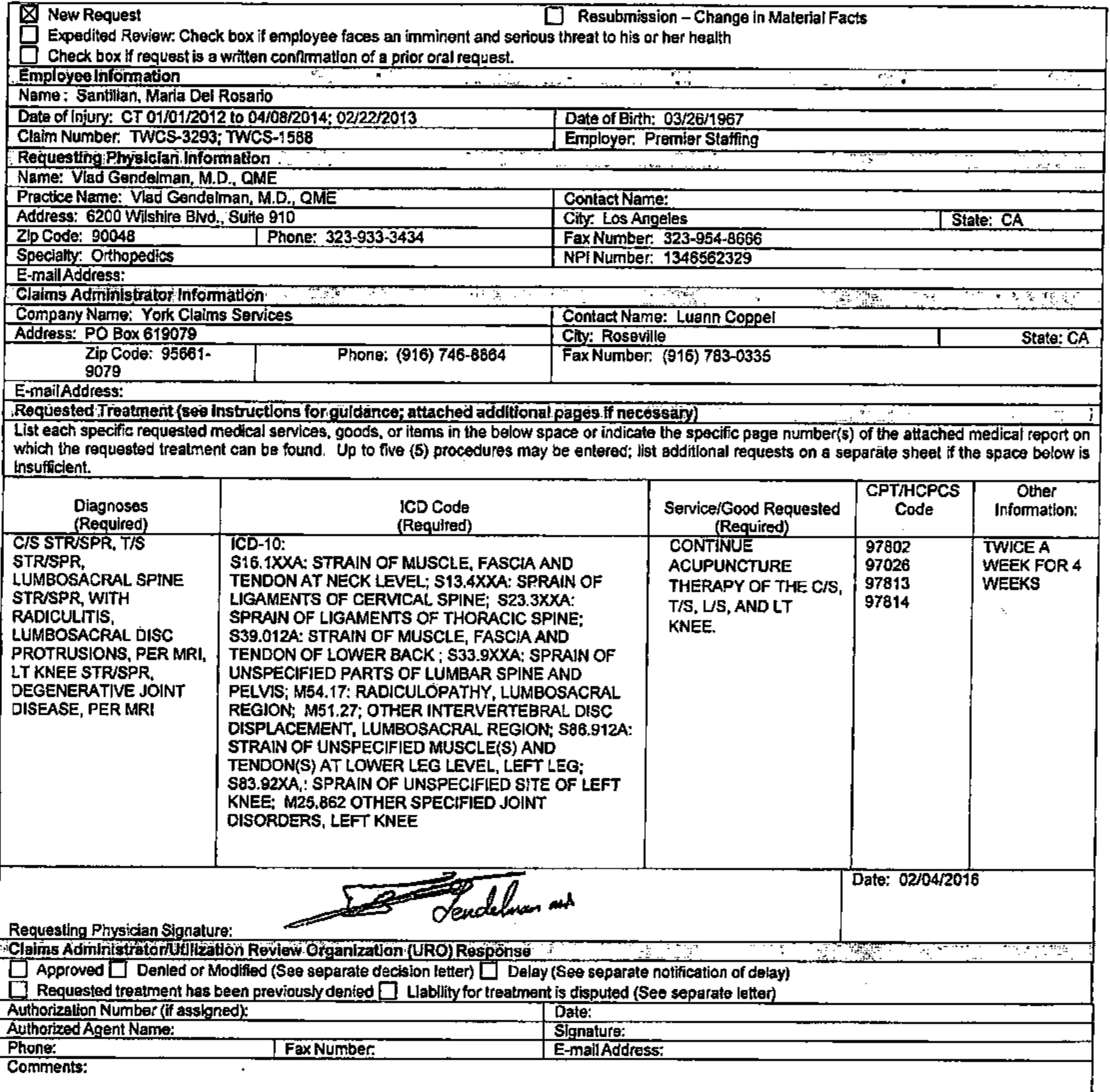
State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

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: Santillan, Maria Del Rosario	
Date of Injury: CT 01/01/2012 to 04/08/2014; 02/22/2013	Date of Birth: 03/26/1967
Claim Number: TWCS-3293; TWCS-1588	Employer: Premier Staffing

