



**State of California
Division of Workers' Compensation
REQUEST FOR AUTHORIZATION**

DWC Form RFA - California Code of Regulations, title 8, section 9785.

This form must accompany the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or 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

Employee Name (Last, First, Middle):	
Date of Injury (MM/DD/YYYY):	Date of Birth (MM/DD/YYYY):
Claim Number:	Employer:

Provider Information

Provider Name:		
Practice Name:	Contact Name:	
Address:	City:	State:
Zip Code:	Phone:	Fax Number:
Provider Specialty:	NPI Number:	
E-mail Address:		

Claims Administrator Information

Claims Administrator Name:		Contact Name:	
Address:	City:	State:	
Zip Code:	Phone:	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

Either state the requested treatment in the below space or indicate the specific page number(s) of the accompanying medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; attach additional requests on a separate sheet.

Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)

Treating Physician Signature:	Date:
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Claims Administrator 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

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 to initiate the utilization review process required by Labor Code section 4610. This form is used as an attachment to the Treating Physician's Progress Report – DWC Form PR-2, Doctor's First Report of Occupational Injury – Form DLSR 5021, or an equivalent to request authorization for treatment. The intent of the form is to facilitate communication back and forth between the provider and the claims administrator, and also to furnish a verification of authorization for the requesting provider. Additional sheets should be used if appropriate.

Checkboxes: Please check the appropriate box(es) 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.
- The request is a written confirmation of an earlier oral request.

Routing Information: The DWC Form RFA can either be mailed or faxed to the claims administrator. The requesting provider must complete all identifying information regarding the employee, the claims administrator, and the provider.

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, the ICD Code, the procedure requested, and applicable CPT/HCPCS code.
- Include, as necessary, the frequency, duration, quantity, facility, etc. Reference to specific guidelines used to support treatment should also be included.
- For requested medical 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.

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

Claims Administrator 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, sections 9792.9 or 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 requests; 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.