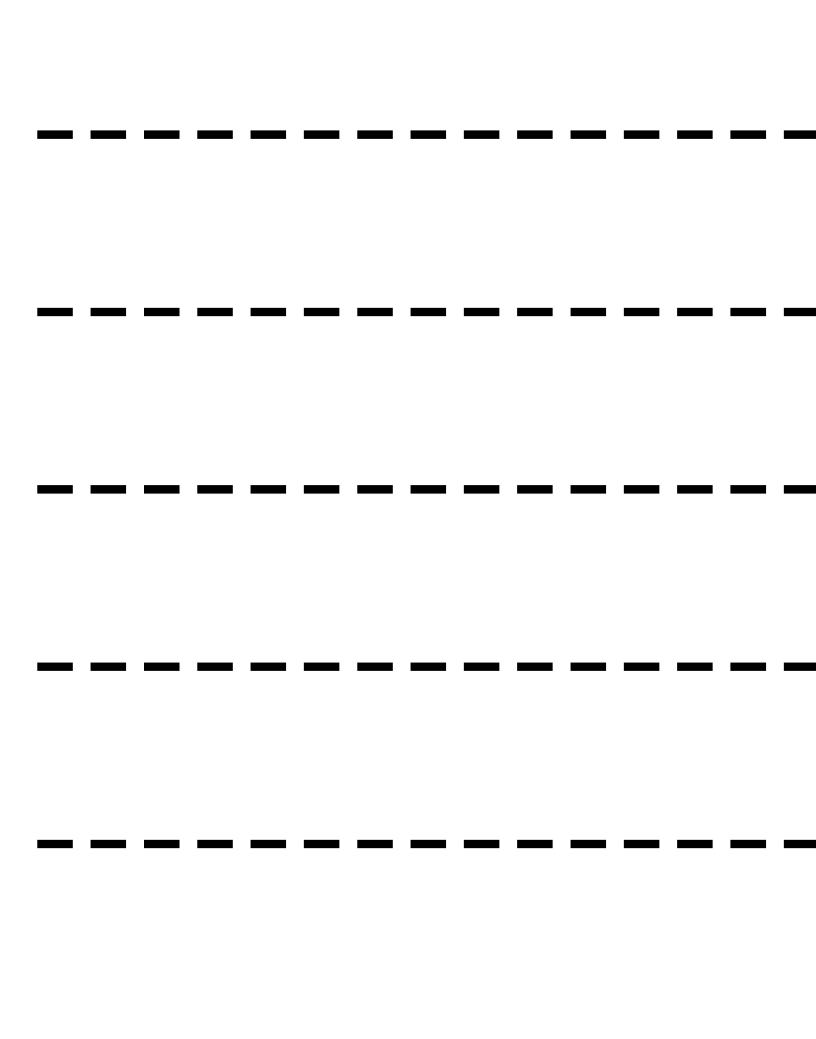
#### Anticipated Length Needed: 0 Schedule: Frequency: 0

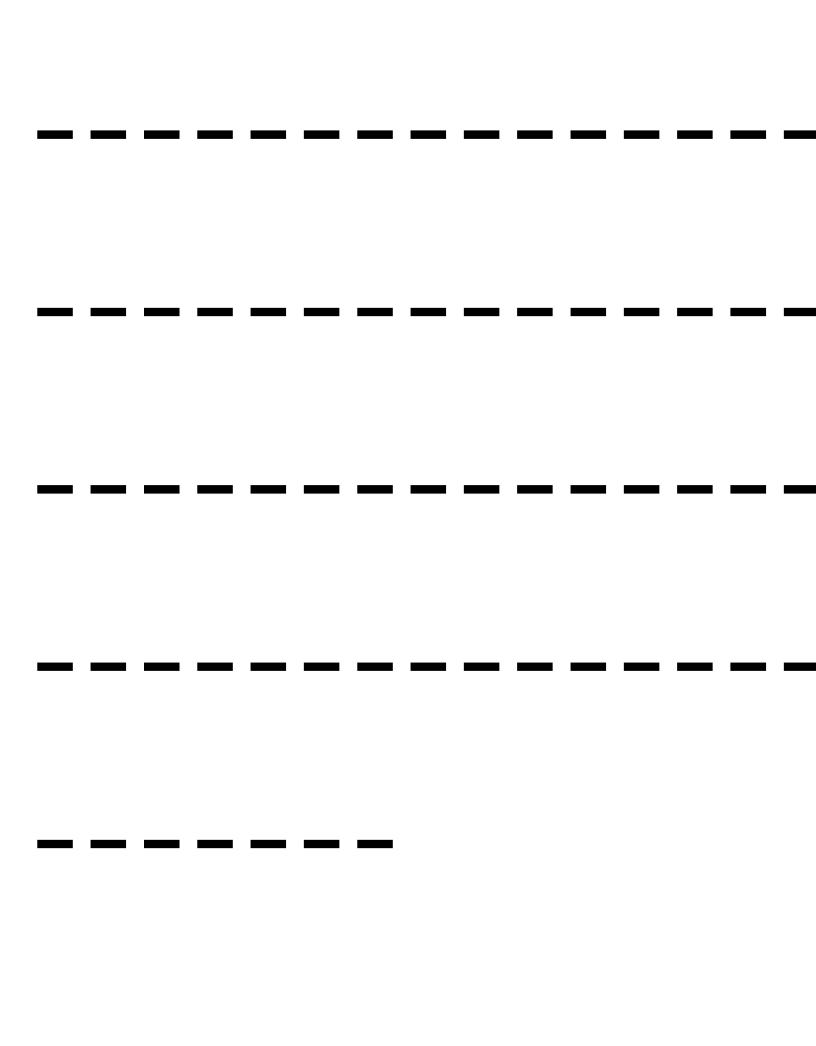
#### per Discharge Date: Discharge: Place of

