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; 02/22/2013	Date of Birth: 03/26/1967	
Claim Number: TWCS-1688	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: 1346662329	
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.)
C/S M/L STR/SPR T/S M/L STR/SPR LUMBOSACRAL SPINE M/L STR/SPR W/ RADICULITIS R/O LUMBOSACRAL SPINE DISCOGENIC DISEASE LT KNEE STR/SPR	847.0 SPRAIN & STRAIN OF NECK 847.1 SPRAIN & STRAIN OF THORACIC 846.0 SPRAIN OF LUMBOSACRAL; 724.4 LUMBOSACRAL SPINE NEURITIS OR RADICULITIS, UNSPECIFIED V71.9 OBSERVATION FOR UNSPECIFIED SUSPECTED CONDITION 844.9 SPRAIN & STRAIN OF KNEE	CONT PT OF THE C/S, T/S, L/S, & LT KNEE	97014, 97024, 97026, 97110, 97124, 97035, 97140	2X/WK FOR 6WKS
SAME AS ABOVE	SAME AS ABOVE	URINE TOXICOLOGY	G0431	

Requesting Physician Signature: Vlad Gendelman M.D. Date: 10/09/14

Claims Administrator/Utilization Review Organization (UR©) 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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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	

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	
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SAME AS ABOVE	SAME AS ABOVE	URINE TOXICOLOGY	G0431	

Requesting Physician Signature: Gendelman MD Date: 10/09/14

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)