

P.O. Box 1061 Bradenton, FL 34206 T: 941.306.2393

F: 941.444.6200

Proof of Service By Mail

(STATE OF CALIFORNIA)

I am a citizen of the United States and a resident of the County of Sacramento; I am over the age of eighteen years and not a party to the within entitled action; and my business address is in Folsom, CA 95630.

Claimant:

Sandra Roquemore

Claim #:

UW2000031101

On this date, I served the within:

RFA Response Letter: 4/19/2021

RFA: 3/8/2021

On the following persons:

Eric Gofnung, DC 6221 Wilshire Blvd., Ste. 604 Los Angeles, CA 90048

Workers Defender Law Firm 8018 E Santa Ana Canyon Rd., Suite 100 Anaheim, CA 92808

DJG Law Group David Gonzales 8181 East Kaiser Blvd., Ste. 100 Anaheim, CA 92808

Sandra Roquemore 1763 Exposition Blvd Los Angeles, CA 90018

By placing a true copy thereon fully prepaid, in the United States mail in Folsom, CA.

I certify under penalty of perjury, that the foregoing is true and correct.

Executed on this April 19, 2021 in Folsom, CA.

Signed

Michael Mangels



P.O. Box 1061 Bradenton, FL 34206 T: 941.306.2393 F: 941.444.6200

April 19, 2021

Eric Gofnung, DC 6221 Wilshire Blvd., Ste. 604 Los Angeles, CA 90048

RE: Employee: Sandra Roquemore

Carrier: United Wisconsin Insurance Company

Policyholder: Cornerstone Capital Group Inc LCF Vets Securing America Inc American Guard

Services (dba)

Employer: Vets Securing America Inc American Guard Services (dba)

Claim#: UW2000031101 D/A: 11/03/2020

Dear Eric Gofnung, DC,

I received your Request for Authorization for medical Treatment (RFA) on 4/16/2021 for Interventional Pain Management Consultation, Acupuncture Consultation with Dr. Edmond Feder, Electrical Stimulation, Therapeutic Exercises, Massage Therapy, CMT 3-4 regions and Extraspinal Manipulation w/spinal.

Per CCR 6460.9(1) your RFA cannot be processed because this claim has been denied.

Please be advised that any and all future RFA's will not be submitted to Utilization Review pursuant to CCR 9792.9(1). Any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, Patricia Carruthers at (941) 900-4764. You also have the right to be represented by an attorney of your choice. However, if you are represented, please contact your attorney with any questions you have.

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an Information and Assistance (I&A) Officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call 1-800-736-7401.

Sincerely,

Patricia Carruthers Claim Adjuster

CC:



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Workers Defender Law Firm 8018 E Santa Ana Canyon Rd., Suite 100 Anaheim, CA 92808

DJG Law Group David Gonzales 8181 East Kaiser Blvd., Ste. 100 Anaheim, CA 92808

Sandra Roquemore 1763 Exposition Blvd Los Angeles, CA 90018

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 6021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

		ployee faces an immir firmation of a prior on		rious threat to his or I	Change in Material Facts her health	
Name (Last, First, Mide	de): Roquemore, 5	Sanda A.				
Date of Injury (MM/DD	/YYYY): 10/26/202	20	Date	of Birth (MM/DD/YY	YY):02/11/1 95 5	
Claim Number: 584-92-	3586	-115		loyer: American Guard		
		44.0		N. Colombia		
Name: Eric Gofnung, DC						
Practice Name: Eric Go	fnung Chiro Corp.		Cont	act Name: Ilse Ponce		
Address: 6221 Wilshire Blvd Suita 604			City:	City: Los Angeles State: CA		
Zip Code: 90048	ip Code: 90048 Phone: (323) 933-2444		Fax Number: (323) 903-0301			
Specialty: Chiroprector	The same		MPII	Number: 1821137134		
E-mail Address: itse.por	nce@att.net					
		THE RESERVE OF	Con St			
Company Name: Ned	Level Administrate	3	Cont	Contact Name: Ruerina Brychia		
Address: P.O. Box 1061			City:	Bradenton	State: FI	
Zip Code:	Phone: (f	B77) 306 -63 9 8	Fax	Number: (941) 444-620)	
E-mail Address:				1 1 1		
of the attached medica		the requested treatm	ent can he			
	NO TON	neet if the space belov	v is insuffici	lent.		
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Diagnosis	ICD-Code	Service/Good Re	v is insuffici iquested i)	cpt/Hcpcs	Other Information: (Frequency, Duration Quantity, etc.)	
Diagnosis (Required)	ICD-Code (Required)	Service/Good Re (Required	v is insuffici quested i) isnegement	cpt/Hcpcs	Other Information: (Frequency, Duration Quantity, etc.)	
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Diagnosis (Required) Sacrollec Joint Sprain Lumber Facet	ICD-Code (Required) S33.6XXD M47.816	Service/Good Re (Required	v is insuffici quested i) isnegement	cpt/Hcpcs	Other Information: (Frequency, Duration Quantity, etc.)	
Diagnosis (Required) Sacrollac Joint Sprain Lumber Facet Hip Trochentaric Bursitis	ICD-Code (Required) S33.6XXD M47.816 M70.61	Service/Good Re (Required	v is insuffici quested i) isnegement	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.) RECEIVE APR 1 6 202	
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Diagnosis (Required) Sacrollac Joint Sprain Lumber Facet Hip Trochantaric Bursitis Requesting Physician	ICD-Code (Required) S33.6XXD M47.816 M70.61 Signature:	Service/Good Re (Required Interventional Pain M Consultatio	v is insuffici	Date:	Other Information: (Frequency, Duration Quantity, etc.) RECEIVE APR 1.6. 202 NI.A cs/0a/2021 e notification of delay) See separate letter)	
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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.