#### Service: Home Diag: ICD-10: A92.5 Desc: Zika virus disease Dat

#### of Onset: 12/12/2024 Rendering / Prescribing ID 1982756425

#### Price: 123.33 MSRP / Inv: 456.33 Field Office:





# SERVICE INFORMATIO N

#### TCN #: 0539476744 TAR Service Num: 4 Pric Indicator: 7 -

# Admit/ext corhosp\hosp\hosp in open area

Service Cd: 2

#### Service Desc: Admin Days Inpatient Hospital Service

#### Indicator Description: Hospital Days Status: Approved

#### Status Date: 03/10/2025 Units: 5 Used: 0 Quantity:

#### From Date: 03/03/2025 Thru Date: 03/15/2025 Admit Date:

#### 03/03/2025 Admit From: Anticipated -Length Needed: 0

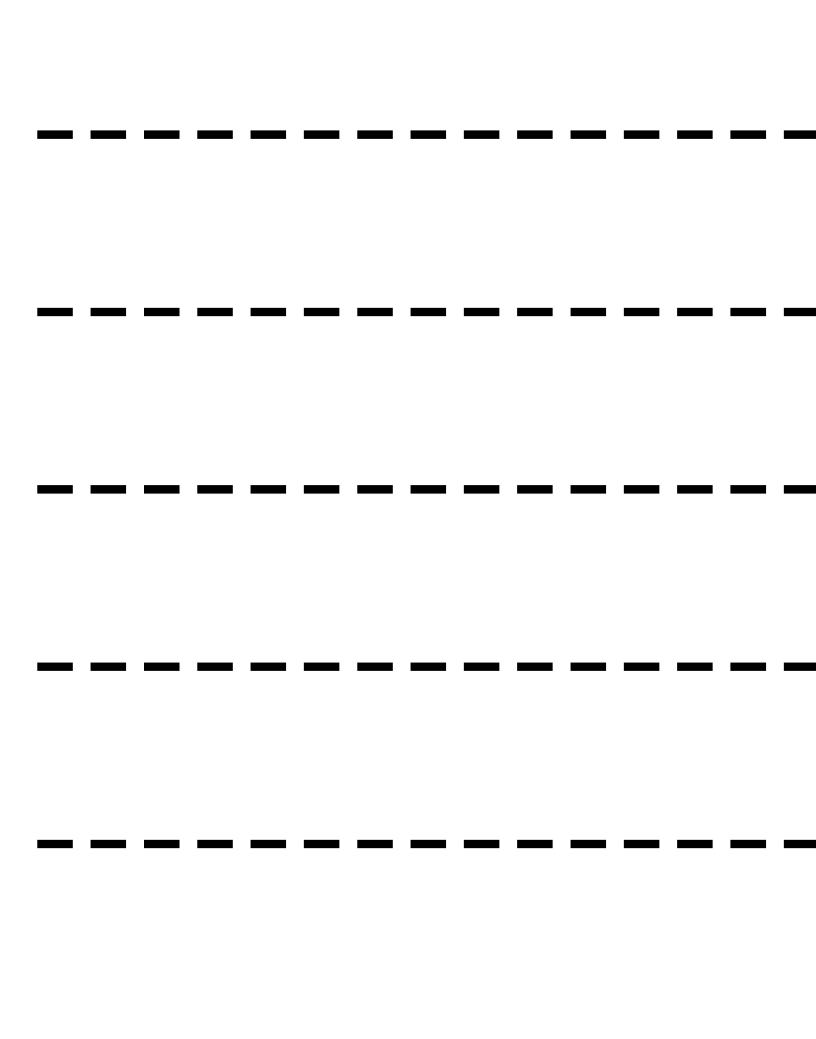
#### Frequency: 0 Discharge Date: 03/16/2025 Discharge:

