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: MRI
First Name: MICHAEL
Last Name: LUKKO
Claim Number: HST085573
Date of Injury: 2023-09-22
ICD Code S93.401A
Describe Injury: SPRAIN OF UNSPECIFIED LIGAMENT OF RIGHT ANKLE, INIT ENCNTR

Working: YES
Occupation: FIRE FIGHTER
Date of Birth: 1985-11-02
Gender: MALE
Home Phone: 308-370-3963
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 20 WENTWORTH ROAD
Address 2:
City: BEDMINSTER
State: NJ
Zip: 07921
Preferred Language:

Employee

Company: HILSIDE TOWNSHIP

Phone Number: 973-926-3002 EXT 333
Contact: HOPE SMITH
Address 1: 1409 LIBERTY AVE
Address 2:
City: HILLSIDE
State: NJ
Zip: 07205
PT - Schedule during work hours?
What hours does patient work?

Referring Doctor

First Name: JAMES
Last Name: BELLAMY,DO
Practice Name: CONCENTRA MEDICAL CENTER NJ
Phone Number: 908-231-0777
Email Address:
Fax: 908-722-6031
Address 1: 350 GROVE STREET
Address 2:
City: BRIDGEWATER
State NJ
Zip: 08807
Did patient have surgery? NO
Surgery Date:
DX:
Body Parts:
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD: 2023-10-17

Special Instructions

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