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.

R-2							
New Request Resubmission - Change in Material Facts							
Expedited Review: Check b	ox if employee faces an imminent and serior	is threat to his or her health					
Check box if request is a written confirmation of a prior gral request.							
Employee Information:							
Name: Santillan, Maria Del Ros	sario						
Date of Injury: CT 01/01/2012 To	O 04/08/2014; 02/22/2013	Date of Birth: 03/26/1967					
Claim Number: TWC\$-1588		Employer: Premier Staffing Management					
Requesting Physician Information							
Name: Vlad Gendelman, M.D.,	QME		· · · · · · · · · · · · · · · · · ·				
Practice Name: Vlad Gendelman, M.D., QME		Contact Name:	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 informa	tion						
Company Name: York Claims 5	Services, Inc.	Contact Name: Luann Coppel					
Address: P.O. Box 619079	ress: P.O. Box 619079 City: Roseville			State: CA			
Zlp Code: 95661-9079	Phone: (916) 746-8864	none: (916) 746-8864 Fax Number: (916) 783-0335					
E-mail Address:							
Requested Treatment (see Ins	tructions for guidance; attached addition	al pages if necessary):	Charles Transport	The state of the second			
List each specific requested mer	dical services, goods, or items in the below :	space or indicate the specific page purp	nher(s) of the attach	ed medical report on			
which the requested treatment of	can be found. Up to five (5) procedures ma	y be entered; list additional requests o	. a separate sheet	if the space below is			
insufficient.				• • • • • • • • • • • • • • • • • • • •			
-			,	Other Information:			
Diagnoses	ICD Code	Service/Good Requested	CPT/	(Frequency,			
(Required)	(Required)	(Required)	HCPCS	Duration Quantity,			
	-		Code (If known)	Facility, etc.)			
C/C M/L STD/CDD	ICD-9	CONTINUE ACUPUNCTURE	97802, 97026,	2X/WK FOR			
C/S M/L STR/SPR	847.0: NECK SPRAINS & STRAINS	THERAPY OF THE CERVICAL	97813, 97814	6WKS			
T/S M/L STR/SPR	PATA TUDDA OLD ODDAING A	SPINE, THORACIC SPINE,					
170 MAC STRASPK	847.1: THORACIC SPRAINS &	LUMBAR SPINE, AND LEFT	!				
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LUMBOSACRAL M/L	846.0: LUMBOSACRAL SPRAINS &		•				
STR/SPR W/ RADICULITIS	STRAINS; 724.4; LUMBOSACRAL]			
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LUMBOSACRAL DISC	141515521715		!	İ			
PROTRUSIONS, PER MRI	722.10: DISPLACEMENT OF LUMBAR						
	INTERVERTEBRAL DISC W/O						
LEFT KNEE STR/SPR.	MYELOPATHY						
DEGENERATIVE JOINT		_					
DISEASE, PER MRI	844.9: KNEE SPRAINS & STRAINS.	·					
•	NOS; 715.96: OSTEOARTHROSIS.						
	UNSPECIFIED WHETHER						
	GENERALIZED OR LOCALIZED		_				
SAME AS ABOVE	SAME AS ABOVE	NORCO 5/325 MG 1 TO 2	J8499				
		TABLETS BY MOUTH EVERY 4					
	H	TO 6 HOURS AS NEEDED FOR	ì				
·		PAIN					
			Date: 09/24/	2015			
·	Sendelman mi	L					
Requesting Physician Signature:							
Claims Administrator/Utilization Review Organization (URO) Response							
Approved Denied or Modified (See separate decision letter) Delay (See separate notification of delay)							
Authorized Agent Name:	* /-	Date:					
Phone:	Fax Number:	Signature:					
Comments:	i FAX NUCIDEL	E-mail Address:					
e e							