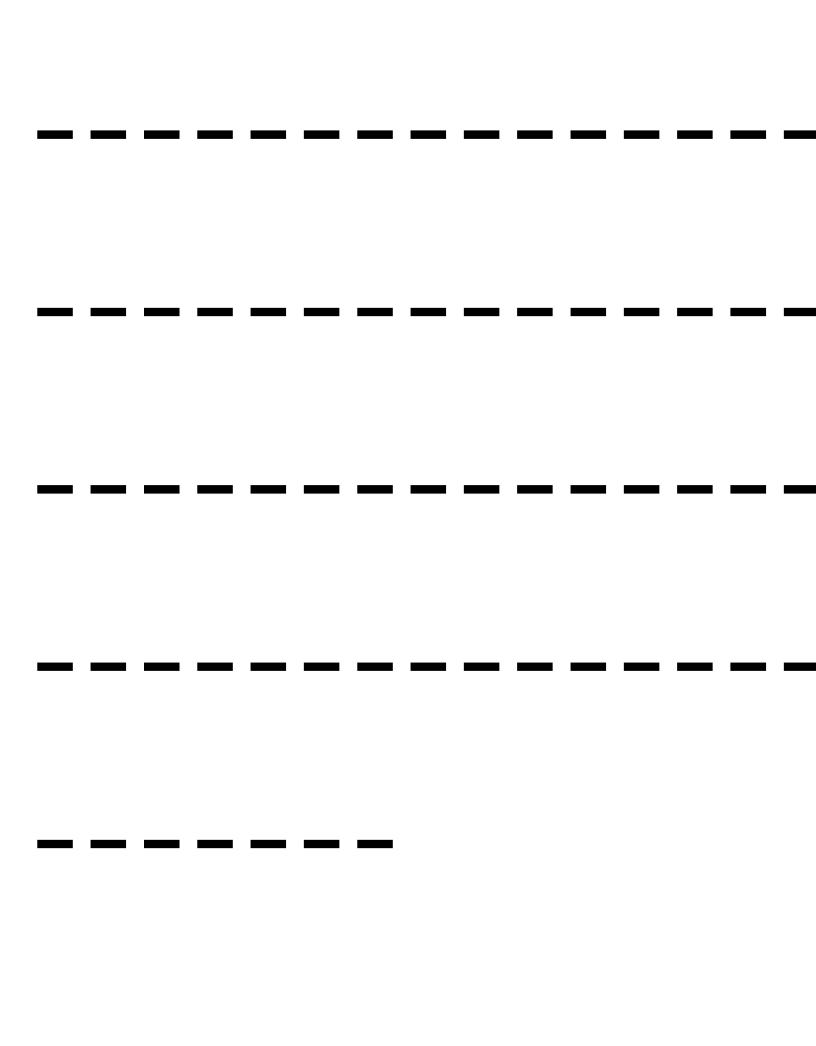
#### Diag: ICD-10: A92.5 Desc: Zika virus disease Dat of Onset:

#### 10/10/2024 Place of Service: Rendering / Prescribing ID

#### 1982756425 Price: Adjudication Reason(s): Approved as

#### submitted Field Office: ACS/PSD ONSITE





# SERVICE INFORMATIO N

#### TCN #: 0539476744 TAR Service Num: 5 Pric Indicator: 0 -

## No special conditions

### Service Cd: 58562

## Modifiers: Service Desc: HYSTEROSCO PY REMOVE

FB

#### Service Indicator Description: **FPACT** Status:

#### Rejected Status Date: 03/10/2025 Units: 5 Used: 0

#### Quantity: Side: L From Date: 02/02/2025 Thru Date:

### 02/10/2025 Admit Date: 02/02/2025 Admit From: Anticipated -

#### Length Needed: 1 Day Schedule: Frequency: 1

### per Day Discharge Date: 02/11/2025 Discharge:

# Home Place of Service:

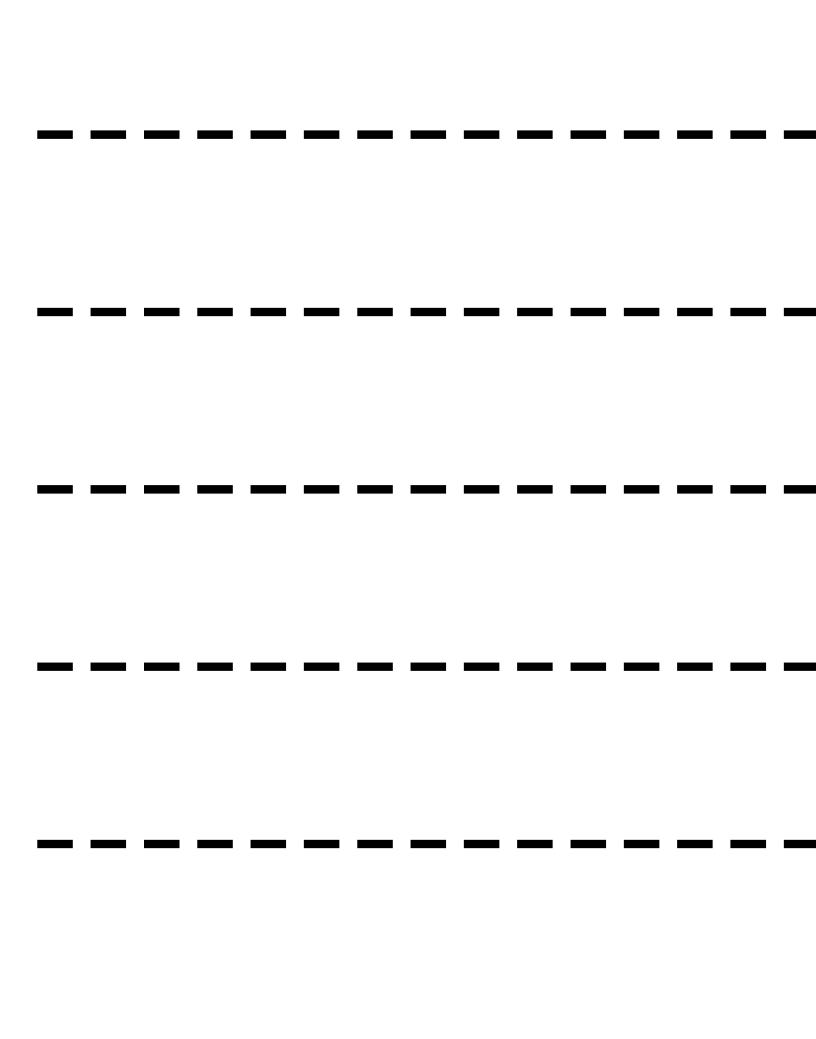
Diag: ICD-10:

