State of California
Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA - California Code of Regulations, title 8, section 9785.5

~~This form must accompany~~ *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			
Employee Name (Last, First, Middle):			
Date of Injury (MM/DD/YYYY):		Date of Birth (MM/DD/YYYY):	
Claim Number:		Employer:	
~~Provider~~ Treating Physician Information			
~~Provider~~ Treating Physician Name:			
Practice Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
~~Provider~~ Treating Physician 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~~ **sState** the requested treatment in the below space or indicate the specific page number(s) of the **~~accompanying~~ attached** medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; attach a requests on a separate sheet.

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

Treating Physician Signature:	Date:

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:

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. ~~**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.**~~ **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 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. **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: 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. **A request for an expedited, urgent, or rush review not made in good faith may result in civil or criminal penalties and removal from a Medical Provider Network.**
- 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**~~ **treating physician** must complete all identifying information regarding the employee, the claims administrator, and the ~~**provider**~~ **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, the ~~**procedure**~~ **service/good** 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/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~~s~~ ~~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.