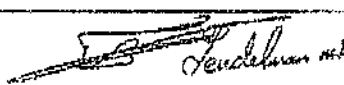


State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

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.

<input type="checkbox"/> New Request		<input type="checkbox"/> Resubmission - Change in Material Facts		
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health				
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.				
Employee Information				
Name: Santillan, Marla 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: 1340562329	
E-mail Address:				
Claims Administrator Information				
Company Name: York Risk Services/LA Claims			Contact Name: Luann Coppel	
Address: P.O. Box 819079			City: Roseville State: CA	
Zip Code: 95681-9079		Phone: (916) 746-8664	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	847.0 SPRAIN & STRAIN OF NECK	CONT PT OF THE C/S, T/S, L/S, & LT KNEE	97014, 97024, 97026, 97110, 97124, 97035, 97140	2X/WK FOR 6WKS
T/S M/L STR/SPR	847.1 SPRAIN & STRAIN OF THORACIC			
LUMBOSACRAL SPINE M/L STR/SPR W/ RADICULITIS	848.0 SPRAIN OF LUMBOSACRAL; 724.4 LUMBOSACRAL SPINE NEURITIS OR RADICULITIS, UNSPECIFIED			
R/O LUMBOSACRAL SPINE DISCOGENIC DISEASE	V71.9 OBSERVATION FOR UNSPECIFIED SUSPECTED CONDITION			
LT KNEE STR/SPR	844.9 SPRAIN & STRAIN OF KNEE			
SAME AS ABOVE	SAME AS ABOVE	URINE TOXICOLOGY	G0431	
Requesting Physician Signature: 			Date: 10/09/14	
Claims Administrator/Utilization Review Organization (URO) Response				
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay)				
<input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> 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
REQUEST FOR AUTHORIZATION
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<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health				
<input type="checkbox"/> 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-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:				
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LUMBOSACRAL SPINE M/L STR/SPR W/ RADICULITIS	848.0 SPRAIN OF LUMBOSACRAL; 724.4 LUMBOSACRAL SPINE NEURITIS OR RADICULITIS, UNSPECIFIED			
R/O LUMBOSACRAL SPINE DISCOGENIC DISEASE	V71.9 OBSERVATION FOR UNSPECIFIED SUSPECTED CONDITION			
LT KNEE STR/SPR	844.9 SPRAIN & STRAIN OF KNEE			
SAME AS ABOVE	SAME AS ABOVE	URINE TOXICOLOGY	G0431	
Claims Administrator/Utilization Review Organization (URO) Response				
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay)				
<input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)				
Authorization Number (if assigned):		Date:		
Authorized Agent Name:		Signature:		
Phone:	Fax Number:	E-mail Address:		
Comments:				