ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Blvd., Suite 604 • Los Angeles, California 90048 • Tel. (323)933-2444• Fax (323) 933-2909

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am a citizen of the United States. I am over the age of 18 years and not a party of the above-entitled action; my business address is 6221 Wilshire Blvd, Suite 604 Los Angeles, CA 90048. I am familiar with a Company's practice where the mail, after being placed in a designated area, is given the appropriate postage and is deposited in a U. S. mailbox in the City of Los Angeles, after the close of the day's business. On **February 11, 2022**, I served the within following letter / forms on all parties in this action by placing a true copy thereof enclosed in a sealed envelope in the designated area for out-going mail addressed as set forth above or electronically on the specified parties with email addresses as identified. I declare under the penalty of perjury that the foregoing is true and correct under the laws of the State of California and that this declaration was executed at 6221 Wilshire Blvd, Suite 604 Los Angeles, CA 90048.

On 11 day of **February,** 2022, I served the within concerning:

Patient's Name: JOHNSON, MARVETTA
Claim Number: 546-19-7076

- ☐ MPN Notice
- ☐ Designation of Primary Treating Physician & Authorization for Release of Medical Records
- ☐ Financial Disclosure
- ☒ Request for Authorization – **01/10/22**
- ☒ Itemized – (Billing) / HFCA – **01/10/22**
- ☐ QME Appointment Notification
- ☐ Primary Treating Physician's Referral
- ☐ Initial Consultation Report –
- ☒ Re-Evaluation Report / Progress Report (PR-2) **01/10/22**
- ☐ Permanent & Stationary Evaluation Report – _____
- ☐ Post P&S Follow Up - _____
- ☐ Review of Records - _____
- ☐ PQME / Med Legal Report - _____
- ☐ Computerized Dynamic Range of Motion (Rom) And Functional Evaluation Report - _____

List all parties to whom documents were mailed to:

Law offices of Natalia Foley
751 S Weir Canyon, Suite 157-455
Anaheim, CA 92808

Sedgwick
P.O. Box 51350
Ontario, CA 91761

I declare under penalty and perjury under the laws of the State of California, that the foregoing is true and correct, and that this Declaration was executed at Los Angeles, California on 11 day of **February**, 2022.

ILSE PONCE

ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Boulevard, Suite 604/Los Angeles, California90048/ Tel. (323) 933-2444 / Fax (323) 933-2909

January 10, 2022

Law offices of Natalia Foley
751 S Weir Canyon, Suite 157-455
Anaheim, CA 92808

Re:	Patient:	Johnson, Marvetta
	EMP:	Los Angeles County Probation Dept
	INS:	Sedgwick
	Claim #:	Unassigned
	WCAB #:	ADJ14891825
	DOI:	11/06/2020
	D.O.E./Consultation:	January 10, 2022

Primary Treating Physician's
Follow up Evaluation Report
And Request for Authorization

Time Spent Face to face:	15 Mins
Time Spent on Report Preparation	15Mmins

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Follow up Evaluation on January 10, 2022 in my office located at 6221 Wilshire Boulevard, Suite 604, Los Angeles, California 90048. The following information contained in this report is derived from a review of the available medical records, as well as the oral history as presented by the patient. **My associate, Dr. Kravchenko, examined the patient and I, Dr. Gofnung, the primary treating physician, agree with Dr. Kravchenko's physical examination findings and conclusions.**

The history of injury as related by the patient, the physical examination findings, my conclusions and overall recommendations are as follows.

This authorization for treatment is made in compliance with Labor Code 4610 and 8 CCR 9792.6(o) and therefore serves as a written request for authorization for today's evaluation/consultation and treatment recommendations as described in this report. Please

