

# 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:** PT  
**First Name:** ANGEL  
**Last Name:** SOTO  
**Claim Number:** PJWC087553  
**Date of Injury:** 2024-04-07  
**ICD Code**  
**Describe Injury:** INJ R BICEP FELT PAIN WHILE MOVING GRILL BACK TO IT'S LOCATION  
**Working:** YES  
**Occupation:** POLICE  
**Date of Birth:** 1985-05-01  
**Gender:** MALE  
**Home Phone:** (848)459-1589  
**Cell Phone:**  
**Work Phone:**  
**Ext.:**  
**Alternate Phone:**  
**Alt. Phone Description:**  
**Email Address:**  
**Address 1:** 514 SAYRE AVENUE  
**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?**  
**What hours does patient work?** 5:00PM-3:00AM, 4 ON 4 OFF

## Referring Doctor

**First Name:** ANDREW A.  
**Last Name:** WILLIS, MD  
**Practice Name:** TRI COUNTY ORTHOPEDICS  
**Phone Number:** 973-538-2334  
**Email Address:**  
**Fax:** 973-829-9174  
**Address 1:** 197 RIDGEDALE AVE  
**Address 2:**  
**City:** CEDAR KNOLLS  
**State:** NJ  
**Zip:** 07927  
**Did patient have surgery?**  
**Surgery Date:** 2024-04-26  
**DX:** RT ELBOW DISTAL BICEPS RUPTURE  
**Body Parts:** RIGHT ARM  
**# of Auth visits:**  
**Freq/Duration:** 2-3X A WEEK/ 6 WEEKS  
**Script:** YES  
**Follow-up MD:**

## Special Instructions

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

LWINTER@RISKSOLUTIONS.COM

THANK YOU