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.**
☐ **Check box if request is written confirmation of a prior oral request.**

Patient Information

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

Claims Administrator Information

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

Requested Treatment: (See Instructions for guidance; attach additional pages if more space is required.)
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. Include supporting evidence as necessary.

_____ **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 Labor Code section 4610 and California Code of Regulations, title 8, sections 9792.9 and 9792.9.1.

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)**