

Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOLUTIONS
First Name: JESSICA
Last Name: LEMASSON
Main Phone: 9739401851
Ext.:
Fax: 9739401852
Email Address JLEMASSON@RISKSOLUTIONS.COM

Claimant

Request: MRI
First Name: GARRY
Last Name: HOWARD
Claim Number: PJWC085939
Date of Injury: 2023-10-31
ICD Code
Describe Injury: CERVICAL STRAIN, THORACIC STRAIN
Working: YES
Occupation: TRUCK DRIVER
Date of Birth: 1963-07-03
Gender: MALE
Home Phone: (908)296-7260
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 717 WASHINGTON AVENUE
Address 2: APT. A3
City: LINDEN
State: NJ
Zip: 07036
Preferred Language:

Employee

Company: DEPARTMENT OF PUBLIC WORKS
Phone Number: (908)241-2014

Contact: KHEESHA WALLS
Address 1: 210 CHESTNUT ST
Address 2:
City: ROSELLE
State: NJ
Zip: 07203
PT - Schedule during work hours? YES
What hours does patient work? 5AM ? 1PM (M-F)

Referring Doctor

First Name: CHARLES A
Last Name: GATTO
Practice Name: THE ADVANCED SPINE CENTER
Phone Number: 973-538-0900
Email Address:
Fax: 973-538-0909
Address 1: 160 EAST HANOVER
Address 2:
City: MORRISTOWN
State: NJ
Zip: 07960
Did patient have surgery? NO
Surgery Date:
DX: CERVICAL STRAIN, THORACIC STRAIN
Body Parts: BACK
of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD:

Special Instructions

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

KWILKINSON@RISKSOLUTIONS.COM

THANK YOU