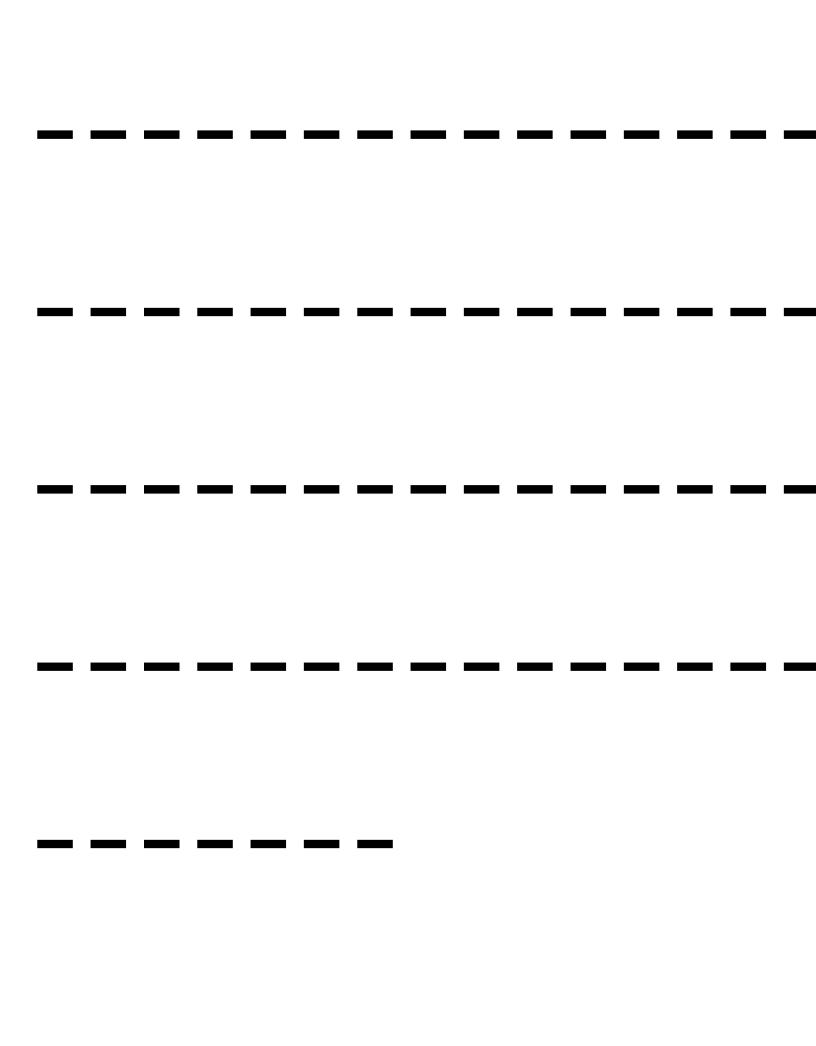
A92.5 Desc:

Zika virus

#### disease Dat of Onset: 10/10/2024 Rendering / Prescribing ID

#### 1982756425 Price: MSRP / Inv: Field Office:





#### PATIENT ASSESSMENT ATTACHMEN (A)

## TCN#: 0539476744

#### POT

#### Adherence: Feeding Method: In Home Assistance: 0

#### Hrs/Day Care giver: 0 Days/Wk Height: \_\_ft in Weight: C

#### Lbs 0 Ozs

Current medical statuses

### relevant to requested services: Parenteral nutrition (TPN

## or lipids): peripheral

Current functional

#### limitations / physical conditions: Ambulation: assistance:

#### human help needed for steps or uneven surfaces

### Previous functional limitations/ph ysical

#### conditions: Ambulation: assistance: human help needed to

#### stand

TAR Diagnosis
Code /
Description:

