

Referral

Submitter

Company Name: DH ALTERNATIVE RISK SOLUTIONS
First Name: KRISTIN
Last Name: WILKINSON
Main Phone: 9739401851
Ext.:
Fax: 973-940-1852
Email Address KWILKINSON@RISKSOLUTIONS.COM

Claimant

Request: PT
First Name: JAMES
Last Name: SHAW
Claim Number: PVS066108
Date of Injury: 2019-01-03
ICD Code RIGHT SHOULDER RTC
Describe Injury: RIGHT SHOULDER RTC

Working: YES
Occupation: OPERATOR
Date of Birth: 1965-03-25
Gender: MALE
Home Phone: 908-525-9825
Cell Phone:
Work Phone:
Ext.:

Alternate Phone:
Alt. Phone Description:
Email Address:

Address 1: 1240 BARBARA AVE
Address 2:
City: UNION
State: NJ
Zip: 07083
Preferred Language:

Employee

Company: PASSAIC VALLEY SEWAGE AUTHORITY
Phone Number: 973-817-5695

Contact: CHRISTINE CATENARO
Address 1: 600 WILSON AVE
Address 2:
City: NEWARK
State: NJ
Zip: 07105
PT - Schedule during work hours? YES
What hours does patient work? 6AM -2PM

Referring Doctor

First Name: DAVID M.
Last Name: EPSTEIN, MD
Practice Name: TRI COUNTY ORTHOPEDICS & SPORTS MEDICINE
Phone Number: 973-538-2334
Email Address:
Fax: 973-538-4081
Address 1: 160 EAST HANOVER AVE
Address 2:
City: MORRISTOWN
State: NJ
Zip: 07962
Did patient have surgery? YES
Surgery Date: 2023-09-18
DX:
Body Parts:
of Auth visits: 8 -12
Freq/Duration: 2-3 TIMES PER WEEK FOR 4 WEEKS
Script: YES
Follow-up MD: 2023-10-16

Special Instructions

Special Instructions: ANY QUESTIONS PLEASE CONTACT
CSHELL@RISKSOLUTIONS.COM