State 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.

☐ 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

Name (Last, First, Middle): Quevedo, Abel		
Date of Injury (MM/DD/YYYY): 2/20/2020	Date of Birth (MM/DD/YYYY): 10/28/1978	
Claim Number: 022221-018347-WC-01	Employer: Demco Enterprises, Inc.	

Requesting Physician Information

Name: Jon Noordeloos, Psy.D.		
Practice Name:	Contact Name: 760-908-8169	
Address: 60 West Stone Loop., # 1920	City: Tucson	State: AZ
Zip Code: 85704	Fax Number: 520-207-2447	
Specialty: Psychology	NPI Number: 1649443458	
Email Address:		

Claims Administrator Information

Company Name: Gallagher Bassett Services		Contact Name;	
Address: P.O.Box 2840		City: Clinton	State: IA
Zip Code: 52733-2840	Phone: (916) 576-8200	Fax Number: (916) 576-8206	
Email 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 Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)

Requesting 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:	Email Address:
Comments:		