#### Diag: ICD-10: A92.5 Desc: Zika virus disease Dat of Onset:

### 10/10/2024 Diag: ICD-10: B00.0 Desc: Eczema herpeticum

## Date of Onset 10/10/2024

## Summary of treatment /

```
procedures /
surgeries /
clinical
findings /
history
```

# relevant to requested services:

### Explanation if it is known that the patient has ever received

### the requested or similar services (including dates):

# Summary of therapeutic goal to be

# met with the requested services:

### Explanation if the requested service(s) is not the least costly

#### alternative:

## Physician Information:

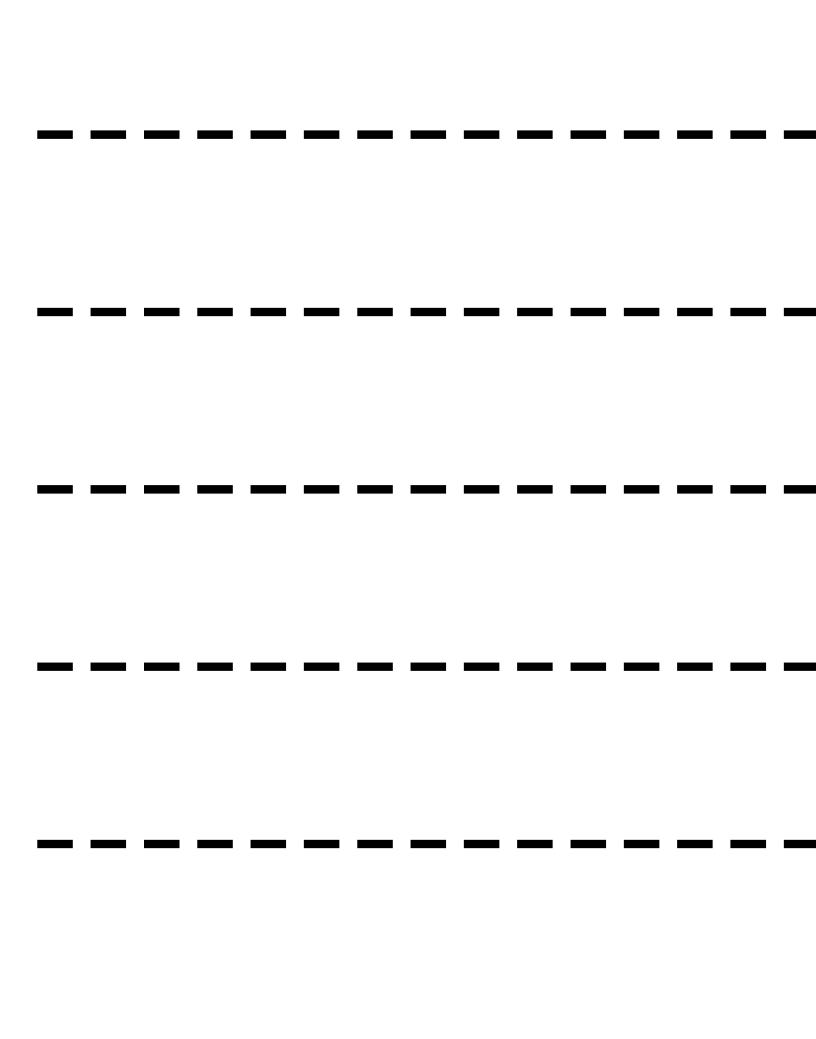
#### Physician Prescription information a submitted by Provider:

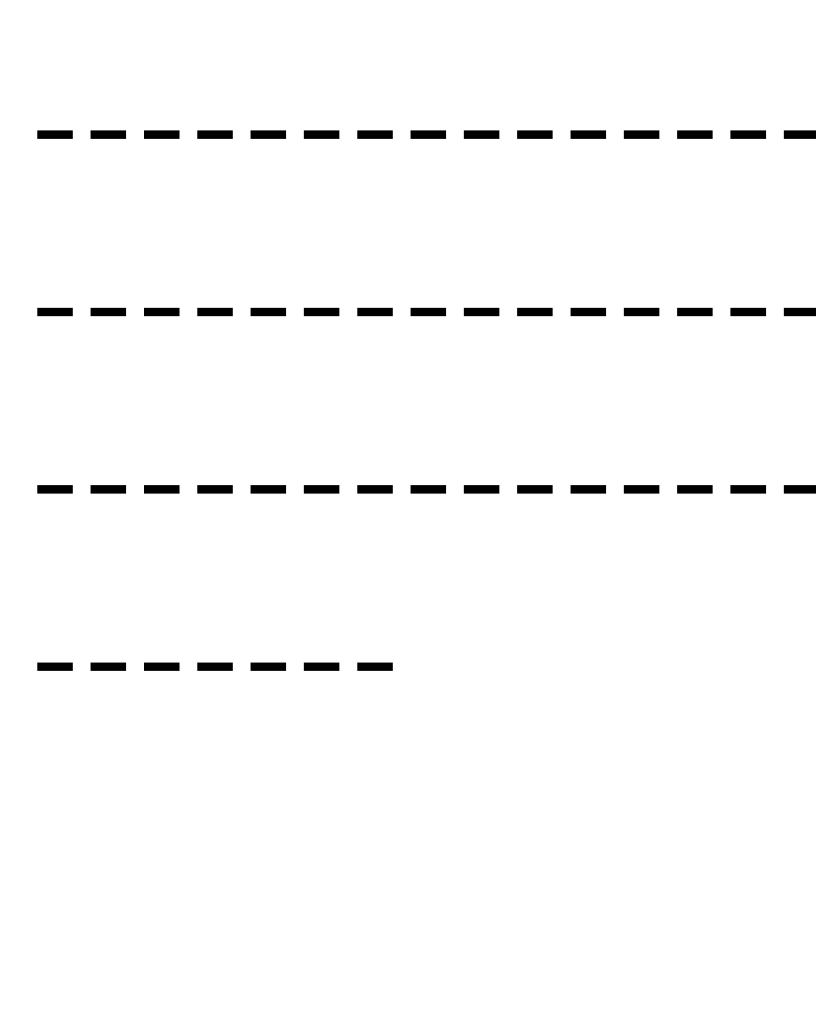
#### DOLO 650

## Physician License#: 1780673376

#### Physician Name: SWARO()P Phone: (123) 456-7890

# Prescription Date: 10/10/2010





# DME ATTACHMENT (B)

TCN #:

#### 0539476744

Service Cd: E8000 TAR Service Num:

Specific Comments from Provider Replacement:

#### Replacement Reason(s): Equipment lost Does

### not meet medical need Does not function properly

#### Unlisted Reason(s): Home Accessible: Y Safe

### Operation: Y Independent Operation: Y Ideal Patient Weight: 125

### Lbs Equipment Already in Home:

Item: Bed Rail

## Usage (Hrs / Day): 2

Turning schedule,

#### Every 5 Hours Unavailable Turning Surface: Back Reason: Bed

#### Sores

Blood Gas: pH: pCO2:

