** INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY **

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
November 7, 2023 at 11:05:33 AM PST	2148534482	41	1	Received

11/07/23 11:04AM 2148534482 Accounts Payable 5625060360 Pg 1/1

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 (Last, First, Middle): **Christiansen, Victor**

Date of Injury (MM/DD/YYYY): **09/07/2023**	Date of Birth (MM/DD/YYYY): **09/15/1986**
Claim Number: **231106069**	Employer: **Washington Hospital Healt**

Requesting Physician Information

Name: **Natalia Cortez, PA-C**

Practice Name: **CMC-San Leandro East**		Contact Name:	
Address: **13939 E. 14th Street Suite 150**		City: **San Leandro**	State: **CA**
Zip Code: **94578**	Phone: **510-343-8300**	Fax Number: **510-343-8301**	
Specialty: **Primary Treating Physician MD/DO**		NPI Number: **1790073682**	
E-mail Address:			

Claims Administrator Information

Company Name: **Tri-Star Risk Management**		Contact Name: **W/C CLAIMS**	
Address: **PO Box 2805**		City: **Clinton**	State: **IA**
Zip Code: **52733**	Phone: **6264070400**	Fax Number: **6264070435**	
E-mail Address:			

Requested Treatment (See Instructions for guidance; attach 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.

Diagnosis (Required)	ICD Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information (Frequency, Duration Quantity, etc.)
Crush injury, ankle, right, initial encounter Sprain of deltoid	**S97.01XA S93.421A**	**Physical Therapy Referral**		Frequency: 3 x week, Duration: 2 weeks, Body Part 1: Ankle, Laterality 1: Right

Supervising Provider Name: **John Sheppard, M.D.**

Requesting Physician Signature: Date: **11/06/2023**

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: