Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOLUTIONS
First Name: JESSICA
Last Name: LEMASSON
Main Phone: 973-940-1851
Ext.: 286
Fax: 973-940-1852
Email Address JLEMASSON@RISKSOLUTIONS.COM

Claimant

Request: MRI
First Name: JAMES
Last Name: GARRISON
Claim Number: PJWC086746
Date of Injury: 2024-01-27
ICD Code
Describe Injury: LEFT SHOULDER SPRAIN/STRAIN

Working: YES
Occupation: PAID FIRE FIGHTER
Date of Birth: 1986-12-02
Gender: MALE
Home Phone: (732) 433-4323
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 556 HAZEL AVENUE
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08861
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY
Phone Number: (732)826-0290

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? 24 ON 72 OFF

Referring Doctor

First Name: DOROTA
Last Name: SOHAIL, APN
Practice Name: HACKENSACK MERIDIAN HEALTH
Phone Number: 732-362-3871
Email Address:
Fax: 732-362-3873
Address 1: 742 US-1N
Address 2:
City: ISELIN
State NJ
Zip: 08830
Did patient have surgery? NO
Surgery Date:
DX: LEFT SHOULDER SPRAIN/STRAIN
Body Parts: LEFT SHOULDER
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD:

Special Instructions

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

LWINTER@RISKSOLUTIONS.COM

THANK YOU