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: PT
First Name: LESLIE
Last Name: CUMMINGS
Claim Number: PJWC08199-01
Date of Injury: 2022-11-16
ICD Code
Describe Injury: S/P OPERATIVE SHOULDER, BICEPS TENODESIS

Working: YES
Occupation: LABORER
Date of Birth: 1976-11-11
Gender: MALE
Home Phone: 908-532-7320
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 216 E. 8TH AVE
Address 2:
City: ROSELLE
State: NJ
Zip: 07203
Preferred Language:

Employee

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

Contact: KHEESHA WALLS
Address 1: 210 CHESNUT STREET
Address 2:
City: ROSELLE
State: NJ
Zip: 07203
PT - Schedule during work hours? YES
What hours does patient work? 6AM -230 PM

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: 07083-4848
Did patient have surgery? YES
Surgery Date: 2023-01-12
DX: LEFT SHOULDER ARTHROSCOPY, SUBACROMIAL DECOMPRESSION
Body Parts:
# of Auth visits: 9
Freq/Duration: 3XS A WEEK FOR 2 WEEKS
Script: YES
Follow-up MD: 2023-02-01

Special Instructions

Special Instructions: ANY QUESTIONS OR FURTHER CORRESPONDENCE PLEASE CONTACT DFORGIONE@RISKSOLUTIONS.COM

THANK YOU