#### pO2: Saturation: O2 Liter Flow: Analysis Date

### Blood Tests: Hemoglobin: 111

### Hematocrit: 111

#### Albumin: 1.1 Lab Date: 02/02/2010

For Repairs,

#### Information about this equipment: Serial #: SL121212

#### Manufacturer MNF232323 Model: MD32323 Warranty

#### Expiration Date: 10/10/2055 Purchased By Medi-Cal

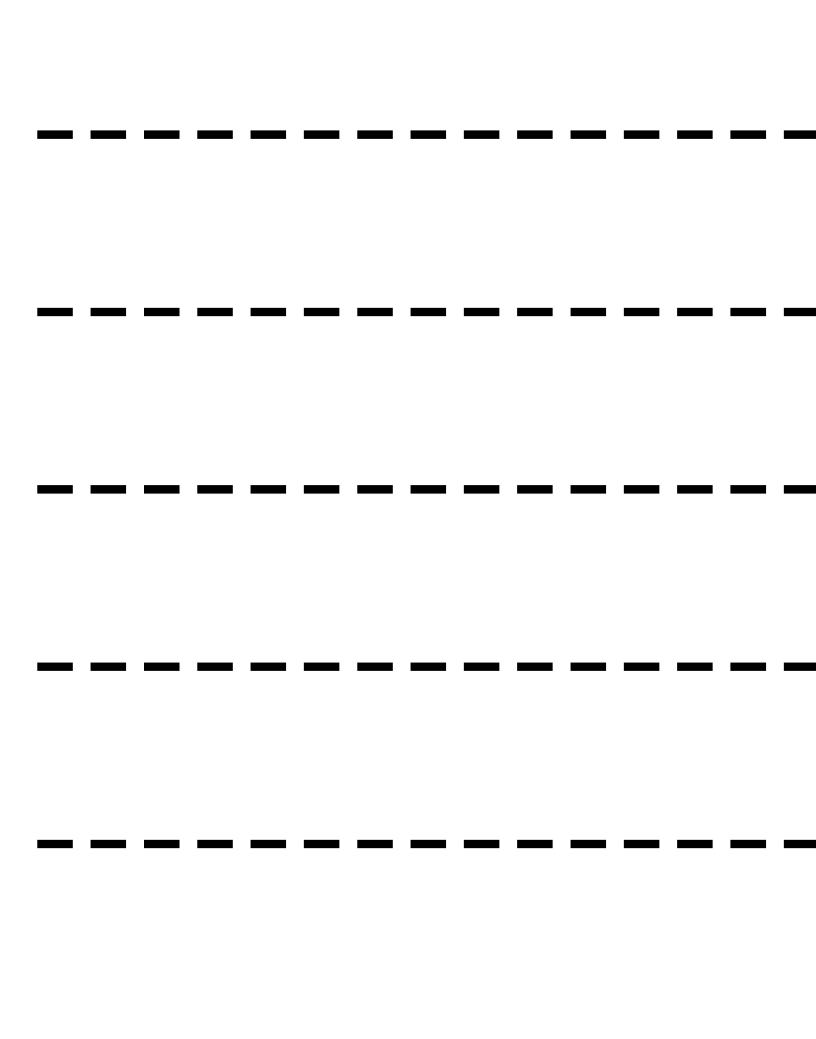
# Purchase Date: 10/10/2000

#### Equipment

#### Trial Period: Begin Date: 02/02/2010 End Date: 02/10/2010

#### Result:

## Incompatible with patient



#### VISION ATTACHMEN

#### (G) - Vision -Contact Lens

TCN #: 0539476744

#### Service Cd: V2799 TAR Service Num: 3

### Date of Comprehensi e Eye Exam: N/A Date of Prior Eye

#### Exam: N/A Replacement: Y Reason(s) Does not function

### properly, Doe not meet medical needs, Equip damaged

### beyond repai First Time Wearer: N Uncorrected Visual Acuity:

#### Distance (RE): 1 Near (RE): 1 Distance (LE): Near (LE):

1

