Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOULUTIONS
First Name: KRISTIN
Last Name: WILKINSON
Main Phone: 973-940-1851
Ext.:
Fax: 973-940-1852
Email Address KWILKINSON@RISKSOLUTIONS.COM

Claimant

Request: DME
First Name: KIRBY
Last Name: JOHNSTON
Claim Number: MT078771
Date of Injury: 2021-12-14
ICD Code M75.122
Describe Injury: LEFT SHOULDER TOTAL SHOULDER ARTHROPLASTY

Working: YES
Occupation: SANITATION
Date of Birth:
Gender: MALE
Home Phone: 908-938-9099
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 5 BURNHAM PARKWAY
Address 2:
City: MORRISTOWN
State: NJ
Zip: 07960
Preferred Language:

Employee

Company: TOWN OF MORRISTOWN
Phone Number: 973-292-6627

Contact: CATILIN CASTILLO
Address 1: 200 SOUTH ST
Address 2: PO BOX 914
City: MORRISTOWN
State: NJ
Zip: 07960
PT - Schedule during work hours? YES
What hours does patient work?

Referring Doctor

First Name: ANDREW
Last Name: WILLIS
Practice Name: SURGICAL CENTER AT CEDAR KNOLLS
Phone Number: 973-538-2334
Email Address:
Fax:
Address 1: 197 RIDGEDALE AVENUE
Address 2:
City: CEDAR KNOLLS
State NJ
Zip: 07927
Did patient have surgery?
Surgery Date: 2023-06-01
DX: LT SHOULDER REVERSE TOTAL SHOULDER ARTHROPLASTY
Body Parts:
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD:

Special Instructions

Special Instructions: ANY QUESTIONS OR FURTHER CORRESPONDENCE PLEASE CONTACT LUCIA WINTER AT LWINTER@RISKSOLUTIONS.COM

THANK YOU