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 | Date of Birth: 03/26/1967
Claim Number: Pending | Employer: Premier Staffing

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:

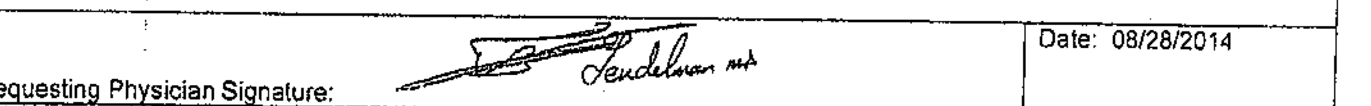
Claims Administrator Information

Company Name: York Risk Services/LA Claims | Contact Name: Pending
Address: P.O. Box 619079 | City: Roseville | State: CA
Zip Code: 95661-9079 | Phone: (661) 775-9550 | Fax Number: (866) 548-2637
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.)
SEE ATTACHED	SEE ATTACHED	PHYSICAL THERAPY TO THE CERVICAL SPINE, THORACIC SPINE, LUMBAR SPINE AND LEFT KNEE	97014; 97024; 97026; 97110; 97124; 97035; 97140	2X/WK FOR 6 WKS
		ULTRASOUND OF THE LEFT KNEE	76882	

Requesting Physician Signature: 
Date: 08/28/2014

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

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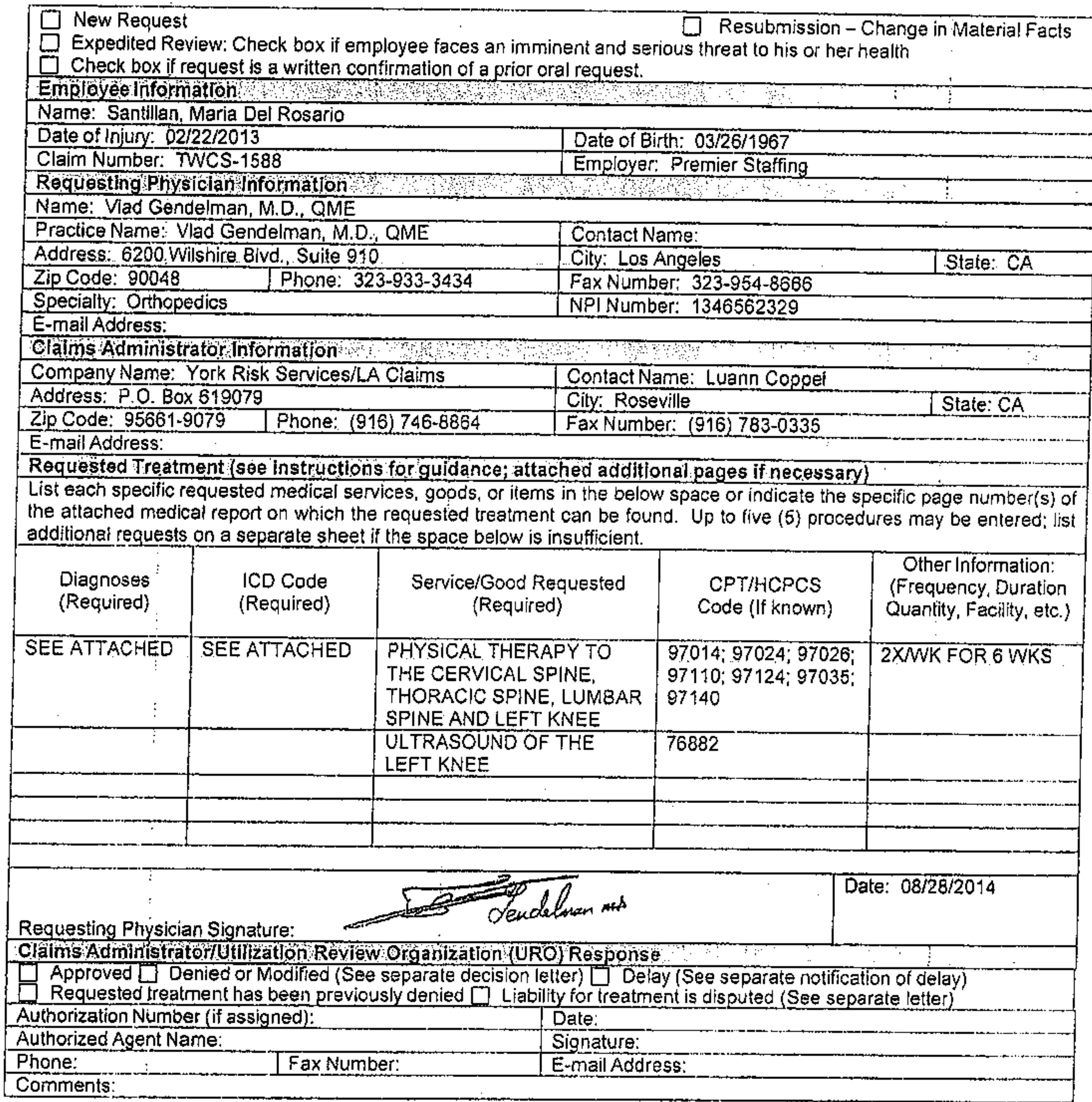

