

**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): Chaney, Anisa  
Date of Injury (MM/DD/YYYY): 07/05/2020 Date of Birth (MM/DD/YYYY): 09/06/1973  
Claim Number: 2080381794 Employer: Sunbridge Hallmark Health Services DBA Playa de

**Requesting Physician Information**

Name: Eric E Gofnung  
Practice Name: Eric E. Gofnung Chiropractic Corp. Contact Name:  
Address: 6221 Wilshire Blvd Suite 604 City: Los Angeles State: CA  
Zip Code: 90048 Phone: (323) 933-2444 Fax Number: (323) 933-2909  
Specialty: Chiropractor NPI Number: 1821137134  
E-mail Address:

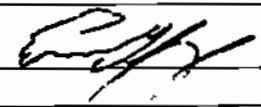
**Claims Administrator Information**

Company Name: Zurich Contact Name:  
Address: P.O.Box 968005 City: Schaumburg State: IL  
Zip Code: Phone: (800) 338-3160 Fax Number: (818) 227-1740  
E-mail 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.)
Left shoulder tenosynoviti	M75.52	Left shoulder MRI		



Requesting Physician Signature: X Date: 06/23/2021

**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: