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

RFA
CDia2

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 prior oral request.

Employee Information

Name (Last, First, Middle): HERMOSILLO, CRUZ	
Date of Injury (MM/DD/YYYY): 06/02/2022	Date of Birth (MM/DD/YYYY): 11/05/1979
Claim Number: 141237	Employer: COUNTY OF SAN BERNARDIN

Requesting Physician Information

Name: RICHARD DORSEY, MD	
Practice Name: WESTERN ORTHO SURGICAL A	Contact Name:
Address: 25431 CABOT ROAD #110	City: LAGUNA HILLS State: CA
Zip Code: 92653 Phone: (949) 716-1900	Fax Number: (949) 716-1919
Specialty: 001	NPI Number: 1801987300
E-mail Address: cruzillo626@yahoo.com	

Claims Administrator Information

Company Name: COUNTY OF SAN BERNARDINO	Contact Name: KAREN DARBY, Mr.
Address: 222 W. HOSPITALIY LN 3RDLOOR	City: SAN BERNARDINO State: CA
Zip Code: 92415 Phone: (909) 386-8655	Fax Number: (909) 386-8711
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.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS (Required)	Other Information: (Frequency, Duration Quantity, etc.)
Sprain of lumb intervertebral Unspecified sp Sprain of unsp	S335XXA M5126 S63502A S8392XA	REQ MRI OF LT KNEE TO R/O PAIN. REQ MEDICAL RECORDS. REQ DR. PODOLSKY SURGICAL CONSULT FOR LT KNEE PAIN. F/U 4 WEEKS		

Requesting Physician Signature: Date: 07/21/2023

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (see separate letter)

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

Comments:

State of California Additional pages attached ☐

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

☐ Periodic Report (Required 45 days after last report) ☐ Change in treatment plan ☐ Release From Care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☒ Request for authorization
☐ Other 57250

Patient

Patient last name:	Patient first name:	MI
HERMOSILLO	CRUZ	

Patient Street Address/PO Box	Patient City	State	Zip Code	Sex
106 S. LOUISE AVE	AZUSA	CA	91702-4345	M

Occupation	Phone Number	Date of Birth
MAINTENANCE	(626) 608-8795	11/05/1979

Claims Administrator Date of Injury 06/02/2022

Claims Administrator Name	Claim number
COUNTY OF SAN BERNARDINO	141237

Claims Administrator Street Address/	Claims Administrator City	State	Zip Code
222 W. HOSPITALIY LN 3RDLOOR	SAN BERNARDINO	CA	92415

Phone Number	Fax Number	Employer Name	Phone Number
(909) 386-8655		COUNTY OF SAN BERNARDINO	

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective Complaints:

CHEST PAIN IS 3 WITH CONSTANT PAIN. L/S PAIN IS 5 WITH CONSTANT PAIN. LT WRIST PAIN IS 2 WITH CONSTANT PAIN. LT ARM PAIN IS 3 WITH CONSTANT PAIN PENDING QME. FU WITH DR. RICHARD DORSEY FOR DEPRESSION.MRI OF LT KNEE REVIEWED TODAY.

Objective findings: *(Include significant physical examination, laboratory, imaging, or other diagnostic findings.)*

L/S SPRAIN R/O HNP. LT WRIST SPRAIN R/O TORN MENISCUS. HAS ANXIETY AND DEPRESSION. MRI LT KNEE REVEALS BAKERS CYST. PEDAL HIGH GRADE PARTIAL TEAR OF THE SUPERIOR TO MILD FIBERS OF THE ACL. COMPLEX TEAR OF THE MEDIAL AND LAT MENISCUS WITH ARTHRITIS.

Diagnoses:

1.	Sprain of lumbar spine, initial encounter	ICD-10	S335XXA
2.	intervertebral disc displac, lumbar region	ICD-10	M5126
3.	Unspecified sprain of left wrist, initial encounter	ICD-10	S63502A
4.	Sprain of unspecified site of left knee, initial encounte	ICD-10	S8392XA
5.	Post-traumatic stress disorder, unspecified	ICD-10	F4310
6.		ICD-10	
7.		ICD-10	
8.		ICD-10	
9.		ICD-10	
10.		ICD-10	

11. _____ ICD-10 _____

12. _____ ICD-10 _____

Treatment Plan: Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/ referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

TELEHEALTH APPT WITH PATIENTS CONSENT.PENDING QME P/S. FU WITH DR. RICHAR DORSEY FOR ANXIETY AND DEPRESION. REQ MRI OF LT KNEE TO R/O PAIN. REQ MEDICAL RECORDS. CONT WITH ACTIVE STIM 24.MRI OF LT KNEE REVIEWED TODAY. REQ DR .PODOLSKY FOR LT KNEE SX CONSULT FOR PAIN. FU IN 4 WEEKS.

Work Status: This patient has been instructed to:

☐ Remain off-work until _____

☐ Return to *modified* work on _____ with the following limitations or restrictions. (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

☒ Return to full duty on 07/21/2023 with no limitations or restrictions.

Primary Treating Physician: *(original signature, do not stamp)* Date of Exam 07/21/2023

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.

Physician signature _____ Cal. License Number: G18078

Executed at: _____ Date *(mm/dd/yyyy)*: 07/21/2023

Physician Name JOHN B DORSEY, MD Specialty: ORTHOPEDIC

Physician address: 25431 CABOT RD LAGUNA HI CA 92653 Phone Number (949) 716-1900

PRIVACY NOTICE: A statement of current data collection and use policies and certain privacy rights of injured workers may be found at the following website: http://www.dir.ca.gov/od_pub/privacy.html.