§ 9785.5. Request for Authorization

State of California
Division of Workers' Compensation

Request for Authorization for Medical Treatment (DWC Form RFA)

To accompany the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or narrative report substantiating the requested treatment.

☐ Check box if the patient faces an imminent and serious threat to his or her health.
☐ Check box if request is written confirmation of a prior oral request.

Patient Information
Patient Name: Rosario Santillan
Date of Birth: 3-26-1967
Date of Injury: 2-22-2013
Employer: Premier Personnel Res.
Claim Number: TWCS-1588

Claims Administrator Information
Claims Administrator: York Claims
Adjustor Name: Luann Koppel
Address:
City, State, Zip:
Telephone Number: 916-746-8864
Fax Number: 866-548-2637

Provider Information
Provider Name: Aaron Coppelson, M.D.
Practice Name: U.S. HealthWorks MG
Address: 2499 So. Wilmington Ave.
City, State, Zip Code: Compton, CA 90220
Telephone Number: 310-638-1113
Fax Number: 562-295-5781
Provider Specialty: Occupational Medicine
Provider State License Number: A76120
National Provider ID Number: 1891775235

Requested Treatment: (See Instructions for guidance; attach additional pages if more space is required.)
Either state the requested treatment in the below space or indicate the specific page number(s) of the accompanying medical report on which the requested treatment can be found. Include supporting evidence as necessary. More than one treatment request may be included.

Diagnosis:	See attached report(s)
ICD Code:	724.5
Procedure Requested:	Epidural injection of his lumbar spine
CPT/HCPCS Code:	64483 - 64484
Other Information: (Frequency, Duration Quantity, Facility, etc.)	

8-9-13
Date of Request

Provider Signature

Claim Administrator Response Approving Treatment:
You may use this form for approving a treatment request. A request for additional information, or a decision to modify, delay, or deny a request for authorization cannot be made using this form. Please review all timeframes and requirements set forth in California Labor Code section 4610 and California Code of Regulations, title 8, sections 9792.9 and 9792.9.1.

A decision on the requested medical treatment must be made within five (5) working days from receipt of this request for authorization, or 14 calendar days with a timely request for information necessary to render a decision. For an expedited request, one made in a case of imminent or serious health threat, the maximum is 72 hours. Authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information.

☐ The requested treatment(s) is approved

☐ The request has been previously denied by utilization review

Date request for authorization received

Claims Administrator/Authorized Agent Signature

Date of response to request

Adjuster/Authorized Agent Name (print)