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: PT
First Name: ANTHONY
Last Name: COLON
Claim Number: PJWC084730
Date of Injury: 2023-08-02
ICD Code S60.511A, S43.401A, S83.92XA, S80.812A, W19.XXA
Describe Injury: LEFT KNEE & RIGHT SHOULDER

Working: YES
Occupation: POLICE OFFICER
Date of Birth:
Gender: MALE
Home Phone: 848-250-3509
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 602 MISSISSIPPI STREET
Address 2:
City: TOMS RIVER
State: NJ
Zip: 08755
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY -PD
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? 4 ON 4 OFF

Referring Doctor

First Name: MAXWELL
Last Name: CASTOR
Practice Name: CONCENTRA MEDICAL CENTER NJ
Phone Number: 732-557-9980
Email Address:
Fax: 732-557-9985
Address 1: 368 LAKEHURST RD
Address 2: SUITE 206
City: TOMS RIVER
State NJ
Zip: 08755
Did patient have surgery?
Surgery Date:
DX:
Body Parts: RIGHT SHOULDER & LEFT KNEE
# of Auth visits: 6
Freq/Duration: 3XS A WEEK FOR 2 WEEKS
Script:
Follow-up MD: 0023-08-08

Special Instructions

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