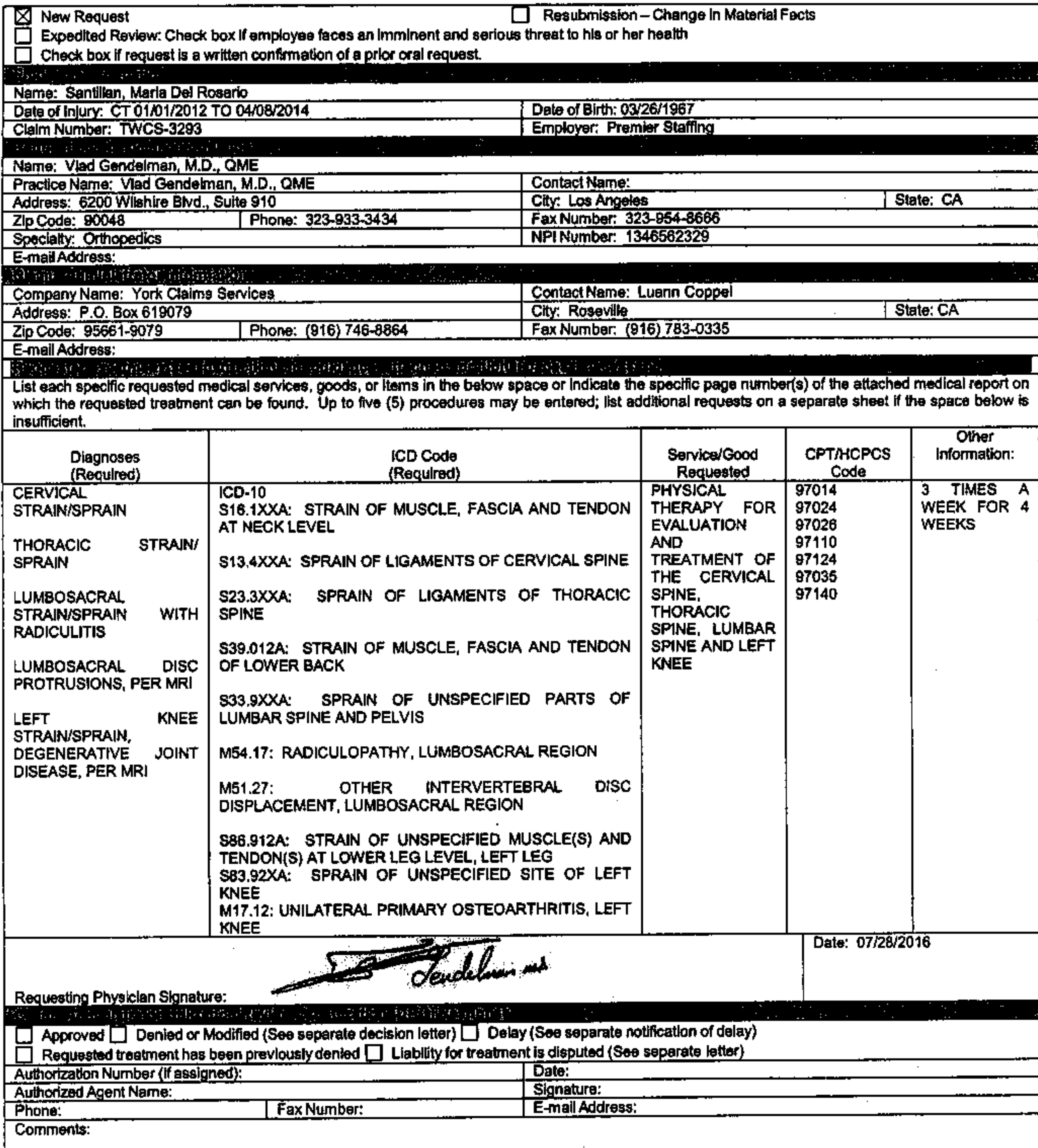
State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

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.

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

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:	

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:	

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	CPT/HCPCS Code	Other Information:
CERVICAL STRAIN/SPRAIN THORACIC STRAIN/ SPRAIN LUMBOSACRAL STRAIN/SPRAIN WITH RADICULITIS LUMBOSACRAL DISC PROTRUSIONS, PER MRI LEFT KNEE STRAIN/SPRAIN, 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 M17.12: UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	PHYSICAL THERAPY FOR EVALUATION AND TREATMENT OF THE CERVICAL SPINE, THORACIC SPINE, LUMBAR SPINE AND LEFT KNEE	97014 97024 97026 97110 97124 97035 97140	3 TIMES A WEEK FOR 4 WEEKS

Requesting Physician Signature: [signature] Date: 07/28/2016

☐ 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:	