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: VESTIBULAR
First Name: FRANK
Last Name: TORRES
Claim Number: PJWC086958
Date of Injury: 2024-02-13
ICD Code
Describe Injury: CONCUSSION, VESTIBULAR DYSFUNCTION AFTER TRAUMATIC INJURY

Working: YES
Occupation: SENIOR MAINTENANCE
Date of Birth: 1970-02-04
Gender: MALE
Home Phone: (732) 277-0182
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 93 LEWIS 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? YES
What hours does patient work? 7:30 AM-3:30 PM, M-F

Referring Doctor

First Name: MATTHEW
Last Name: GRIFFIN, MD
Practice Name: GENESIS ORTHOPEDIC AND SPINE
Phone Number: 973-434-9575
Email Address:
Fax: 973-434-9578
Address 1: 300 EXECUTIVE DR
Address 2: STE 110
City: WEST ORANGE
State NJ
Zip: 07052
Did patient have surgery? NO
Surgery Date:
DX: CONCUSSION, VESTIBULAR DYSFUNCTION AFTER TRAUMATIC INJU
Body Parts: HEAD
# of Auth visits: 12
Freq/Duration: 3X A WEEK/ 4 WEEKS
Script: YES
Follow-up MD:

Special Instructions

Special Instructions: FOR FURTHER QUESTIONS OR CORRESPONDENCE, PLEASE CONTACT:

LWINTER@RISKSOLUTIONS.COM

THANK YOU