comply with Labor Code 4610, 8 CCR 9792.11 – 9792.15, 8 CCR 10112 – 10112.3 (formerly 8 CCR 10225 – 10225.2) and Labor Code 5814.6. Please comply with Sandhagen v. State Compensation Insurance Fund (2008) 44 Cal. 4 ch 230. Please comply with Jesus Cervantes v. El Aguila Food Products, Inc. and Ciga, et al., WCAB en banc, 7-0, November 19, 2009. Be aware that Labor Code 4610(b) requires the defendant to conduct utilization review on any and all requests for treatment. Furthermore, Labor Code 4610 Utilization Review deadlines are mandatory. It is the defendant's duty to forward all consultation and treatment authorization requests to utilization review. Be aware the defendant and insurance company has five working days to authorize, delay, modify or deny a request for all treatment, but 10 days for spinal surgery. Please issue timely payment for medical care and treatment rendered in order to avoid payment of interests and penalties, per labor codes referenced. Failure of the defendant or insurance company to respond in writing within five working days results in an authorization by default. Furthermore, failure to pay for "self-procured" medical care when utilization deadlines are missed triggers penalties for the defendant or the insurance company due to violation of 8 CCR 10225 – 10225.2 and Labor Code 5814/5814.6 and 4603.2b. When there is a dispute with regard to treatment, the right to proceed with the Labor Code 4062 process belongs exclusively to the injured employee. If the treatment recommendations are not authorized by the insurance carrier, this report and bill should be kept together by the Workers' Compensation carrier for the review company. The claims examiner should forward this report to the defense attorney and nurse case manager.

Interim History:

Ms. Johnson is currently working with restrictions as specified in our prior reporting. She is currently undergoing MRI as recommended in prior reporting. She is scheduled to begin acupuncture treatment on 1/24/22. She denies seeing any other specialist and she denied any new accidents or injuries.

Current Complaints (January 10, 2022):

1. Left shoulder pain is moderate and intermittent to frequent.

2. Left elbow pain is slight and intermittent.

3. Low back pain, frequent and moderate.

4. Left hip pain is slight to moderate and frequent.

5. Left knee pain, slight and intermittent. The patient denies buckling or walking; however, report clicking during ranges of motion.

6. Left ankle pain, slight and intermittent.

7. Sleeping problems, anxiety and depression with complaints of chest pain which the patient associates with stress.

Physical Evaluation (January 10, 2022) – Positive Findings:

Shoulders & Upper Arms:

Left Shoulder:

On inspection, healed arthroscopic scars were present.

Tenderness was noted over the anterior shoulder over the anterior supraspinatus near insertion, subacromial-subdeltoid bursa, acromioclavicular joint, and periscapular musculature.

Orthopedic testing was not performed due to postsurgical status.

Ranges of motion of the right shoulder and left shoulder were within normal limits.

Elbows & Forearms:

Left Elbow:

Tenderness was not present on today's evaluation.

Ranges of motion of the bilateral elbows were normal.

Grip Strength Testing:

Grip strength testing performed utilizing the Jamar Dynamometer at the third notch, measured in kilograms, on 3 attempts produced the following results:

Right: 2/4/4
Left: 8/8/8

Thoracic Spine:

Kemp's test elicited increased pain in the left low back area.

Thoracic spine ranges of motion were restricted due to low back pain.

Re: Patient: Johnson, Marvetta
DOI: 11/06/2020
Date of Exam: January 10, 2022

Lumbar Spine:

Examination revealed tenderness over the bilateral paralumbar musculature. Left sacroiliac joint hypomobility present. Tenderness was present at L4-L5 vertebral regions with hypomobility.

Left sacroiliac joint compression test is positive. Milgram's test positive.

Straight Leg Raising Test (seated) was positive for back pain.

Right: 70 degrees
Left: 60 degrees

Range of motion of lumbar spine with decreased and painful, measured as follows: .

Lumbar Spine Range of Motion Testing		
Movement	Normal	Actual
Flexion	60	**45**
Extension	25	**12**
Right Lateral Flexion	25	**15**
Left Lateral Flexion	25	**20**

Hips & Thighs:

Left Hip & Thigh:

Tenderness was noted over the greater trochanteric region and hip bursa.

Left Patrick Fabere test was positive with increased left hip pain predominately over the greater trochanteric region.

Ranges of motion of left hip normal except flexion but all of them painful.

Hip Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	120	**95**	120
Extension	30	30	30
Abduction	45	45	45
Adduction	30	30	30
External rotation	45	**35**	45
Internal rotation	45	45	45

Re: Patient: Johnson, Marvetta
DOI: 11/06/2020
Date of Exam: January 10, 2022

Knees & Lower Legs:

Left Knee:

Examination revealed slight tenderness at medial joint line.

Left McMurray's test was positive.

Range of motion of the knees, right normal and left was decreased and painful, measured as follows:

Knee Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	135	**110**	135
Extension	0	0	0

Ankles & Feet:

Left Ankle & Foot:

Tenderness was present over the left sinus tarsi.