Requesting Physician Information

Name: Vlad Gendelman, M.D., QME			
Practice Name: Vlad Gendelman, M.D., QME		Contact Name:	
Address: 6200 Wilshire Blvd., Suite 910		City: Los Angeles	State: CA
Zip Code: 90048	Phone: 323-933-3434	Fax Number: 323-954-8666	
Specialty: Orthopedics		NPI Number: 1346562329	
E-mail Address:			

Claims Administrator Information

Company Name: York Claims Services		Contact Name: Luann Coppel	
Address: PO Box 619079		City: Roseville	State: CA
Zip Code: 95661-9079	Phone: (916) 746-6864	Fax Number: (916) 783-0335	
E-mail Address:			

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

List each specific requested medical services, goods, or items in the below space 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.

Diagnoses (Required)	ICD Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code	Other Information:
C/S STR/SPR, T/S STR/SPR, LUMBOSACRAL SPINE STR/SPR, WITH RADICULITIS, LUMBOSACRAL DISC PROTRUSIONS, PER MRI, LT KNEE STR/SPR, DEGENERATIVE JOINT DISEASE, PER MRI	ICD-10: S16.1XXA: STRAIN OF MUSCLE, FASCIA AND TENDON AT NECK LEVEL; S13.4XXA: SPRAIN OF LIGAMENTS OF CERVICAL SPINE; S23.3XXA: SPRAIN OF LIGAMENTS OF THORACIC SPINE; S39.012A: STRAIN OF MUSCLE, FASCIA AND TENDON OF LOWER BACK ; S33.9XXA: SPRAIN OF UNSPECIFIED PARTS OF LUMBAR SPINE AND PELVIS; M54.17: RADICULOPATHY, LUMBOSACRAL REGION; M51.27; OTHER INTERVERTEBRAL DISC DISPLACEMENT, LUMBOSACRAL REGION; S86.912A: STRAIN OF UNSPECIFIED MUSCLE(S) AND TENDON(S) AT LOWER LEG LEVEL, LEFT LEG; S83.92XA,: SPRAIN OF UNSPECIFIED SITE OF LEFT KNEE; M25.862 OTHER SPECIFIED JOINT DISORDERS, LEFT KNEE	CONTINUE ACUPUNCTURE THERAPY OF THE C/S, T/S, L/S, AND LT KNEE.	97802 97026 97813 97814	TWICE A WEEK FOR 4 WEEKS

Requesting Physician Signature: Gendelman MD	Date: 02/04/2016

Claims Administrator/Utilization Review Organization (URO) 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:		

Referral for Services to:
Maciej Majzel DC, QME
Chiropractic Corporation

[X] 6200 Wilshire Blvd., Suite 910, Los Angeles, CA 90045 Phone: 323-934-0423 Fax: 323-934-4762

[ ] 14557 Friar Street, Unit 82, Van Nuys, CA 91411 Phone: 818-616-5500 Fax: 818-616-5592

Patient Name: Santillan, Maria DoB: 3/24/1967

Patient Phone Num: ____ Date of Injury: CT: 1/1/12 - 1/18/14 [X] Work Comp [ ] Personal Injury

Diagnosis: C/S, T/S, L/S, (L) knee

Referred by: Vlad Gendelman

Address: 6200 Wilshire Blvd. ste. # 910 Los Angeles, C.A. 90048

Phone Num: (323) 933-3434 Fax Num: (323) 954-8666

[ ] *PHYSICAL THERAPY* [ ] *CHIROPRACTIC* [X] *ACUPUNCTURE* [ ] *BIOFEEDBACK* [ ] *HYPNOTHERAPY*

Frequency of Treatment: 2 times per week for 4 weeks.

PRECAUTIONS: ____

Weight Beaking Status: ____

TREATMENT PLAN:

[ ] Evaluate and treat	[ ] Cervical Program	[ ] HEP
[ ] Back program	[ ] Elbow program	[ ] Wrist / Hand program
[ ] Shoulder program	[ ] Knee program	[ ] Ankle / Foot program
[ ] Hip program	[ ] Alignment& Body Mechanics	[ ] Strength Training program

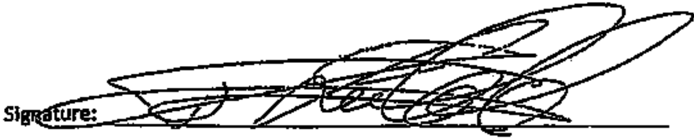
[X] Other Continue TX.

