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: DOROTHEA
Last Name: REED
Claim Number: IWC086891
Date of Injury: 2024-02-07
ICD Code
Describe Injury: BACK AND HIP

Working: YES
Occupation: FIRE OFFICIAL
Date of Birth: 1966-08-06
Gender: FEMALE
Home Phone: (973)202-2611
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 235 BIRCHWOOD AVE.
Address 2: APT.118
City: CRANFORD
State: NJ
Zip: 07016
Preferred Language:

Employee

Company: TOWNSHIP OF IRVINGTON
Phone Number: 973-399-6553

Contact:
Address 1: 1 CIVIC SQUARE
Address 2:
City: IRVINGTON
State: NJ
Zip: 07111
PT - Schedule during work hours? YES
What hours does patient work? 9AM-4 PM, TUES-FRI

Referring Doctor

First Name: VINAY
Last Name: CHOPRA, MD
Practice Name: GENESIS ORTHOPEDIC AND SPINE
Phone Number: 908-588-2311
Email Address:
Fax: 908-588-2319
Address 1: 116 S EUCLID AVE
Address 2:
City: WESTFIELD
State NJ
Zip: 07090
Did patient have surgery? NO
Surgery Date:
DX: LUMBAR RADICULOPOTHY, SPINAL INSTABILITY, RIGHT HIP PAIN, L
Body Parts: BACK, RIGHT HIP, LEFT HIP
# 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