Ranges of motion were normal at both ankles with pain upon extreme of inversion, plantar flexion, and dorsiflexion.

Diagnostic Impressions:

1. Lumbar myofasciitis, M79.1.
2. Left sacroiliac joint dysfunction, sacroiliitis, M53.3.
3. Lumbar facet-induced versus discogenic pain, M47.816.
4. Left shoulder tenosynovitis/bursitis. Mild supraspinatus and subscapularis tendinosis and acromioclavicular degenerative disease, as per MRI dated 03/03/21, M75.52.
5. Left shoulder impingement syndrome, M75.42.
6. Left shoulder status post arthroscopic surgery around 2011 with aggravation due to November 6, 2020 industrial injury, Z53.33.
7. Left brachioradialis tendinitis, M75.22.
8. Left trochanteric bursitis, M70.62.

9. Left knee internal derangement, rule out, M23.92.

10. Left ankle sinus tarsi syndrome, G57.50.

11. Anxiety and depression, F41.9, F34.1.

12. Insomnia, G47.00.

Discussion and Treatment Recommendations:

The patient is recommended comprehensive treatment course consisting of chiropractic manipulations and adjunctive multimodality physiotherapy to include myofascial release, hydrocollator, infrared, cryotherapy, electrical stimulation, ultrasound, strengthening, range of motion (active / passive) joint mobilization, home program instruction, therapeutic exercise, intersegmental spine traction and all other appropriate physiotherapeutic modalities **for lumbar spine, left shoulder, left hip, and left knee at once per six weeks with a followup in six weeks.**

The patient is **recommended at this time MRI of her lumbar spine, left hip as well as x-rays of the lumbar spine, left elbow, left shoulder, and left ankle.**

The patient is **recommended NCV/EMG studies of the lower extremities for further workup of lumbar radicular complaints.**

The patient is **recommended the following specialty evaluations:**

- **Acupuncture treatment.**
- **Interventional pain management evaluation for further workup for spine-related complaints and pharmacological management to explore interventional pain management options.**
- **Orthopedic evaluation for further workup of left upper extremity in view of history of prior left shoulder surgery.**
- **Internal medicine consultation for further workup of chest pain and rule out organic causes.**

The patient is **recommended left knee stabilizer brace and left hip trochanteric brace to use based on pain levels.**

The patient is **recommended home exercise to tolerance of core strengthening utilizing a gym ball, wall squats, McKenzie exercise, and resistance band training for the extremities. The patient is recommended aqua therapy and authorization is hereby requested. The patient also encouraged to swim if she has access to pool to tolerance. The patient is encouraged light resistance training that could be done in gym-like setting with**

machines and free weights to tolerance to maximize functional restoration and expedite recovery. The patient was instructed to avoid high-impact type of activities.

Permanent and Stationary Status:

The patient's condition is not permanent and stationary.

Work Status/Disability Status:

The patient was returned to modified duty at this time on 08/06/21, precluding work with the left arm at or above shoulder height; precluding lifting in excess of 15 pounds and furthermore restricted to occasional basis. The patient is precluded from bending and stooping, as well as repetitive forceful gripping, grasping, torquing, pulling or pushing. The patient is precluded from squatting, kneeling, and climbing and prolonged standing and walking. The patient must be able to sit as needed in a comfortable chair with a back support. The patient should use lumbar spine orthosis, left hip trochanteric brace, left knee brace while working.

If modified duty as indicated is not provided, then the patient is considered temporarily totally disabled until reevaluation in six weeks.

Disclosure:

I derived the above opinions from the oral history as related by the patient, revealed by the available medical records, diagnostic testing, credibility of the patient, examination findings and my clinical experience. This evaluation was carried out at 6221 Wilshire Boulevard, Suite 604, Los Angeles, California 90048. I prepared this report, including any and all impressions and conclusions described in the discussion.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628)(b): " I declare that Dr. Kravchenko examined the patient and may have assisted with initial preparation and assembly of components of this report, and I, Dr. Gofnung, the primary treating physician, have reviewed the report, edited the document, reviewed the final draft and I am in agreement with the findings, including any and all impressions and conclusions as described in the this report."

I performed the physical examination, reviewed the document and reached a conclusion, of this report which was transcribed by Acu Trans Solution LLC and I proofread and edited the final draft prior to signing the report in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (J) of Section 139.2.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628(J)): "I declare under penalty of perjury that the information contained in this report and it's attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."

