

State of California
Division of Workers' Compensation
Request for Authorization for Medical Treatment (DWC Form RFA)

To 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.

Check box if the patient faces an imminent and serious threat to his or her health.

Patient Information

Patient Name:
Date of Birth:
Date of Injury:
Employer:
Claim Number:

Provider Information

Provider Name:
Practice Name:
Address:
City, State, Zip Code:
Telephone Number:
Fax Number:
Provider Specialty:
Provider State License Number:
National Provider ID Number:

Claims Administrator Information

Claims Administrator:
Adjustor Name (if known):
Address:
City, State, Zip:
Telephone Number:
Fax Number:

Instructions:

1. 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. Note that an acceptable narrative report must include subjective complaints, objective findings, diagnosis, and a treatment plan. If applicable, provide the frequency, duration, quantity, facility, and provider.
2. CPT codes are helpful when known, but are optional. CPT codes are required for surgery.
3. For surgery requests, attach or include full surgery orders, and pre- and post-operative orders (if known).
4. If request is to continue a treatment plan or therapy, attach documentation of functional improvement such as the DWC Form FIR.

Requested Treatment (attach additional pages if more space is required):

Date of Request

Provider Signature

Claim Administrator Response Approving Treatment:

You may use this form for approving a treatment request. A request for additional information, or a decision to modify, delay, or deny a request for authorization cannot be made using this form. Please review all timeframes and requirements set forth in California Code of Regulations, title 8, section 9792.9.

A decision on the requested medical treatment must be made within five (5) working days from receipt of this request for authorization, or 14 calendar days with a timely request for information necessary to render a decision. For an expedited request, one made in a case of imminent or serious health threat, the maximum is 72 hours. Authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information.

The requested treatment(s) is approved

Approval tracking number (optional)

Date request for authorization received

Claims Administrator/Authorized Agent Signature

Date of response to request

Adjuster/Authorized Agent Name (print)