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: GEORGE
Last Name: WEISS
Claim Number: IWC031593
Date of Injury: 2009-12-08
ICD Code
Describe Injury: BILATERAL SHOULDER JOINT PAIN

Working: NO
Occupation: RETIRED
Date of Birth: 1959-03-06
Gender: MALE
Home Phone: (908) 687-7848
Cell Phone: (908) 377-5548
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 1182 BURNET AVENUE
Address 2:
City: UNION
State: NJ
Zip: 07083
Preferred Language:

Employee

Company: IRVINGTON TWP
Phone Number: 973-399-6554

Contact:
Address 1: 1 CIVIC SQUARE
Address 2:
City: IRVINGTON
State: NJ
Zip: 07111
PT - Schedule during work hours? NO
What hours does patient work?

Referring Doctor

First Name: GREGORY
Last Name: PINKOWSKY, MD
Practice Name: SUMMIT MEDICAL GROUP
Phone Number: 973-669-5600
Email Address:
Fax: 973-669-0269
Address 1: 1500 PLEASANT VALLEY WAY
Address 2:
City: WEST ORANGE
State NJ
Zip: 07052
Did patient have surgery? YES
Surgery Date: 2017-11-27
DX: BILATERAL SHOULDER JOINT PAIN
Body Parts: RIGHT SHOULDER, LEFT SHOULDER
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD:

Special Instructions

Special Instructions: FOR FURTHER QUESTIONS OR CORRESPONDENCE PLEASE CONTACT:

CSHELL@RISKSOLUTIONS.COM

THANK YOU