[ ] Return to Work program

[ ] Neck [ ] Back or [ ] Spinal Surgery Program

[ ] Post Surgical program

Surgery Date: ____ Type of Surgery: ____



Signature: ____ Date: FEB 04 2016

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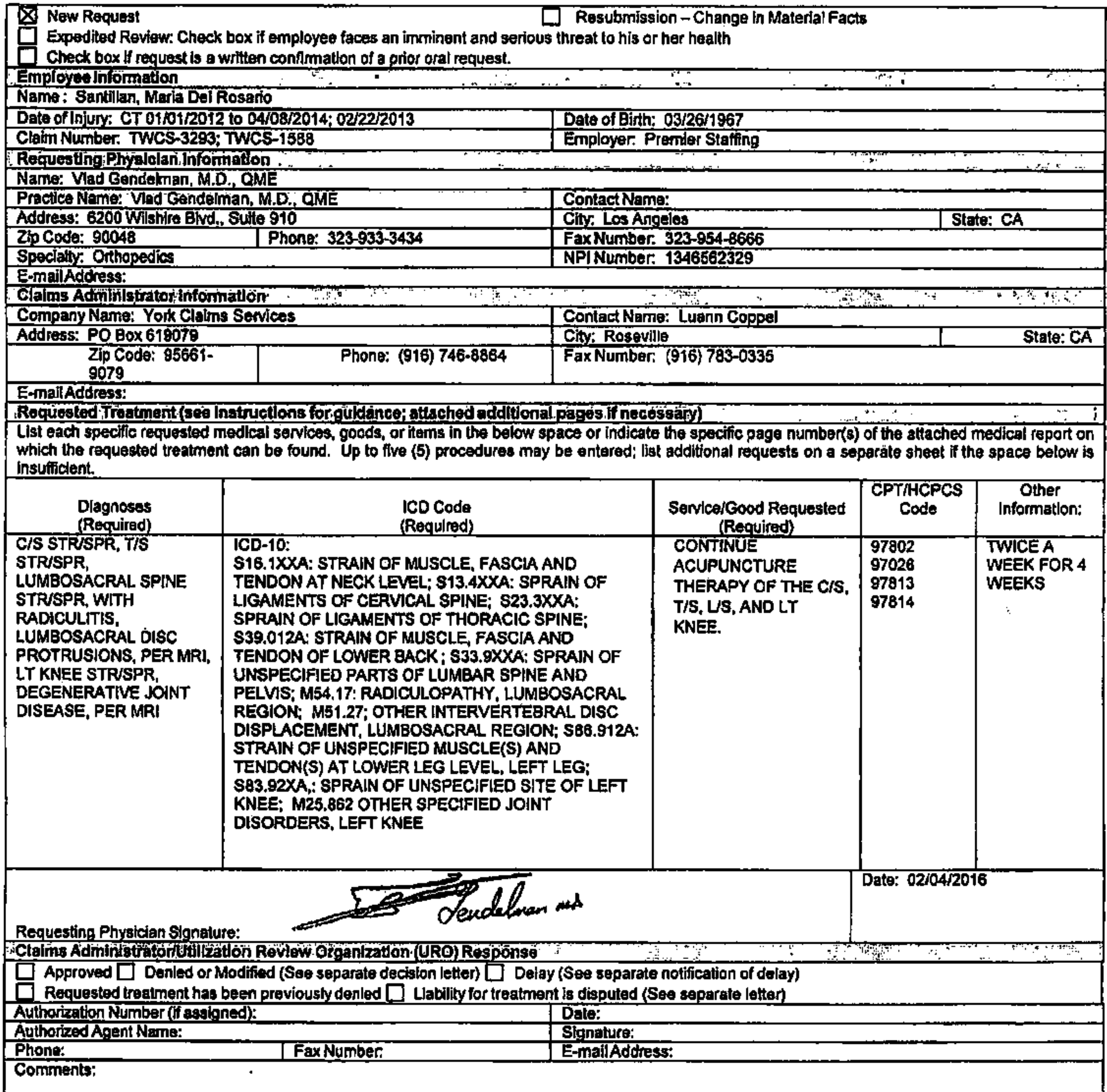

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Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		