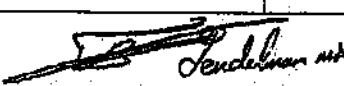



**State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA**

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 checked="" 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, Maria Del Rosario									
Date of Injury: CT 01/01/2012 TO 04/08/2014; 02/22/2013					Date of Birth: 03/28/1967				
Claim Number: TWCS-1588					Employer: Premier Staffing Management				
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: 323-954-8668			NPI Number: 1346562329	
Specialty: Orthopedics					E-mail Address:				
Claims Administrator Information									
Company Name: York Claims Services, Inc.					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.)					
LEFT KNEE STR/SPR, DEGENERATIVE JOINT DISEASE, PER MRI	ICD-10 S88.912A: STRAIN OF UNSPECIFIED MUSCLE(S) AND TENDON(S) AT LOWER LEG LEVEL, LEFT LEG; S83.92XA: SPRAIN OF UNSPECIFIED SITE OF LEFT KNEE, M17.9: OSTEOARTHRITIS OF KNEE, UNSPECIFIED	CONTINUE PHYSICAL THERAPY OF THE LEFT KNEE	97014, 97024, 97026, 97110, 97124, 97035, 97140	3X/WK FOR 4WKS					
Requesting Physician Signature: 								Date: 10/22/2015	
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 checked="" 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, 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 Management				
Requesting Physician Information									
Name: Vlad Gendelman, M.D., QME									
Practice Name: Vlad Gendelman, M.D., QME					Contact Name:				
Address: 8200 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 Claims Services, Inc.					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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<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:									