

**State of California
Division of Workers' Compensation
Request for Authorization for Medical Treatment (DWC for RFA)**

This form must 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.

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

Employee Name (Last, First, Middle): Maria Del Rosario Santillan

Date of Injury (MM/DD/YYYY): 1/1/2012 - 4/8/2014 Date of Birth (MM/DD/YYYY): 3/26/1967

Claim Number: TWCS-3293 Employer: PREMIER STAFFING

Requesting Physician Information

Provider Name: Gendelman, Vlad

Practice Name: Vlad Gendelman, Md Inc Contact Name: Maria Perez

Address: 6200 Wilshire Blvd Ste 910 City: Los Angeles State: CA

Zip Code: 90048 Phone: (323) 933-3434 Fax Number:

Provider Specialty: NPI Number: 1336339738

E-mail Address: maria@acmemmg.com

Claims Administrator Information

Claims Administrator Name: Luann Coppel Contact Name: Luann Coppel

Address: City: State:

Zip Code: Phone: (916) 746-8864 Fax Number: (916) 783-0335

E-mail Address:

Requested Treatment (see instructions for guidance; attach additional pages if necessary)

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. Up to five (5) procedures may be entered; attach additional requests on a separate sheet.

Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration, Quantity, Facility, etc.)
Lumbosacral musculoligamentous strain / sprain	m54.5	Lumbar spine physical therapy		3 times x week x 4 weeks
Left knee strain / sprain degenerative joint disease per MRI dated 12/15/14	m19.90	left knee physical therapy		3 times x week x 4 weeks
headaches	r51			
thoracic musculoligamentous strain / sprain	s39.112a			
Lumbosacral disc protusions per MRI dated 4/15/15	m51.27			

Treating Physician Signature: Date of Request: 9/1/2016

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:

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