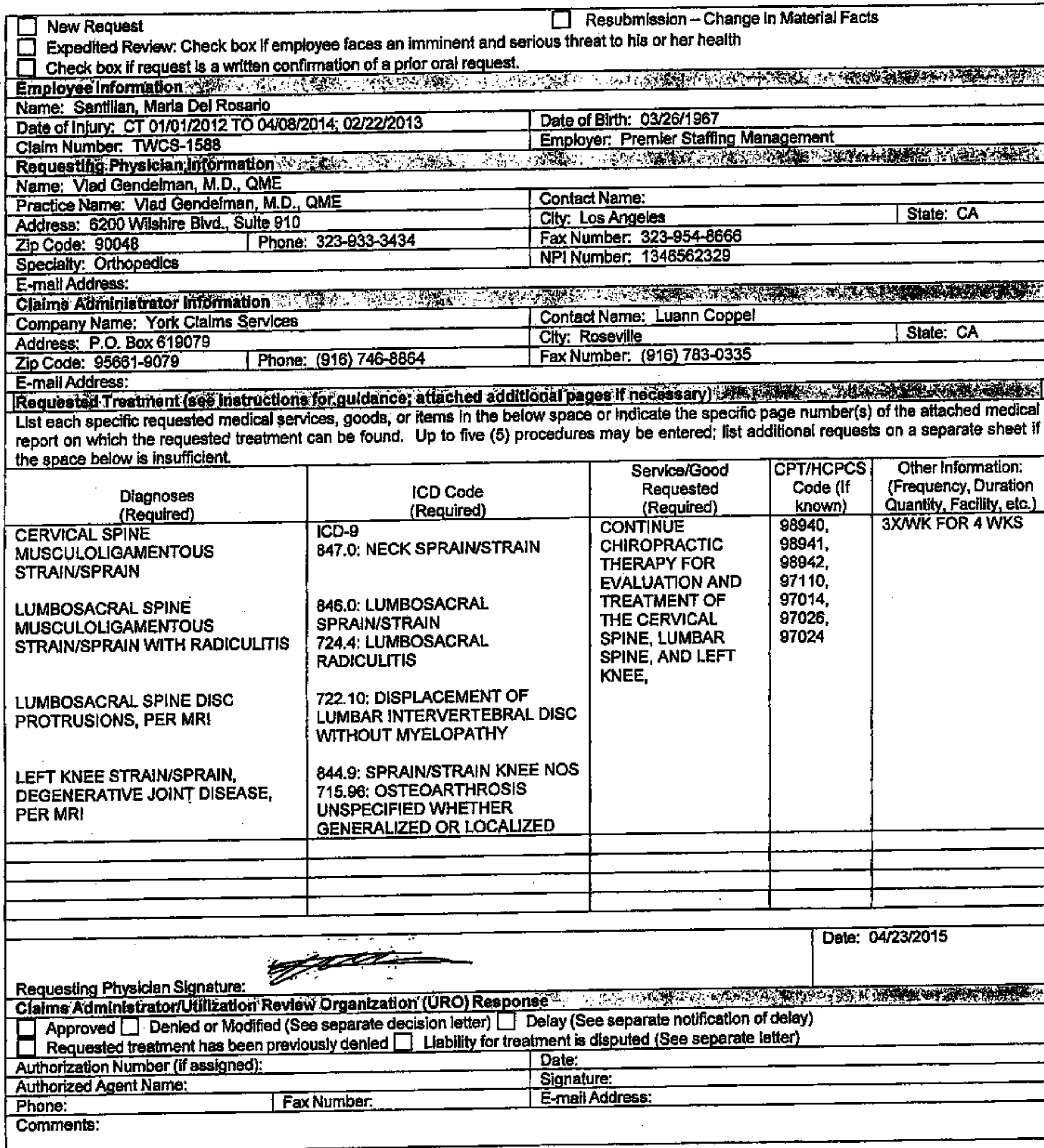
State of California, Division of Workers' Compensation

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-1588 | Employer: Premier Staffing Management

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: P.O. 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.)
CERVICAL SPINE MUSCULOLIGAMENTOUS STRAIN/SPRAIN LUMBOSACRAL SPINE MUSCULOLIGAMENTOUS STRAIN/SPRAIN WITH RADICULITIS LUMBOSACRAL SPINE DISC PROTRUSIONS, PER MRI LEFT KNEE STRAIN/SPRAIN, DEGENERATIVE JOINT DISEASE, PER MRI	ICD-9 847.0: NECK SPRAIN/STRAIN 846.0: LUMBOSACRAL SPRAIN/STRAIN 724.4: LUMBOSACRAL RADICULITIS 722.10: DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY 844.9: SPRAIN/STRAIN KNEE NOS 715.96: OSTEOARTHROSIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED	CONTINUE CHIROPRACTIC THERAPY FOR EVALUATION AND TREATMENT OF THE CERVICAL SPINE, LUMBAR SPINE, AND LEFT KNEE,	98940, 98941, 98942, 97110, 97014, 97026, 97024	3X/WK FOR 4 WKS

Requesting Physician Signature: [signature] | Date: 04/23/2015

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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Employee Information

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Requesting Physician Information

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Practice Name: Vlad Gendelman, M.D., QME | Contact Name:
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Zip Code: 90048 | Phone: 323-933-3434 | Fax Number: 323-954-8666
Specialty: Orthopedics | NPI Number: 1346562329
E-mail Address:

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☐ 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

5/28/1[illegible]

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

[ ] 14557 Friar Street, Unit B2, Van Nuys, CA 91411 Phone: 818-616-5500 Fax: 818-616-5592

#7323

Patient Name: Maria Santillan DoB: 3/26/1967

Patient Phone Num: ______ Date of Injury: 2/22/13, CT 1/1/12-4/8/14 [X] Work Comp [ ] Personal Injury

Diagnosis: C/S, L/S, Lt 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 [ ] ACUPUNCTURE [ ] BIOFEEDBACK [ ] HYPNOTHERAPY

Frequency of Treatment: 3 times per week for 4 weeks.

PRECAUTIONS: Continue Tx. Tues/W/TH.

Weight Bearing Status: 9 9:30/

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

[ ] Other ______

[ ] Return to Work program

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

[ ] Post Surgical program

Surgery Date: ______ Type of Surgery: ______

Signature: [signature] Date: 4/23/15