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			الانتجاب	1413	
Name (Lest, First, Midd	e): Roquemore, S	enda A.	THE SE		
Date of Injury (MM/DD/	YYYY): 10/26/2020	0	Date	of Birth (MM/DD/YYY	Y): 02/11/1955
Claim Number: 584-92-3	TO THE PARK SHOULD BE A STORY OF THE			loyer: American Guard S	Services, DBA
		A Part College	-	Contract of the second	
Name: Eric Gofnung, DC		34777	1000	1.0	
Practice Name: Eric Gots	nung Chiro Corp.		Cont	act Name: Ilse Ponce	
Address: 6221 Wilshire Blvd Suite 604			City: Los Angeles State: CA		
Zip Code: 90048 Phone: (323) 933-2444			Fax	Number: (323) 903-030)1
Specialty: Chiroprector			NPI	Number: 1821137134	
E-mail Address: Ilse.pon	ce@atLnet		-		
		一种一种一种	(d. 14)		
Company Name: Next t				act (4sme: Ruenna Bry	chia
Address; P.O. Box 1061			City:	Bradenton	State: Fl
Zip Code:	Phone: (8	77) 306-6398	Fax	Number: (941) 444-520	0
E-mail Address:					
of the attached medical	report on which	the requested treatment set if the space below is Service/Good Required)	can be insuffic	found. Up to five (5)	che specific page number(s) procedures may be entered; Other Information: (Frequency, Duration Quantity, etc.)
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Lumber Facet	M47.816	with Dr. Edmond Fe	der		
Hip Trochanteric Bursitis	M70.61				
Requesting Physician 8	ignature:	CH		Date:	03/C8/2021
Requested treatme	nt has been prev	See seperaté decision le riously denied Liabil	ty for to	eatment is disputed (S	notification of delay) see separate letter)
Authorization Number (If eseigned):		0	ale:	
Authorized Agent Name	0:		_	ignature:	* * * * * * * * * * * * * * * * * * * *
Phone:	Fax Nu	mber:	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.

	IS 8 WITTEN CON	firmation of a prior oral request.		
	XXX-		(1)	
iame (Last, First, Middl	e): Roquemore, S	ande A.	6-1-4-3 4-4-4 A	
Date of Injury (MM/DD/)			of Birth (MM/DD/YY)	(Y): 02/11/1955
Claim Number: 564-92-3			loyer: American Guard	
	***	THE PARTY OF THE P	MORAL AND CO.	
Name: Eric Gofnung, DC				
Practice Name: Eric Gofr	ung Chiro Corp.	Con	tact Name: ilse Ponce	
Address: 6221 Wilshire Blvd Suite 604			Los Angeles	State: CA
Zip Code: 90048	Phone: (3	23) 933-2444 Fax	Number: (323) 903-030	01
Specially: Chiropractor		NPI	Number: 1821137134	
E-mail Address: itse.pond	ce@att.net	•		
	Te			
Company Name: Next L	evel Administrato	rs Con	Contact Name: Ruenna Brychta	
Address: P.O. Box 1061		City	City: Bradenton State	
Zip Code:	Phone: (8	77) 306-6398 Fax	Number: (941) 444-620	10
E-mail Address:				
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List each specific reque of the attached medical	sted medical ser report on which	rvices, goods, or items in the be the requested treatment can be	low space or indicate	the specific page number(r procedures may be entere
of the attached medical	report on which	rvices, goods, or Items in the be	low space or indicate found. Up to five (5)	Other Information: (Frequency, Duration
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