Referral for Services to:

Maciej Majzel DC, QME

Chiropractic Corporation

[X] 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: 3/26/67

Patient Phone Num: _____ Date of Injury: _____ [X] Work Comp [ ] Personal Injury

Diagnosis: C/S, T/S, L/S, Knee

Referred by: Vlad Gendelman

Address: 6200 Wilshire Blvd. ste.# 910 Los Angeles, C.A. 90048

Phone Num: (323) 933-3434 *Fax Num:* (323) 954-8666

[ ] *PHYSICAL THERAPY* [ ] *CHIROPRACTIC* [X] *ACUPUNCTURE* [ ] *BIOFEEDBACK* [ ] *HYPNOTHERAPY*

Frequency of Treatment: 2 times per week for 4 weeks.

PRECAUTIONS: _____

Weight Bearing Status: _____

TREATMENT PLAN:

[X] 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

[X] 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.

☒ 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-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: Gendelman, MD 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:		

Referral for Services to:

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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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Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

State of California, Division of Workers' Compensation

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Requesting Physician Signature: V. Gendelman MD Date: 12/10/2015

Claims Administrator/Utilization Review Organization (URO) Response

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Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		