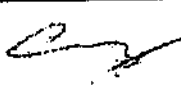


**State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA**

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 6021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

<input checked="" type="checkbox"/> New Request		<input type="checkbox"/> Resubmission - Change in Material Facts		
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health				
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.				
Employee Information				
Name: Santillan, Maria Del Rosario		Date of Birth: 03/26/1967		
Date of Injury: CT 01/01/2012 TO 04/08/2014		Employer: Premier Staffing		
Claim Number: TWCS-3293				
Requesting Physician Information				
Name: Vlad Gendelman, M.D., QME		Contact Name:		
Practice Name: Vlad Gendelman, M.D., QME		City: Los Angeles		
Address: 6200 Wilshire Blvd., Suite 910		State: CA		
Zip Code: 90048		Phone: 323-933-3434		
Specialty: Orthopedics		Fax Number: 323-954-8666		
E-mail Address:		NPI Number: 1346562329		
Claims Administrator Information				
Company Name: York Claims Services		Contact Name: Luann Coppel		
Address: P.O. Box 619079		City: Roseville		
Zip Code: 95661-9079		State: CA		
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.)
CERVICAL SPINE STRAIN/SPRAIN THORACIC SPINE STRAIN/SPRAIN LUMBOSACRAL SPINE STRAIN/SPRAIN WITH RADICULITIS LUMBOSACRAL DISC PROTRUSIONS, PER MRI LEFT KNEE STRAIN/SPRAIN, DEGENERATIVE JOINT DISEASE, PER MRI	ICD-10 S13.4XXA: SPRAIN OF LIGAMENTS OF CERVICAL SPINE S16.1XXA: STRAIN OF MUSCLE, FASCIA & TENDON AT NECK LEVEL S23.3XXA: SPRAIN OF LIGAMENTS OF THORACIC SPINE S33.9XXA: SPRAIN OF UNSPECIFIED PARTS OF LUMBAR SPINE & PELVIS S39.012A: STRAIN OF MUSCLE, FASCIA & TENDON OF LOWER BACK M54.17: RADICULOPATHY, LUMBOSACRAL REGION M51.27: OTHER INTERVERTEBRAL DISC DISPLACEMENT, LUMBOSACRAL REGION S83.92XA: SPRAIN OF UNSPECIFIED SITE OF LEFT KNEE S86.912A: STRAIN OF UNSPECIFIED MUSCLE(S) & TENDON(S) AT LOWER LEG LEVEL, LEFT LEG M17.12: UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	CONTINUE ACUPUNCTURE THERAPY OF THE CERVICAL SPINE, THORACIC SPINE, LUMBAR SPINE, AND LEFT KNEE	97802, 97026, 97813, 97814	2X/WK FOR 4 WKS
SAME AS ABOVE INCLUDING HEADACHES	SAME AS ABOVE INCLUDING R51: HEADACHE	PHYSICAL PERFORMANCE FCE	97750	
Requesting Physician Signature: 			Date: 04/07/2016	
Claims Administrator/Utilization Review Organization (URO) Response:				
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay)				
<input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)				
Authorization Number (if assigned):		Date:		
Authorized Agent Name:		Signature:		
Phone:		Fax Number:		E-mail Address:
Comments:				