Referral for Services to:

Maciej Majzel DC, QME

Chiropractic Corporation

[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

Patient Name: Santillan Maria del Rosario DoB: 3/26/67

Patient Phone Num: Date of Injury: 2/22/13 CT 01/01/12 - 4/18/14 [X] Work Comp [ ] Personal Injury

Diagnosis: C/S, T/S, L/S, L 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* [X] *ACUPUNCTURE* [ ] *BIOFEEDBACK* [ ] *HYPNOTHERAPY*

Frequency of Treatment: 2 times per week for 6 weeks.

PRECAUTIONS:

Weight Beaking Status:

TREATMENT PLAN:

[X] 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: Date: AUG 20 2015

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: 03/26/1957
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: Maira Sanchez	
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: 1194704643	
E-mail Address: mairas@acmemmg.com			

Claims Administrator Information

Company Name: York Claims Services, Inc.		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; attach 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 M/L STR/SPR THORACIC M/L STR/SPR LUMBOSACRAL M/L STR/SPR W/ RADICULITIS LUMBOSACRAL DISC HERNIATIONS WITH STENOSIS, PER MRI LT KNEE STR/SPR, DEGENERATIVE JOINT DISEASE, PER MRI	ICD-9: 847.0: NECK SPRAIN/STRAIN 847.1: THORACIC SPRAIN/STRAIN 846.0: LUMBOSACRAL SPRAIN/STRAIN, 724.4: LUMBOSACRAL RADICULITIS 722.10: DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC W/O MYELOPATHY 844.9: SPRAIN/STRAIN KNEE NOS 715.98: OSTEOARTHROSIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED	ACUPUNCTURE THERAPY FOR EVALUATION & TREATMENT OF THE CERVICAL SPINE, THORACIC SPINE, LUMBAR SPINE, & LEFT KNEE.	97802; 97026; 97813; 97814	2X/WK FOR 6 WKS
SAME AS ABOVE	SAME AS ABOVE	FLURBI (NAP) CREAM-LA (FLURBIPROFEN 20%/LIDOCAINE 5%/AMITRIPTYLINE 5%) 180 GM & GABACYCLOTRAM (GABAPENTIN 10%/CYCLOBENZAPRINE 6%/TRAMADOL 10%) 180 GM, TO APPLY A THIN LAYER TO THE AFFECTED AREAS BID TID	J8499	
HEADACHES	784.0: HEADACHE	CONSULTATION WITH A NEUROLOGIST	99245	

Requesting Physician Signature: [signature] Date: 08/20/2015

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:	

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-1586	Employer: Premier Staffing Management

Requesting Physician Information

Name: Vied Gendelman, M.D., QME			
Practice Name: Vied Gendelman, M.D., QME		Contact Name: Maira Sanchez	
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: 1194704643	
E-mail Address: mairas@acmemmg.com			

Claims Administrator Information

Company Name: York Claims Services, Inc.		Contact Name: Luann Coppel	
Address: P.O. Box 619079		City: Roseville	State: CA
Zip Code: 95661-9079	Phone: (916) 745-8664	Fax Number: (916) 783-0336	
E-mail Address:			

Request for Authorization (See instructions for guidance; attach additional pages as 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.)
LT KNEE STR/SPR, DEGENERATIVE JOINT DISEASE, PER MRI	844.9: SPRAIN/STRAIN KNEE NOS 715.98: OSTEOARTHROSIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED	LEFT KNEE ARTHROSCOPY WITH POSSIBLE PARTIAL MEDIAL MENISCECTOMY	29880 ve. 29881	
SAME AS ABOVE	SAME AS ABOVE	POSTOPERATIVE PHYSICAL THERAPY FOR LEFT KNEE	97014; 97024; 97026; 97110; 97124; 97035; 97140	3X PER WEEK FOR 4 WEEKS
SAME AS ABOVE	SAME AS ABOVE	PREOPERATIVE SCREENING	99201	

Requesting Physician Signature: Vied Gendelman MD Date: 08/20/2015

Claims Administrator Utilization Review (UR) 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:	

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: Maira Sanchez	
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: 1194704643	
E-mail Address: mairas@acmemmg.com			

Claims Administrator Information

Company Name: York Claims Services, Inc.		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 M/L STR/SPR THORACIC M/L STR/SPR LUMBOSACRAL M/L STR/SPR W/ RADICULITIS LUMBOSACRAL DISC HERNIATIONS WITH STENOSIS, PER MRI LT KNEE STR/SPR, DEGENERATIVE JOINT DISEASE, PER MRI	ICD-9: 847.0: NECK SPRAIN/STRAIN 847.1: THORACIC SPRAIN/STRAIN 846.0: LUMBOSACRAL SPRAIN/STRAIN, 724.4: LUMBOSACRAL RADICULITIS 722.10: DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC W/O MYELOPATHY 844.9: SPRAIN/STRAIN KNEE NOS 715.96: OSTEOARTHROSIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED	ACUPUNCTURE THERAPY FOR EVALUATION & TREATMENT OF THE CERVICAL SPINE, THORACIC SPINE, LUMBAR SPINE, & LEFT KNEE.	97802; 97026; 97813; 97814	2X/WK FOR 6 WKS
SAME AS ABOVE	SAME AS ABOVE	FLURBI (NAP) CREAM-LA (FLURBIPROFEN 20%/LIDOCAINE 5%/AMITRIPTYLINE 5%) 180 GM & GABACYCLOTRAM (GABAPENTIN 10%/CYCLOBENZAPRINE 6%/TRAMADOL 10%) 180 GM, TO APPLY A THIN LAYER TO THE AFFECTED AREAS BID TID	J8499	
HEADACHES	784.0: HEADACHE	CONSULTATION WITH A NEUROLOGIST	99245	

Requesting Physician Signature: Vlad Gendelman MD Date: 08/20/2015

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:		

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: Maira Sanchez	
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: 1194704643	
E-mail Address: mairas@acmemmg.com			

Claims Administrator Information

Company Name: York Claims Services, Inc.		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.)
LT KNEE STR/SPR, DEGENERATIVE JOINT DISEASE, PER MRI	844.9: SPRAIN/STRAIN KNEE NOS 715.96: OSTEOARTHROSIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED	LEFT KNEE ARTHROSCOPY WITH POSSIBLE PARTIAL MEDIAL MENISCECTOMY	29880 vs. 29881	
SAME AS ABOVE	SAME AS ABOVE	POSTOPERATIVE PHYSICAL THERAPY FOR LEFT KNEE	97014; 97024; 97026; 97110; 97124; 97035; 97140	3X PER WEEK FOR 4 WEEKS
SAME AS ABOVE	SAME AS ABOVE	PREOPERATIVE SCREENING	99201	

Requesting Physician Signature: Gendelman MD Date: 08/20/2015

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:		