☐ New Request ☐ Resubmission – Change in Material Facts

☐ 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: 02/22/2013	Date of Birth: 03/26/1967
Claim Number: TWCS-1588	Employer: Premier Staffing

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 Risk Services/LA Claims		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.)
SEE ATTACHED	SEE ATTACHED	PHYSICAL THERAPY TO THE CERVICAL SPINE, THORACIC SPINE, LUMBAR SPINE AND LEFT KNEE	97014; 97024; 97026; 97110; 97124; 97035; 97140	2X/WK FOR 6 WKS
		ULTRASOUND OF THE LEFT KNEE	76882	

Requesting Physician Signature: Gendelman MD — Date: 08/28/2014

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:		

Patient's Name________________________ Acc. #__________

☐ L Arm
☐ Lifting ☐ Reaching ☐ Grasping ☐ Driving
☐ Pushing ☐ Pulling ☐ Overhead Activities ☐ ______ ☐ ______ ☐ ______

☐ R Elbow
☐ Lifting ☐ Reaching ☐ Grasping ☐ Driving
☐ Pushing ☐ Pulling ☐ Overhead Activities ☐ ______ ☐ ______ ☐ ______

☐ L Elbow
☐ Lifting ☐ Reaching ☐ Grasping ☐ Driving
☐ Pushing ☐ Pulling ☐ Overhead Activities ☐ ______ ☐ ______ ☐ ______

☐ R Forearm
☐ Lifting ☐ Reaching ☐ Grasping ☐ Driving
☐ Pushing ☐ Pulling ☐ Overhead Activities ☐ ______ ☐ ______ ☐ ______

☐ L Forearm
☐ Lifting ☐ Reaching ☐ Grasping ☐ Driving
☐ Pushing ☐ Pulling ☐ Overhead Activities ☐ ______ ☐ ______ ☐ ______

☐ R Wrist
☐ Lifting ☐ Reaching ☐ Grasping ☐ Driving
☐ Pushing ☐ Pulling ☐ Overhead Activities ☐ ______ ☐ ______ ☐ ______

☐ L Wrist
☐ Lifting ☐ Reaching ☐ Grasping ☐ Driving
☐ Pushing ☐ Pulling ☐ Overhead Activities ☐ ______ ☐ ______ ☐ ______

☐ R Hand
☐ Lifting ☐ Reaching ☐ Grasping ☐ Driving
☐ Pushing ☐ Pulling ☐ Overhead Activities ☐ ______ ☐ ______ ☐ ______

☐ L Hand
☐ Lifting ☐ Reaching ☐ Grasping ☐ Driving
☐ Pushing ☐ Pulling ☐ Overhead Activities ☐ ______ ☐ ______ ☐ ______

☐ R Hip
☐ Walking ☐ Standing ☐ Bending ☐ Twisting ☐ Squatting ☐ Kneeling ☐ Stairs
☐ Supine-sit ☐ Sit-stand ☐ Sitting ☐ Lifting ☐ Driving ☐ Pushing ☐ Pulling
☐ ______ ☐ ______ ☐ ______

☐ L Hip
☐ Walking ☐ Standing ☐ Bending ☐ Twisting ☐ Squatting ☐ Kneeling ☐ Stairs
☐ Supine-sit ☐ Sit-stand ☐ Sitting ☐ Lifting ☐ Driving ☐ Pushing ☐ Pulling
☐ ______ ☐ ______ ☐ ______

☐ R Thigh
☐ Walking ☐ Standing ☐ Bending ☐ Twisting ☐ Squatting ☐ Kneeling ☐ Stairs
☐ Supine-sit ☐ Sit-stand ☐ Sitting ☐ Lifting ☐ Driving ☐ Pushing ☐ Pulling
☐ ______ ☐ ______ ☐ ______

☐ L Thigh
☐ Walking ☐ Standing ☐ Bending ☐ Twisting ☐ Squatting ☐ Kneeling ☐ Stairs
☐ Supine-sit ☐ Sit-stand ☐ Sitting ☐ Lifting ☐ Driving ☐ Pushing ☐ Pulling
☐ ______ ☐ ______ ☐ ______

