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: CT
First Name: JAMES
Last Name: BULLOCK
Claim Number: IWC088558
Date of Injury: 2024-06-26
ICD Code
Describe Injury: INJ L HIP/GROIN FELT PAIN, WHEN EE WAS LIFTING A METAL DOOR

Working: YES
Occupation: LABORER
Date of Birth: 1967-04-25
Gender: MALE
Home Phone: (551)313-3895
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 249 S. ARLIGTON AVE.
Address 2:
City: EAST ORANGE
State: NJ
Zip: 07018
Preferred Language:

Employee

Company: TOWNSHIP OF IRVINGTON

Phone Number: 973-399-6603
Contact:
Address 1: 1 CIVIC SQUARE
Address 2:
City: IRVINGTON
State: NJ
Zip: 07111
PT - Schedule during work hours?
What hours does patient work? 8AM-4PM, M-F

Referring Doctor

First Name: CHRISTINA
Last Name: ONORATO, NP
Practice Name: OAKTREE HEALTHCARE PC DBA METRODOC OF BELLEVILLE
Phone Number: 973-412-3600
Email Address:
Fax: 973-310-6000
Address 1: 115 BELMONT AVE
Address 2:
City: BELLEVILLE
State NJ
Zip: 07109
Did patient have surgery? NO
Surgery Date:
DX: LOW BACK PAIN, LEFT HIP PAIN
Body Parts: LOW BACK, 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