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

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New Request					
	6	Resubmission - Change in Material Facts			
Chart have described an	box if employee faces an imminent and serio	us threat to his or her health			
Employed Information (127)	written confirmation of a prior oral request.	and the second s			
Name: Santillan, Maria Del Ro	TO AND THE SECOND SECTION OF THE PROPERTY SECTION OF SECTION OF	N DESCRIPTION OF THE PROPERTY	2017年2月18日 19.10	<u>的特别。在世界政</u>	
Date of Injury: CT 01/01/2012	TO NAMEDINA DODODINA	Date of Birth: 03/26/1967			
Oale of Injury: CT 01/01/2012 TO 04/08/2014; 02/22/2013 Claim Number: TWCS-1588		Employer Promies Staffing Massage			
Requesting Physician Inform	sation of the San Assessment Park Care	Employer: Premier staming Management			
Maine: Viad Gendelman M.D.),, QME	Company of the state of the sta	Section Visiting	CONTRACTOR AND SERVICE	
Practice Name: Vlad Gendelm	nan, M.D., QME	Contact Name:	·		
Address: 6200 Wilshire Blvd.,	Suite 910			State: CA	
Zip Code: 90048	Phone: 323-933-3434	Fax Number: 323-954-8666		Dipite. Con	
Specialty: Orthopedics		NP/ Number: 1346562329			
E-mail Address:					
Company Name: York Claims	ation	Special Company Services		en 1918 og fram d	
Address: P.O. Box 619079	Services, Inc.	Contact Name: Luann Coppel			
Zip Code: 95661-9079	Phone: (916) 746-8864	City: Roseville State: CA		State: CA	
E-mail Address:	FRONE. (\$10) (40-0004	Fax Number: (916) 783-0335			
	structions for guidance, attached addition	int annual II manage and the last	Park & Street Co. Co. Complete and A.		
Lace and appoint independently ille	edical services, goods, or items in the below can be found. Up to five (5) procedures ma	ERBCO OF IRAICSIO ON CONTROL COMO	mmar(a) -1 +h111	led medical report on if the space below is	
Olagnoses (Required)	ICD Code (Required)	Service/Good Requested (Required)	CPT/ HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, Facility, etc.)	
C/S M/L STR/SPR	ICD-9 847.0: NECK SPRAINS & STRAINS	CONTINUE ACUPUNCTURE THERAPY OF THE CERVICAL SPINE, THORACIC SPINE,	97802, 97026, 97813, 97814	2XWK FOR 6WKS	
T/S M/L STR/SPR	847.1: THORACIC SPRAINS & STRAINS	LUMBAR SPINE, AND LEFT KNEE			
LUMBOSACRAL M/L STR/SPR W/ RADICULITIS LUMBOSACRAL DISC	845.0: LUMBOSACRAL SPRAINS & STRAINS; 724.4: LUMBOSACRAL RADICULITIS				
	700 10. 01001 10011517 05 11010		İ		
PROTRUSIONS, PER MRI	722.10: DISPLACEMENT OF LUMBAR				
LEFT KNEE STR/SPR, DEGENERATIVE JOINT	INTERVERTEBRAL DISC W/O MYELOPATHY				
DISEASE, PER MRI	844.9: KNEE SPRAINS & STRAINS, NOS; 715.96: OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED				
SAME AS ABOVE	SAME AS ABOVE	NORCO 5/325 MG 1 TO 2	J8499		
		TABLETS BY MOUTH EVERY 4	30-93	}	
		TO 6 HOURS AS NEEDED FOR			
		PAIN			
Requesting Physician Signature	Jendelman an	Date: 09/24/2015			
Claims Administrator/Utilization	on Review Organization (URO) Response	CANDAL DESCRIPTION OF THE	"Maring Programmes and the control of the control o		
The Upper The Deplet of Mid	odified (See separate decision letter) Del een previously denied Liability for treatme	av (See senarate cotification of dates)	18 18 18 18 18 18 18 18 18 18 18 18 18 1	<u> </u>	
Authorization Number (if assigne	eq. bigaional ocurso T Tispital for trestile	ant is disputed (See separate letter)			
Authorized Agent Name:	л.	Date: Signature:			
Phone:	Fax Number:	Signature:			
Comments: E-mail-Address:					
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