State of California
Division of Workers' Compensation

Primary Treating Physician's Progress Report & REQUEST FOR AUTHORIZATION

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

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

☐ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ **Request for authorization**
Other: _____

Employee Information			
Employee Name (Last, First, Middle):			
Date of Injury (MM/DD/YYYY):		Date of Birth (MM/DD/YYYY):	
Claim Number:		Employer:	
Treating Physician Information			
Treating Physician Name:			
Practice Name:		Contact Name:	
Address:		City:	Zip Code:
Phone:	Fax Number:	E-mail Address:	
Treating Physician Specialty:		NPI Number:	
Claims Administrator Information			
Claims Administrator Name:		Contact Name:	
Address:		City:	Zip Code:
Phone:	Fax Number:	E-mail Address:	

The information below must be provided.

Subjective complaints:

Review prior treatment outcomes (Include treatment rendered since last report. Have there been any **changes** in treatment plan? If so, why?)

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Diagnoses:

1. ICD- _____ 2. ICD- _____ 3. ICD- _____

Primary Treating Physician: (original signature, do not stamp) Date of exam: _____

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Signature: _____ Cal. Lic. # _____NPI _____
Executed at: _____ Date: _____
Name:_____ Specialty: _____
Address:_____ Phone:_____FAX_____

☐ New Request for Authorization ☐ 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.

Requested Treatment (see instructions for guidance; attach additional pages if necessary & supporting documentation)

State the requested treatment below. Up to eight (8) services/goods may be entered; attach additional requests on separate sheet.

Diagnosis (Required)	ICD-Code	Service/Good Requested	Other Information: (Method, Frequency, Duration, Quantity, 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:	Email Address:

Comments:

Warning: Private healthcare information is contained in the Primary Treating Physician's Progress Report & Request for Authorization DWC Form RFA. The form can only go to other physicians and to the claims administrator, except for the work status page which may go to the employer.

Work Status: This patient has been instructed to:

___Return to full duty on ___________________with no limitations or restrictions.

__Remain off-work until__________.

___Return to *modified* work on________________________ with the following limitations or restrictions

(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

_ _

Overview: A Request for Authorization for Medical Treatment on a Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021 or on this form is required for the employee's treating physician to initiate the utilization review process required by Labor Code section 4610. The intent of the form is to facilitate communication 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. This Form is a reimbursable report under the Official Medical Fee Schedule, found at California Code of Regulations, title 8, section 9789.10 et seq. when completed and submitted by the Primary Treating Physician.

Checkboxes: Check the appropriate box(es). 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 treating physician must complete all applicable fields on the form, including all identifying information regarding the employee, the claims administrator, and the physician.

Requested Treatment: The Form must contain all the information needed to substantiate the request for authorization. If the request is to continue a treatment plan or therapy, attach documentation indicating progress, if applicable.

- ☐ List the diagnosis (required), the ICD Code, the service/good requested, and applicable CPT/HCPCS code.
- ☐ Include, as necessary, the frequency, duration, quantity, 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 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 approval; 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.