# 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): 2/22/2013 | Date of Birth (MM/DD/YYYY): 3/26/1967

Claim Number: TWCS-1588 | Employer: PREMIER STAFFING

**Requesting Physician Information**

Provider Name: Gendelman, Vlad

Practice Name: Vlad Gendelman, Md Inc | Contact Name: Maira Sanchez

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: mairas@acmemmg.com

**Claims Administrator Information**

Claims Administrator Name: YOMC | Contact Name: Luann Coppel

Address: PO BOX 819079 | City: Roseville | State: CA

Zip Code: 95661 | Phone: (916) 746-8864 | Fax Number: 866-548-2637

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.) |
|---|---|---|---|---|
| LEFT KNEE STR/SPR, DEGENERATIVE JOINT DISEASE, PER MRI | 844.9: STRAIN/SPRAIN KNEE NOS 715:96 OSTEOARTHROSIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED | LEFT KNEE ARTHROSCOPY WITH POSSIBLE PARTIAL MEDIAL MENISCECTOMY | 29880 VS. 29881 | TRANSPORTATION REQUIRED TO & FROM TARZANA OUTPATIENT SURGICAL CENTER |
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Treating Physician Signature: [signature] | Date of Request: 9/25/2015

**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:

DWC Form RFA (version 012014)