

Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOLUTIONS
First Name: JESSICA
Last Name: LEMASSON
Main Phone: 9739401851
Ext.:
Fax: 9739401852
Email Address JLEMASSON@RISKSOLUTIONS.COM

Claimant

Request: MRI
First Name: JULIUS
Last Name: MADDEN
Claim Number: PJWC086685
Date of Injury: 2024-01-23
ICD Code
Describe Injury: THUMB HYPEREXTENSION/SPRAIN
Working: YES
Occupation: POLICE
Date of Birth: 1996-01-08
Gender: MALE
Home Phone: (732)766-9462
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 365 NEW BRUNSWICK AVE.
Address 2:
City: PERTH AMBOY
State:
Zip: 08861
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY
Phone Number: 732-827-2096

Contact: MARIA RIVERA
Address 1: 260 HIGH STREET
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08861
PT - Schedule during work hours? YES
What hours does patient work?

Referring Doctor

First Name: YVONNE
Last Name: FARNACIO, MD
Practice Name: HACKENSACK MERIDIAN HEALTH
Phone Number: 732-362-3871
Email Address:
Fax: 732-362-3873
Address 1: 742 US-1 N
Address 2:
City: ISELIN
State: NJ
Zip: 08830
Did patient have surgery? NO
Surgery Date:
DX: THUMB HYPEREXTENSION/SPRAIN
Body Parts: RIGHT HAND
of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD: 2024-01-29

Special Instructions

Special Instructions: FOR FURTHER QUESTIONS OR CORRESPONDENCE, PLEASE
CONTACT:

LWINTER@RISKSOLUTIONS.COM

THANK YOU