In compliance with recent Workers' Compensation legislation (Labor Code Section 5703 under AB 1300): "I have not violated Labor Code Section 139.3 and the contents of this report are true and correct to the best of my knowledge. This statement is made under penalty of perjury and is consistent with WCAB Rule 10978."

The undersigned further declares that the charges for this patient are in excess of the RVS and the OMFS codes due to high office and staff costs incurred to treat this patient, that the charges are the same for all patients of this office, and that they are reasonable and necessary in the circumstances. Additionally, a medical practice providing treatment to injured workers

experiences extraordinary expenses in the form of mandated paperwork and collection expenses, including the necessity of appearances before the Workers' Compensation Appeals Board. This office does not accept the Official Medical Fee Schedule as prima facie evidence to support the reasonableness of charges. I am a board-certified Doctor of Chiropractic, a state-appointed Qualified Medical Evaluator, a Certified Industrial Injury Evaluator and certified in manipulation under anesthesia. Based on the level of services provided and overhead expenses for services contained within my geographical area, I bill in accordance with the provisions set forth in Labor Code Section 5307.1.

NOTE: The carrier/employer is requested to immediately comply with 8 CCR Section 9784 by overnight delivery service to minimize duplication of testing/treatment. This office considers "all medical information relating to the claim" to include all information that either has, will, or could reasonably be provided to a medical practitioner for elicitation of medical or medical-legal opinion as to the extent and compensability of injury, including any issues regarding AOE/COE - to include, but not be limited to, all treating, evaluation, and testing reports, notes, documents, all sub rosa films, tapes, videos, reports; employer-level investigation documentation including statements of individuals; prior injury documentation; etc. This is a continuing and ongoing request to immediately comply with 8 CCR Section 9784 by overnight delivery service should such information become available at any time in the future. Obviously, time is of the essence in providing evaluation and treatment. Delay in providing information can only result in an unnecessary increase of treatment and testing costs to the employer.

I will assume the accuracy of any self-report of the examinee's employment activities, until and unless a formal Job Analysis or Description is provided. Should there be any concern as to the accuracy of the said employment information, please provide a Job Analysis/Description as soon as possible.

I request to be added to the Address List for Service of all Notices of Conferences, Mandatory Settlement Conferences and Hearings before the Workers' Compensation Appeals Board. I am advising the Workers' Compensation Appeals Board that I may not appear at hearings or Mandatory settlement Conferences for the case in chief. Therefore, in accordance with Procedures set forth in Policy and Procedural Manuel Index No. 6.610, effective February 1, 1995, I request that defendants, with full authority to resolve my lien, telephone my office and ask to speak with me.

The above report is for medicolegal assessment and is not to be construed as a report on a complete physical examination for general health purposes. Only those symptoms which I believe have been involved in the injury, or might relate to the injury, have been assessed. Regarding the general health of the patient, the patient has been advised to continue under the care of and/or to get a physical examination for general purposes with a personal physician.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Should you have any questions with regard to this consultation please contact me at my office.

Re: Patient: Johnson, Marvetta
DOI: 11/06/2020
Date of Exam: January 10, 2022

Sincerely,

Eric E. Gofnung, D.C.
Manipulation Under Anesthesia Certified
State Appointed Qualified Medical Evaluator
Certified Industrial Injury Evaluator

Signed this 17 day of January, 2022, in Los Angeles, California.

EEG:svl

Sincerely,

Mayya Kravchenko, D.C., QME
State Appointed Qualified Medical Evaluator
Certified Industrial Injury Evaluator

Signed this 17 day of January, 2022, in Los Angeles, California.

MK:svl

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): Johnson, Marvetta

Date of Injury (MM/DD/YYYY): 11/06/2020 | Date of Birth (MM/DD/YYYY): 12/11/1967

Claim Number: | Employer: Los Angeles County Probation Dept.

