

Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOLUTIONS
First Name: CAROLINA
Last Name: SHELL
Main Phone: 9739401851
Ext.: 239
Fax: 9739401852
Email Address: CSHELL@RISKSOLUTIONS.COM

Claimant

Request:
First Name: KEVIN
Last Name: WILLIAMS
Claim Number: IWC083920
Date of Injury: 2023-05-11
ICD Code: S32.401A
Describe Injury: RIGHT ACETABULAR FRACTURE ORIF
Working: NO
Occupation: DPW WORKER
Date of Birth: 1967-03-30
Gender: MALE
Home Phone: (973)306-6220
Cell Phone: 973-336-2503
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 422 SANTA FE CT.
Address 2:
City: HAMILTON
State: NJ
Zip: 08619
Preferred Language: ENGLISH

Employee

Company: TOWNSHIP OF IRVINGTON
Phone Number: 610.283.4375

Contact: CHRISTI KELLY
Address 1: 11 CIVIC SQ
Address 2:
City: IRVINGTON
State: NJ
Zip: 07111
PT - Schedule during work hours?
What hours does patient work? HE IS NOT WORKING

Referring Doctor

First Name:
Last Name:
Practice Name:
Phone Number:
Email Address:
Fax:
Address 1:
Address 2:
City:
State:
Zip:
Did patient have surgery?
Surgery Date:
DX:
Body Parts:
of Auth visits:
Freq/Duration:
Script:
Follow-up MD:

Special Instructions

Special Instructions: THE SCRIP WAS PROVIDED BY THE DR. AT THE REHAB FACILITY, HOWEVER, THE CURRENT TREATING DOCTOR IS DR. ADAMS. HE IS AUTHORIZED FOR PT 3X WK FOR 2 WEEKS. F/U 7/24/23.