

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: DME
First Name: SANDRO
Last Name: PEREZ-JIMENEZ
Claim Number: PJWC080185
Date of Injury: 2022-06-13
ICD Code M19.011
Describe Injury: RIGHT SHOULDER GLENOHUMERAL JOINT OSTEOARTRITIS
Working: YES
Occupation: MAINTENACE 1
Date of Birth: 1971-10-14
Gender: MALE
Home Phone: 787-368-3107
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 469 MCKEAN STREET
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?
What hours does patient work? 730-330 (M-F)

Referring Doctor

First Name: ANDREW
Last Name: WILLIS
Practice Name: SURGICAL CENTER AT CEDAR KNOLLS
Phone Number: 973-998-8950
Email Address:
Fax: 973-998-7610
Address 1: 197 RIDGEDALE AVENUE
Address 2:
City: CEDAR KNOLLS
State: NJ
Zip: 07927
Did patient have surgery?
Surgery Date:
DX:
Body Parts:
of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD:

Special Instructions

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

SURGERY DATE IS SET FOR MARCH 16TH, 2023

THANK YOU