Requesting Physician Information

Name: Eric Gofnung, DC

Practice Name: Eric Gofnung Chiro Corp. | Contact Name: Ilse Ponce

Address: 6221 Wilshire Blvd Suite 604 | City: Los Angeles | State: CA

Zip Code: 90048 | Phone: (323) 933-2444 | Fax Number: (323) 903-0301

Specialty: Chiropractor | NPI Number: 1821137134

E-mail Address: ilse.ponce@att.net

Claims Administrator Information

Company Name: Sedgwick | Contact Name:

Address: P.O. Box 51350 | City: Ontario | State: CA

Zip Code: | Phone: (909) 942-8918 | Fax Number:

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.)
Sacroiliac Joint Sprain	S33.6XXD	Electrical Stimulation	G0283	1x 6 weeks
Lumbar Facet	M47.816	Therapeutic Exercises	97110	
Shoulder Tenosynovitis	M65.812	Massage Therapy	97124	
Hip Trochanteric Bursitis	M70.62	CMT 3-4 regions	98941	
Knee Internal Derangeme	M23.92	Extraspinal Manipulation w/spinal	98943	

Requesting Physician Signature: | Date: 01/10/2022

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:

State of California, Division of Workers' Compensation

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Sacroiliac Joint Sprain	S33.6XXD	NCV/EMG		
Lumbar Facet	M47.816	Lower extremities		
Shoulder Tenosynovitis	M65.812			
Hip Trochanteric Bursitis	M70.62			
Knee Internal Derangeme	M23.92			

Requesting Physician Signature:	Date: 01/10/2022

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Sacroiliac Joint Sprain	S33.6XXD	Acupuncture Consultation		
Lumbar Facet	M47.816	and Treatment		
Shoulder Tenosynovitis	M65.812			
Hip Trochanteric Bursitis	M70.62			
Knee Internal Derangeme	M23.92			

Requesting Physician Signature:	Date: 01/10/2022

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Sacroiliac Joint Sprain	S33.6XXD	Interventional Pain Management		
Lumbar Facet	M47.816	Consultation		
Shoulder Tenosynovitis	M65.812			
Hip Trochanteric Bursitis	M70.62			
Knee Internal Derangeme	M23.92			

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Specialty: Chiropractor		NPI Number: 1821137134	
E-mail Address: ilse.ponce@att.net			

Claims Administrator Information

Company Name: Sedgwick		Contact Name:	
Address: P.O. Box 51350		City: Ontario	State: CA
Zip Code:	Phone: (909) 942-8918	Fax Number:	
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.)
Sacroiliac Joint Sprain	S33.6XXD	Orthopedic Consultation		
Lumbar Facet	M47.816			
Shoulder Tenosynovitis	M65.812			
Hip Trochanteric Bursitis	M70.62			
Knee Internal Derangeme	M23.92			

Requesting Physician Signature: Date: 01/10/2022

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:		

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): Johnson, Marvetta			
Date of Injury (MM/DD/YYYY): 11/06/2020		Date of Birth (MM/DD/YYYY): 12/11/1967	
Claim Number:		Employer: Los Angeles County Probation Dept.	

Requesting Physician Information

Name: Eric Gofnung, DC			
Practice Name: Eric Gofnung Chiro Corp.		Contact Name: Ilse Ponce	
Address: 6221 Wilshire Blvd Suite 604		City: Los Angeles	State: CA
Zip Code: 90048	Phone: (323) 933-2444	Fax Number: (323) 903-0301	
Specialty: Chiropractor		NPI Number: 1821137134	
E-mail Address: ilse.ponce@att.net			

Claims Administrator Information

Company Name: Sedgwick		Contact Name:	
Address: P.O. Box 51350		City: Ontario	State: CA
Zip Code:	Phone: (909) 942-8918	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

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Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Hypertension	I10	Internal Medical Consultation		

Requesting Physician Signature: Date: 01/10/2022

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:		

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

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Employee Information

Name (Last, First, Middle): Johnson, Marvetta			
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Specialty: Chiropractor		NPI Number: 1821137134	
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Claims Administrator Information

Company Name: Sedgwick		Contact Name:	
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Zip Code:	Phone: (909) 942-8918	Fax Number:	
E-mail Address:			

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Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Sacroiliac Joint Sprain	S33.6XXD	x-rays		
Lumbar Facet	M47.816	lumbar spine		
Shoulder Tenosynovitis	M65.812	left elbow		
Hip Trochanteric Bursitis	M70.62	left shoulder		
Knee Internal Derangeme	M23.92	left ankle		

Requesting Physician Signature: Date: 01/10/2022

Claims Administrator/Utilization Review Organization (URO) Response

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☐ 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:		