




**XState 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	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			
<b>Employee Information</b>				
Name (Last, First, Middle): Ortega, Blanca				
Date of Injury (MM/DD/YYYY): 04/13/2021		Date of Birth (MM/DD/YYYY): 09/19/1971		
Claim Number: 189678725-001	Employer: MCNIB Corporation			
<b>Requesting Physician Information</b>				
Name: Ron Y. Goldstein, M.D.				
Practice Name: Institute for Hand and Microsurgery		Contact Name: SOS RFA		
Address: 3000 W MacArthur Blvd Suite 600		City: Santa Ana State: California		
Zip Code: 92704	Phone: 714-988-7827	Fax Number: 833-301-0273		
Specialty: Orthopedic Hand Surgery/ Plastic & Reconstructive Surgery		NPI Number: Goldstein 1841347044		
Email Address: SOSRFA1@dr4hands.com				
<b>Claims Administrator Information</b>				
Company Name: Broadspire 1		Contact Name:		
Address: P.O. Box 14352		City: Lexington State: KY		
Zip Code: 40512	Phone: 628-333-7906	Fax Number:		
Email 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 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.)
Lateral epicondylitis, right elbow Injury of ulnar nerve at forearm level, right arm, sequela Pain in right wrist Injury of median nerve at wrist and hand level of right arm, sequela	M77.11 Lateral epicondylitis, right elbow S54.01XS Injury of ulnar nerve at forearm level, right arm, sequela M25.531 Pain in right wrist S64.11XS Injury of median nerve at wrist and hand level of right arm, sequela	1. NAPROXEN CR 375MG #60 (NDC 47781-0153-01) SIG: Take 1 tablet by mouth 2 times a day for pain. Take with food or milk NSAID used to treat pain or inflammation caused by arthritis and mild to moderate pain (non-arthritis) COMMON SIDE EFFECTS: Heart burn, stomach pain, nausea, diarrhea, or constipation  2. DICLOFENAC SODIUM 3% GEL 100GM (NDC 51672-1363-07) SIG: Apply 1-2 grams to affected areas 3-4 times daily for pain &		RX& REPORT ATTACHED

	inflammation NSAID used to relieve pain and to treat symptoms of arthritis such as inflammation, swelling & stiffness COMMON SIDE EFFECTS: Skin rash, itching, burning, redness or soreness  3. LIDOTHOL 4.5%/5% PATCHES #30 (LIDOCAINE 4.5% MENTHOL 5%) (NDC 53225-1025-01) SIG: Apply 1-2 patches to affected areas of pain 12 hours on & 12 hours off TOPICAL ANESTHETIC used in treatment of mild to moderate acute or chronic aches or pain COMMON SIDE EFFECTS: Burning, itching, redness or scaling at application site.  UDT: •REQUEST FOR AUTHORIZATION FOR URINE DRUG TESTING.					
<table border="1"> <tr> <td>Requesting Physician Signature:</td> <td></td> <td>Date:</td> <td>10/03/2022</td> </tr> </table>			Requesting Physician Signature:		Date:	10/03/2022
Requesting Physician Signature:		Date:	10/03/2022			
<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:				
Authorized Agent Name:		Signature:				
Phone:	Fax Number:	E-mail Address:				
Comments:						

### Instructions for Request for Authorization Form

**Warning: Private healthcare information is contained in the Request for Authorization for Medical Treatment, DWC Form RFA. The form can only go to other treating providers and to the claims administrator.**

**Overview:** The Request for Authorization for Medical Treatment (DWC Form RFA) is required for the employee's treating physician to initiate the utilization review process required by Labor Code section 4610. A 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 must be attached. The DWC Form RFA is not a separately reimbursable report under the Official Medical Fee Schedule, found at California Code of Regulations, title 8, section 9789.10 et seq.

**Checkboxes:** Check the appropriate box at the top of the form. Indicate whether:

- This is a new treatment request for the employee or the resubmission of a previously denied request based on a change in material facts regarding the employee's condition. A resubmission is appropriate if the facts that provided the basis for the initial utilization review decision have subsequently changed such that the decision is no longer applicable to the employee's current condition. Include documentation supporting your claim.
- Review should be expedited based on an imminent and serious threat to the employee's health. A request for expedited review must be supported by documentation substantiating the employee's condition.
- The request is a written confirmation of an earlier oral request.

**Routing Information:** This form can be mailed, faxed, or e-mailed to the address, fax number, or e-mail address designated by the claims administrator for this purpose. The requesting physician must complete all identifying information regarding the employee, the claims administrator, and the physician.

**Requested Treatment:** The DWC Form RFA must contain all the information needed to substantiate the request for authorization. If the request is to continue a treatment plan or therapy, please attach documentation indicating progress, if applicable.

- List the diagnosis (required), the ICD Code (required), the specific service/good requested (required), and applicable CPT/HCPCS code (if known).
- Include, as necessary, the frequency, duration, quantity, etc. Reference to specific guidelines used to support treatment should also be included.
- For requested treatment that is: (a) inconsistent with the Medical Treatment Utilization Schedule (MTUS) found at California Code of Regulations, title 8, section 9792.20, et seq.; or (b) for a condition or injury not addressed by the MTUS, you may include scientifically based evidence published in peer-reviewed, nationally recognized journals that recommend the specific medical treatment or diagnostic services to justify your request.

**Requesting Physician Signature:** Signature/Date line is located under the requested treatment box. A signature by the treating physician is mandatory.

**Claims Administrator/URO Response:** Upon receipt of the DWC Form RFA, a claims administrator must respond within the timeframes and in the manner set forth in Labor Code section 4610 and California Code of Regulations, title 8, section 9792.9.1. To communicate its approval on requested treatment, the claims administrator may complete the lower portion of the DWC Form RFA and fax it back to the requesting provider. (Use of the DWC Form RFA is optional when communicating approvals of treatment; a claims administrator may utilize other means of written notification.) If multiple treatments are requested, indicate in comments section if any individual request is being denied or referred to utilization review.