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: PT
First Name: YASIN
Last Name: WELCH
Claim Number: PJWC085684
Date of Injury: 2023-10-13
ICD Code
Describe Injury:

Working: YES
Occupation: LABORERLUMBOSACRAL/ THORACIC STRAIN, CERVICAL/THORACIC
Date of Birth: 1979-04-27
Gender: MALE
Home Phone: (973)220-7704
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 515 ELIZABETH AVE
Address 2:
City: NEWARK
State: NJ
Zip: 07112
Preferred Language:

Employee

Company: BOROUGH OF ROSELLE
Phone Number: (908)241-2014

Contact: KHEESHA WALLS
Address 1: 210 CHESTNUT ST
Address 2:
City: :ROSELLE
State: NJ
Zip: 07203
PT - Schedule during work hours? YES
What hours does patient work? 6:00 AM-2:00PM, M-F

Referring Doctor

First Name: GREGORY S
Last Name: GALLICK, MD
Practice Name:
Phone Number: 908-686-6665
Email Address:
Fax:
Address 1: 2780 MORRIS AVE
Address 2: 2C
City: UNION
State NJ
Zip: 07083
Did patient have surgery? NO
Surgery Date:
DX: LUMBOSACRAL/ THORACIC STRAIN, CERVICAL/THORACIC STRAIN
Body Parts: BACK
# of Auth visits: 6
Freq/Duration: 3X A WEEK FOR 2 WEEKS
Script: YES
Follow-up MD:

Special Instructions

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

KWILKINSON@RISKSOLUTIONS.COM

THANK YOU