

Referral for Services to:
Maciej Majzel DC, QME
Chiropractic Corporation

6200 Wilshire Blvd., Suite 910, Los Angeles, CA 90045 Phone: 323-934-0423 Fax: 323-934-4762
 14557 Friar Street, Unit B2, Van Nuys, CA 91411 Phone: 818-616-5500 Fax: 818-616-5592

Patient Name: Maria Del Rosario Santillan DOB: 3/26/47
Patient Phone Num: _____ Date of Injury: _____ Work Comp Personal Injury
Diagnosis: C/S, T/S, C/S, Knees

Referred by: Vlad Gendelman
Address: 6200 Wilshire Blvd. ste. #910 Los Angeles, CA. 90048
Phone Num: (323) 933-3434 Fax Num: (323) 954-8666

PHYSICAL THERAPY CHIROPRACTIC ACUPUNCTURE BIOFEEDBACK HYPNOTHERAPY
Frequency of Treatment: 2 times per week for 4 weeks.

PRECAUTIONS: _____

Weight Beaking Status: _____

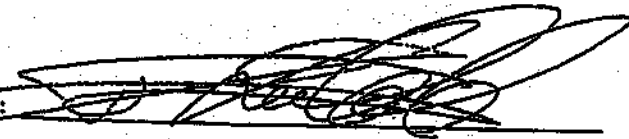
TREATMENT PLAN:

- Evaluate and treat Cervical Program HEP
- Back program Elbow program Wrist / Hand program
- Shoulder program Knee program Ankle / Foot program
- Hip program Alignment & Body Mechanics Strength Training program

Other Continue TX

- Return to Work program
- Neck Back or Spinal Surgery Program
- Post Surgical program

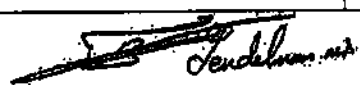
Surgery Date: _____ Type of Surgery: _____

Signature: 

Date: DEC 10 2015

**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-3293; 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: 323-954-8666		
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		
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.)
CERVICAL STR/SPR THORACIC STR/SPR LUMBOSACRAL STR/SPR W/ RADICULITIS LUMBOSACRAL DISC PROTRUSIONS, PER MRI LEFT KNEE STR/SPR, DEGENERATIVE JOINT DISEASE, PER MRI	ICD-10: S16.1XXA STRAIN OF MUSCLE, FASCIA & TENDON AT NECK LEVEL; S13.4XXA SPRAIN OF LIGAMENTS OF CERVICAL SPINE S23.3XXA SPRAIN OF LIGAMENTS OF THORACIC SPINE S39.012A STRAIN OF MUSCLE, FASCIA AND TENDON OF LOWER BACK; S33.9XXA SPRAIN OF UNSPECIFIED PARTS OF LUMBAR SPINE AND PELVIS, M54.17 RADICULOPATHY, LUMBOSACRAL REGION M51.27 OTHER INTERVERTEBRAL DISC DISPLACEMENT, LUMBOSACRAL REGION S86.912A 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	ACUPUNCTURE THERAPY FOR EVAL & TREATMENT OF THE C/S, T/S, L/S, & LT KNEE	97802, 97026, 97813, 97814	2X/WK FOR 4 WKS
Requesting Physician Signature: 			Date: 12/10/2015	
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:				

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Patient Name: Wana Del Rosario SAAHILLAKI DOB: 3/26/17
Patient Phone Num: _____ Date of Injury: _____ Work Comp Personal Injury
Diagnosis: C/S, T/S, C/S, Knee

Referred by: Vlad Gendelman
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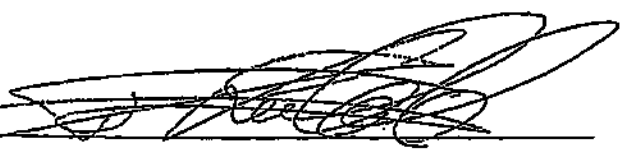
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Surgery Date: _____ Type of Surgery: _____

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Name: Santillan, Maria Dei Rosario Date of Birth: 03/26/1967
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 Address: 6200 Wilshire Blvd., Suite 910 Fax Number: 323-954-8666
 Zip Code: 90048 Phone: 323-933-3434 NPI Number: 1346562329
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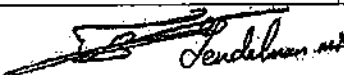
Claims Administrator Information:

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

Requested Treatment (see instructions for guidance; attached additional pages if necessary):

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Requesting Physician Signature:  Date: 12/10/2015

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:

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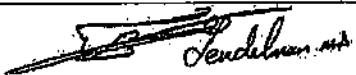
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