

Referral for Services to:
Maciej Majzel DC, QME
Chiropractic Corporation

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 11/8/14 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 ACUPUNCTURE BIOFEEDBACK HYPNOTHERAPY
Frequency of Treatment: 2 times per week for 6 weeks.

PRECAUTIONS: _____
Weight Beaking Status: _____

TREATMENT PLAN:

- Evaluate and treat Cervical Program H E P
- 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.

<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: Santhan, Maria Del Rosario		Date of Birth: 03/26/1957		
Date of Injury: CT 01/01/2012 TO 04/08/2014; 02/22/2013		Employer: Premier Staffing Management		
Claim Number: TWCS-1588				
Requesting Physician Information:				
Name: Vlad Gendelman, M.D., OME		Contact Name: Maira Sanchez		
Practice Name: Vlad Gendelman, M.D., OME		City: Los Angeles		
Address: 6200 Wilshire Blvd., Suite 910		State: CA		
Zip Code: 90048	Phone: 323-833-3434	Fax Number: 323-854-8856		
Specialty: Orthopedics	NPI Number: 1184704843			
E-mail Address: mairs@acmemmo.com				
Claims Administrator Information:				
Company Name: York Claims Services, Inc.		Contact Name: Luann Coppel		
Address: P.O. Box 819079		City: Roseville		
Zip Code: 95681-8079		State: CA		
Phone: (916) 746-8864	Fax Number: (916) 763-0335			
E-mail Address:				
Requested Treatment: 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/MCPCS Code (If known)	Other Information: (Frequency, Duration, Quantity, Facility, etc.)
CERVICAL W/L STR/SPR THORACIC W/L STR/SPR LUMBOSACRAL W/L STR/SPR W/ RADICULITIS LUMBOSACRAL DISC HERNIATIONS WITH STENOSIS, PER MRI LT KNEE STR/SPR, DEGENERATIVE JOINT DISEASE, PER MRI SAME AS ABOVE	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 844.8: 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.	87802; 87026; 87813; 87814	2X/WK FOR 6 WKS
HEADACHES	784.0: HEADACHE	FLUREI (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 CONSULTATION WITH A NEUROLOGIST	J6499 89245	

Date: 08/20/2015

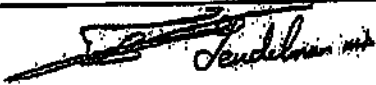
Requesting Physician Signature:

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:	E-mail Address:
Fax Number:	
Comments:	


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<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: 03/28/1967		
Date of Injury: CT 01/01/2012 TO 04/08/2014; 02/22/2013		Employer: Premier Staffing Management		
Claim Number: TWCS-1686				
Requesting Physician Information:				
Name: Vlad Gendelman, M.D., OME		Contact Name: Maira Sanchez		
Practice Name: Vlad Gendelman, M.D., OME		City: Los Angeles State: CA		
Address: 6200 Wilshire Blvd., Suite 910		Fax Number: 323-664-8688		
Zip Code: 90048	Phone: 323-833-3434	NPI Number: 1184704643		
Specialty: Orthopedics		E-mail Address: mairas@acmammg.com		
E-mail Address: mairas@acmammg.com				
Company/Agent Information:				
Company Name: York Claims Services, Inc.		Contact Name: Luann Coppel		
Address: P.O. Box 819079		City: Roseville State: CA		
Zip Code: 95681-9079	Phone: (916) 745-8664	Fax Number: (916) 783-0336		
E-mail Address:				
<p>State to which you wish to direct the request for benefits, or check/add/del on the box(es) below.</p> <p>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.</p>				
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 715.99: OSTEOARTHRISIS 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	
<p>Requesting Physician Signature: </p>			Date: 08/20/2015	
<p>Requesting Physician Signature: <i>Vlad Gendelman</i></p>				
<p><input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay)</p> <p><input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)</p>				
Authorization Number (if assigned):		Date:		
Authorized Agent Name:		Signature:		
Phone:	Fax Number:	E-mail Address:		
Comments:				

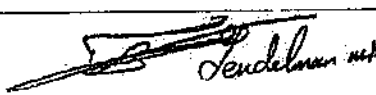
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Date of Injury: CT 01/01/2012 TO 04/08/2014; 02/22/2013		Date of Birth: 03/26/1967		
Claim Number: TWCS-1588		Employer: Premier Staffing Management		
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Name: Vlad Gendelman, M.D., QME				
Practice 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)				
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HEADACHES	784.0: HEADACHE	CONSULTATION WITH A NEUROLOGIST	99245	
Requesting Physician Signature: 			Date: 08/20/2015	
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)				
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Authorization Number (if assigned):			Date:	
Authorized Agent Name:			Signature:	
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Comments:				