Zhinian Wan, M.D. Inc.
3737 Martin Luther King Jr. Suite 404
Lynwood, CA 90262
Phone: (424) 213-4290 Fax: (424) 213-4295

Surgery /Procedure Authorization

Date: _____

Attn: _____ Fax # _____

Patient Name: _____ D. O. B. _____

Based on medical necessity, **Zhinian Wan, M.D.** is requesting that the following procedure(s) be authorized

Date of Surgery: _____ **ICD-9**(s):_____

Diagnosis: _____

_____

CPT Code: _____

Procedure(s): _____

_____

_____

Postoperative Therapy: _____ times per week _____weeks

Special Supplies / equipment: _____

Please Sign and fax back to (424) 213-4295 with your signature. If your office has any questions, please call our office at (424) 213-4290. Thank you for your prompt attend concerning this matter.

_____ _____
Signature of adjuster/Case Manager Date

_____
Printed Name of Person Authorizing Service