☐ R Knee
☐ Walking ☐ Standing ☐ Bending ☐ Twisting ☐ Squatting ☐ Kneeling ☐ Stairs
☐ Supine-sit ☐ Sit-stand ☐ Sitting ☐ Lifting ☐ Driving ☐ Pushing ☐ Pulling
☐ ______ ☐ ______ ☐ ______

State of California, Division of Workers' Compensation

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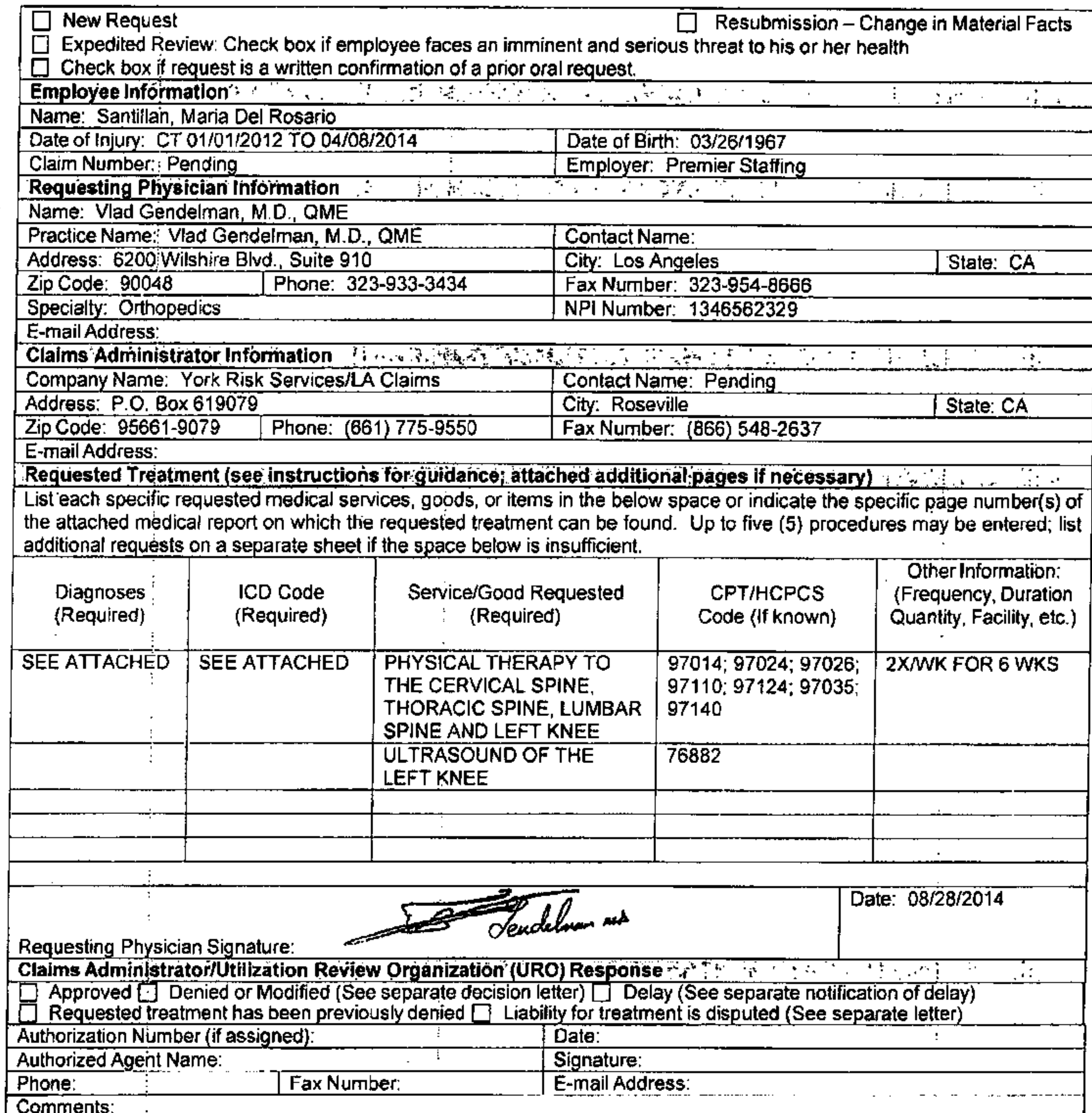

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Employee Information

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		ULTRASOUND OF THE LEFT KNEE	76882	

Requesting Physician Signature: [signature] Date: 08/28/2014

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:		

DWC Form RFA (Effective 2/2014)

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

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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			
Address: P.O. Box 619079		Contact Name: Luann Coppel	
Zip Code: 95661-9079	Phone: (916) 746-8864	City: Roseville	State: CA
E-mail Address:		Fax Number: (916) 783-0335	

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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:

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:		