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		Date of Birth: 03/26/1967	
Claim Number: TWCS-3293		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) 746-8864	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 (if known)	Other Information: (Frequency, Duration Quantity, Facility, etc.)
LT KNEE STR/SPR, DEGENERATIVE JOINT DISEASE, PER MRI	ICD 10 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	INTRA-ARTICULAR INJECTION OF 1 CC OF 40 MG KENALOG AND OF 9 CC OF 2% LIDOCAINE INTO THE LEFT KNEE	20610; J3301	
SAME AS ABOVE INCLUDING C/S STR/SPR T/S STR/ SPR LUMBOSACRAL SPINE STR/SPR W/ RADICULITIS LUMBOSACRAL DISC PROTRUSIONS, PER MRI	SAME AS ABOVE INCLUDING 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.	CONTINUE ACUPUNCTURE THERAPY OF THE CERVICAL SPINE, THORACIC SPINE, LUMBAR SPINE AND LEFT KNEE	97802, 97026, 97813, 97814	2 TIMES A WEEK FOR 4 WEEKS

Requesting Physician Signature: Gendelman md Date: 03/10/2015

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:		

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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) 746-8864	Fax Number: (916) 783-0335	
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Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		