
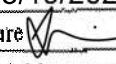


ALTMAN AND BLISTEN  
(818)995-3419  
UR FAX:

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

Gordon & Gordon  
(310)276-7004

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.		D.O.S: 4/28/2022	
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.			
<b>Employee Information</b>			
Name: RAMIREZ, Norma			
DOI: 6/19/2021	CT: --	GT: --	Date of Birth MM/DD/YYYY: 12/07/1968
Claim Number: 189559257-001		Employer: Mc Donalds	
<b>Requesting Physician Information</b>			
Name: Arthur Harris MD.			
Practice Name: Arthur Harris M.D.		Contact Name: UR Dept. Rosie	
Address: 3800 E Cesar E Chavez Ave		City: Los Angeles	State: CA
Zip Code: 90063	Phone: 323-264-6296	Fax Number: (323) 267-0208	
Specialty: Orthopedic Surgeon		NPI #: 1841341807	TIN #: 95-4895183
Utilization Review Department E-mail Address: urdepartment@atlantishealthmgmt.com			
<b>Claims Administrator Information</b>			
Company Name: Broadspire		Contact Name:	
Address: P.O. Box 14352		City: LEXINGTON	State: KY
Zip Code: 40512	Phone:	Fax Number: (770)777-6447	
E-mail Address:			
<b>Requested Treatment (see instructions for guidance; attached additional pages if necessary)</b>			
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 separate sheet if the space below is insufficient.			
Diagnosis (Required)	ICD Code (Required)	Service/Good Requested (Required)	CPT/HCPCS
Sprain of ligaments of lumbar spine, subsequent encounter	S33.5XXD	Request to continue	
Radiculopathy, lumbar region	M54.16	physical therapy to	2x3
Unsprain of right hip, subq enc	S73.101D	the lumbar spine.	
Unsprain of left hip, subq enc	S73.102D		
Request denied. Lumbar spine is not an accepted body part.			
<input type="checkbox"/> (if checked off) We are requesting authorization for the use of an interpreter.			
Requesting Physician Signature: 			Date: 05-10-22
<b>Claims Administrator/Utilization Review Organization (URO) Response</b>			
<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: 05/19/2022	
Authorized Agent Name:		Signature: 	
Phone: 628-333-7906	Fax Number: 859-550-2170	E-Mail Address: marie_krueger@choosebroadspire.com	