# Refraction Results: Sphere (RE)

### 1 Diopters Cylinder (RE): 1 Diopters Axis (RE): 1 Degrees

## Add Power (RE): 1 Diopters Sphere (LE) 1 Diopters

### Cylinder (LE): 1 Diopters Axis (LE): 1 Degrees Add Power

# (LE): 1 Diopters

# Best Correcte Visual Acuity:

#### Distance (RE): 1 Near (RE): 1 Distance (LE): Near (LE):

1

# Keratometry (RE): 1 Keratrometry

#### (LE): 1 Grade of Mire Distortion (RE): +1Grade of Mire

#### Distortion (LE +1 Contact Lens: Wear (RE): Extended

## Wearing Schedule (RE) 1-day Wear (LE): Extended Wearing

### Schedule (LE) 1-day Base Curve (RE): 1 Diameter (RE)

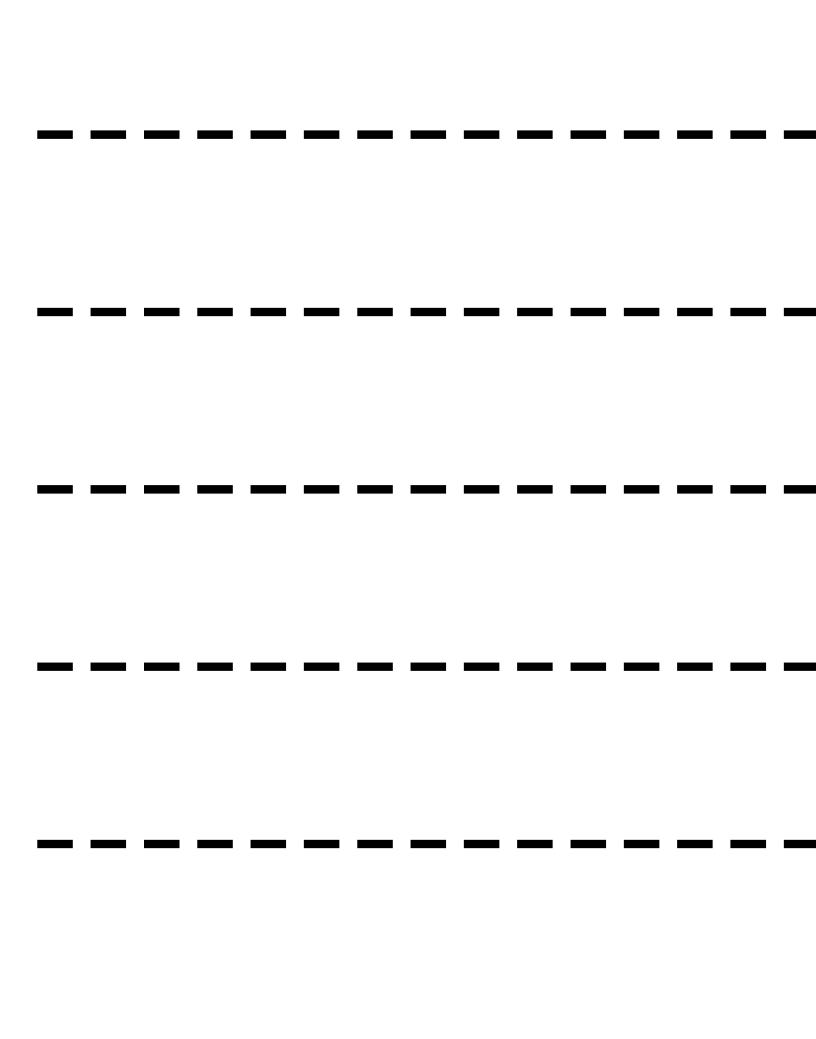
#### Powe 1 mm (RE): 1 Diopters Base Curve (LE): 1

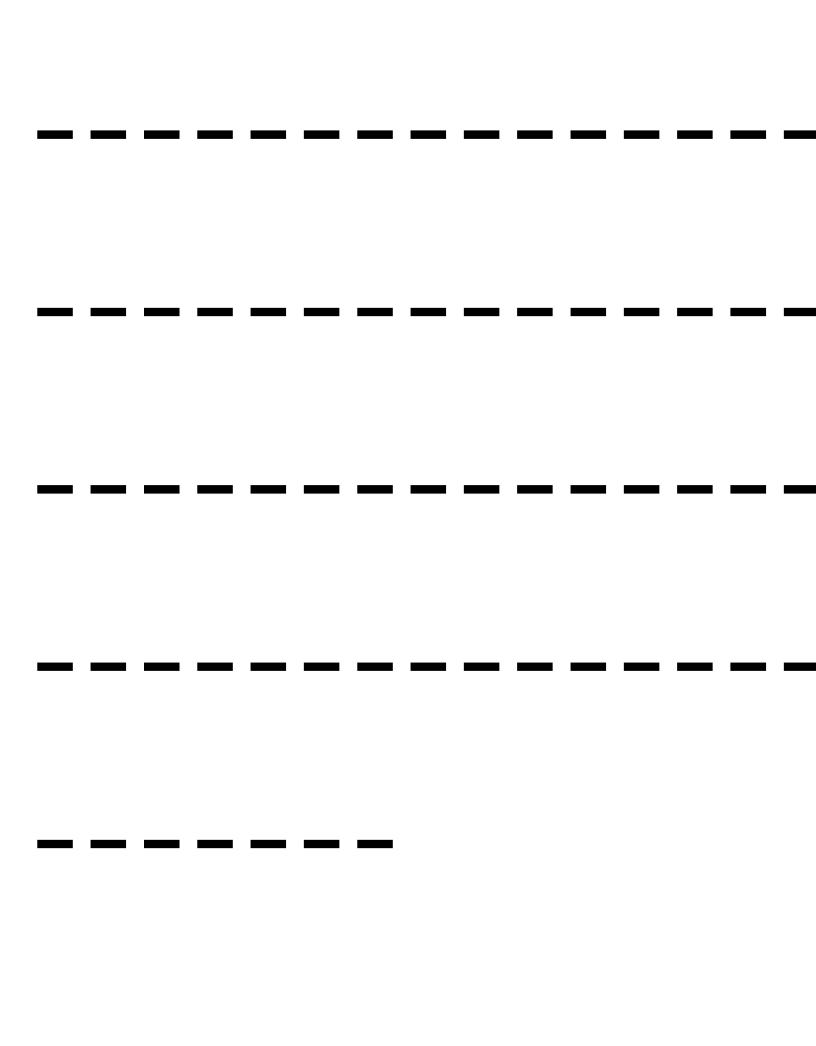
#### Diameter (LE) Powe 1 mm (LE): 1 Diopters

