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MFP

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02/05/2015 11:59

Job No.: 047437 Total Time: 0°01'18" Page: 004

Complete

Document: doc04743720150205114425

State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☑ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle): SANTILLAN, MARIADEL ROSARIO
Date of Injury (MM/DD/YYYY): Date of Birth (MM/DD/YYYY): 03/26/1987
Claim Number: PENDING Employer: PREMIER STAFFING

Treating Physician Information

Name: DR.MACIEJ MAJZEL, DC , QME
Practice Name: CHIROPRACTIC CORPORATION Contact Name: MADELINE
Address: 8200 WILSHIRE BLVD SUITE P10 City: LOS ANGELES State: CA
Zip Code: 90048 Phone: (323) 934-0423 Fax Number: (323) 934-4702
Specialty: NPI Number: 1568747854
E-mail Address:

Claims Administrator Information

Company Name: YORK CLAIM SERVICES Contact Name:
Address: PO BOX 619073 City: ROSEVILLE State: CA
Zip Code: 95661 Phone: (951) 231-5500 Fax Number: (800) 540-2057
E-mail Address:

Requested Treatment (see instructions for guidance; attach additional pages if necessary)

List each specific requested medical services, goods, or items in the below spaces or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
SEE ATTACHMENT		SEE ATTACHMENT		SEE ATTACHMENT.

Requesting Physician Signature: Date: 2/4/15

Claims Administrator Utilization Review Organization Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (If assigned): Date:
Authorized Agent Name: Signature:
Phone: Fax Number: E-mail Address:
Comments:

DWC Form RFA (Effective 2/2014) Page 1

No.	Date and Time	Destination	Times	Type	Result	Resolution/ECM
001	02/05/15 11:58	918665482637	0°01'18"	FAX	OK	200x100 Normal/On

[NHJ2Y01003]

PATIENT NAME

SANTILLAN, MARIA DEL ROSARIO CLAIIM # PENDING DOI: 1/1/12-4/8/14

DIAGNOSIS

CERVICAL MUSCULOLIGAMEANTOUS STR/SPR

THORACIC MUSCULOLIGAMEANTOUS STR/SPR

LUMBOSACRAL MUSCULOLIGAMEANTOUS STR/SPR WITH RADICULITIS

LEFT KNEES STR/SPR, R/O INTERNAL DERANGEMENT

ICD CODE

847.0

847.1

846.0

844, 717.9

SERVICE GOOD/REQUESTED

CHIROPRACTIC EVALUATION AND TREATMENT

CPT-HCPCS

97001, 97016, 97032, 97035, 97026, 97010, 98940, 97530, 97110, 97124

FREQUENCY

2X6 WEEKS