

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: WILLIAM
Last Name: DICKSON
Claim Number: GSCR085043
Date of Injury: 2023-08-30
ICD Code S46.912A
Describe Injury: LEFT SHOULDER

Working: YES
Occupation: DRIVER
Date of Birth:
Gender: MALE
Home Phone: 732-374-2948
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 1230 CELLAR AVE
Address 2: APT 21
City: CLARK
State: NJ
Zip: 07066
Preferred Language:

Employee

Company: CITY OF RAHWAY
Phone Number: 732-827-2096

Contact: MOLLY ORTIZ
Address 1: 1 CITY HALL PLAZA
Address 2:
City: RAHWAY
State: NJ
Zip: 07065
PT - Schedule during work hours? YES
What hours does patient work? 7AM -230PM

Referring Doctor

First Name: LUCKNIE
Last Name: QVINCY, PA
Practice Name: CONCENTRA MEDICAL CENTER NJ
Phone Number: 732-381-3636
Email Address:
Fax: 732-381-5977
Address 1: 2 CITY HALL PLAZA
Address 2:
City: RAHWAY
State: NJ
Zip: 07065
Did patient have surgery? NO
Surgery Date:
DX:
Body Parts: LEFT SHOULDER
of Auth visits: 6
Freq/Duration: 3XS A WEEK FOR 2 WEEKS
Script:
Follow-up MD: 2023-09-01

Special Instructions

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

THANK YOU