## Visual Acuity thru Eye Appliances (RE): 1 Visua Acuity thru

#### EYE Appliances (LE): 1 Manufacturer (RE): 1

#### Model (RE): 1 Manufacturer (LE): 1 Model (LE): 1





## LTC SUBACUTE ATTACHMEN (F)

# TCN#: 0539476744

#### PAS/PASRR

#### Information:

Exempt Reason: Self

### Certification: Date Completed: DDS/DMH Referral

## Reason: DDS/DMH Referral Date: Community Placement:

#### DDS/DMH Response: Level II Self Certification: Level II N

#### Date:

Sub acute car service information:

### Pediatric/Adu t Care: Pediatric Patient's condition

#### warrants 24hour nursing care by an RN N

Summarize

#### care requirements for each shift: TEST 123

# Qualifying Conditions:

A--Patient has a

#### tracheostomy and requires mechanical ventilation (at least 12-

### hours/day for adult - at leas 6-hours/day for pediatric): Yes

# B--Patient has

tracheostomy and requires

## suctioning (at least 6hours/day for pediatric) and room air mist

#### oroxygen plus one of the treatment procedures: No

## Administratio n of at least three

# treatment procedures: No

D--

## Dependence on total parenteral nutrition (TPN) or othe

#### intravenous nutritional support plus one of the treatment

# procedures. Not applicabl to adult: No

Treatment

#### Procedures Related To Th Qualifying Condition:

### **A**--Continuous o intermittent ıntravenous (IV) therapy

### (via periphera or central line): Yes Reason:

Glucose Drips

#### Frequency: 1 Hrs/Day Rate: 1 cc/hr

B--Tube

#### feeding (nasograstic Or gastrostomy): No

## Frequency and Rate:

C--Total parenteral

#### nutrition (TPN). Not applicable to pediatric: No

### D--Inpatient phsyical, occupational, and/or speed therapy at

### least 2 hours/day, 5 days/week. Not applicable to pediatric:

#### No

E-Inhalation/res
piratory

### therapy treatments at least 4 times per 24 hour period (not

### self administered by resident. Not applicable to pediatric:

#### No

# F--Wound debridement, packing, and

### medicated irrigation with/without whirlpool therapy. Not

# applicable to pediatric: No Explanation:

G--Peritoneal

### dialysis treatments requiring at least 4 exchanges

#### every 24 hours. Not applicable to adult: No

### H--Other dail medical technologies required continuously

which require the services o a professiona nurse. Not applicable to

#### adult: No Summarize care:

I--Intermitten

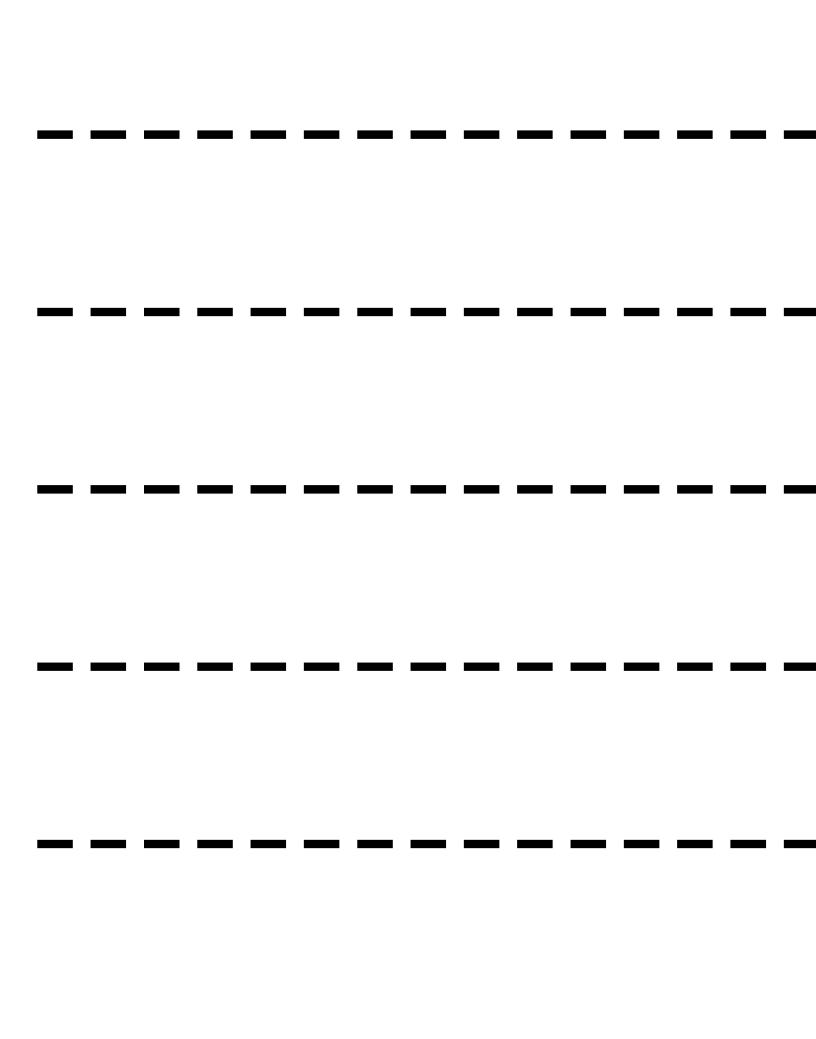
#### suctioning (nontracheostomy at least every 8 hours and

#### room air mist or oxygen. Not applicable to adult: No

#### The patient has potential for discharge from a subacute care

### unit to a lowe level of care (skilled nursing facilit or home): No

#### Explanation:



# Date Time Printed: 10Mar-2025

#### 12:11:48