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.

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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 : Santilian, Maria Del Rosario												
Date of Injury: CT 01/01/2012 TO 04/08/2014				Date of Birth: 03/26/1987								
Claim Number: TWCS-		The second secon	,	Employer: Premier Staffing								
Requesting Physician Information Name: Vlad Gendelman, M.D., QME												
Practice Name: Viad Genderman, M.D., QME Contact Name:												
Address: 6200 Wishire Blvd., Suite 910				City: Los Angeles	State: CA							
Zip Code: 90048 Phone: 323-933-3434				Fax Number: 323-954-8666			Otate. Ort					
Specialty: Orthopedics		10.10. 020 000 0.10.		NPI Number: 1346562329								
E-mail Address:												
Claims Administrator Information												
Company Name: York C				Contact Name: Luann Cop	pel	· · · · · · · · · · · · · · · · · · ·						
Address: PO Box 61907		· · · · · · · · · · · · · · · · · · ·		City: Roseville			State: CA					
Zip Code: 95661-9079		hone: (916) 746-8864		Fax Number: (916) 783-03	35							
E-mail Address:												
Requested Treatment (see instruction	s for guidance; attached additional	page	a if necessary)	· · · · · · · · · · · · · · · · · · ·		•					
List each specific reques	ited medical sen	rices, goods, or items in the below s	pace o	or Indicate the specific page r	number(s) of the	attached me	dical report on which the					
requested treatment can	be found. Up to	five (5) procedures may be entered	; list a	dditional requests on a sepa	rate sheet if the	space below						
	1		_				Other Information:					
Diagnoses		ICD Code	8	Servica/Good Requested	СРТ/НО		(Frequency, Duration					
(Required)		(Required)		(Required)	Code (if i	nown)	Quantity, Facility, etc.)					
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	DISORDERS,		i									
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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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DWC Form RFA (Effective 2/2014)

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.

Check box if region. Check box if amployee faces an imminent and serious threat to his or her health	New Request Resultmission - Change in Maladat Foots												
Detect bos if request is a written confirmation of a prior oral request.													
Employee-Information National Regional Date of Binn: 03/28/1997 Dat	Check has 8 assumed a width a width and serious threat to his or her health												
Name: Settlitien, Maria Del Rosardo Date of Billy: C7 001/02012 TO 0040862014 Date of Billy: C7 001/02012 TO 0040862014 Date of Billy: C7 001/02012 TO 0040862014 Employer: Promiser Statling Requesting Physical Rifformassion. Name: Vand Genderham, M.D., OME Process Promose Statling Requesting Physical Rifformassion. Name: Vand Genderham, M.D., OME Address: 820 Wilshike Bild. Speedally: Orthopodics Phone: 323-984-9868 Phone: 323-984-9868 State: CA Fox Number: 1346562329 Fox N	Employees to the control of the cont												
Date of Binn: contract to the rosals of the rosals of the rosals of the processor of the pr			St. 100			T							
Claim Number: TVICS-1289	Name: Samuan, Maria Del Rosario												
Requesting Physicilan Filinformation. Contract Name: Vast Gendelman, M.D., OME	Claim Number 71/07	/2012 10 04/08/2014											
Name: Vad Gendelman, M.D., GME Practice Name: Vad Gendelman, M.D., GME Address: Reso Writishe But, Suite 910 City: Les Argeles City: Resolution: 1346552325	Posteration Blanchill 2	3293		Employer: Premier Staffing									
Practice Name: Vad Gendefshae, N.D., OME Address: 8000 Milble BMJ, \$19 910 Dity Code: 80046 Prone: \$23-93-344 Fex.Number: \$23-93-345-8688 State: CA Prone: \$23-93-344 Fex.Number: \$1346562323 NPF Number: \$1346562323 NPF Number: \$1346562323 NPF Number: \$1346562323 NPF Number: \$1346562323 Company Name: York Cams Sewbas Address: F0 Gos 19079 Phone: \$1957 Phone: \$195745-8884 Fax.Number: \$1957 Fax.Number: \$195745-8884 Fax.Number: \$1957 Phone: \$195745-8884 Fax.Number: \$1957 Phone: \$195745-8884 Fax.Number: \$1957 Fax.Number: \$195745-8884 Fax.Number: \$1957 Phone: \$195745-8884 Fax.Number: \$1957 Phone: \$195745-8884 Fax.Number: \$1957 Fax.Number: \$195745-8884 Fax.Number: \$195745-9897 Didgnoses ICD Code Sevice/Good Requested CPT/TH/CPCS Code (If Nown) Didgnoses ICD 10 Sevice/Good Requested CPT/TH/CPCS Code (If Nown) Didgnoses ICD 10 NUSCLEIS: AND TENDON(S) AT LOWER AND TENDON SER LEFT NEE: JOHN DISCROEPR LEFT NEE: JOHN	Insqueening rijysician information.												
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Contact Name: Luann Coppet C		Prione: 323-933-3434											
Company Name: Vot Calims Services Company Name: Vot Calims Services Company Name: Vot Calims Services Address: PO Box 619079 Phone: (616) 746-8864 Fax Number: (916) 783-0335 State: CA 2			NPI Number: 1346562329	NPI Number: 1346562329									
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Email Address: Requiseld Treatment (en) be instructions for guildance; strached additional pages (f. nebessary) List sech 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. Disgonases (Required) (Quantity, Facility, etc.) LIT KNEE STR/SPR, DISGONERATIVE JOINT DISGONERAL LEFT LEG, 838,322A: SPRAIN OF UNSPECIFIED JOINT DISGONERS, LEFT KNEE STR SPR LEG LEVEL, LEFT LEG, 838,322A: SPRAIN OF LIGONERAL LEFT KNEE Wissoners and the specific page of the specific page number(s) of the attached medical reports on which the control of the attached medical reports on which the required in the page of the page number(s) of the attached medical reports on which the required in the page number(s) of the attached medical reports on which the required in the page number(s) of the attached medical reports on which the required of COPTINE (Required) (Required) (CPTINECPS COPTINE (Required) (Required) (CPTINECPS COPTINE (Required) (Required) (CPTINECPS COPTINE (Required) (Required) (Required) (CPTINECPS COPTINE (Required) (Requ	Zin Code: 05881-0070					State: CA							
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