D&H Alternative Risk Solutions

Risk Management & Third Party Administration

SURGICAL PRE-CERTIFICATION CERTIFICATE
THIS FORM MUST BE RETURNED TO THE UNDERSIGNED WITHIN 48 HOURS
RETURN FAX – 1 (973) 940-1852

DATE: MAY 22, 2023 DATE OF LOSS: 03/24/2022 CLAIM #: **PLB079309**
CLMT SS #: ###-##-1104 CLMT PHONE #: (908)591-3160

CLAIMANTS NAME: **NABILIAH MUHAMMED-ISMAIL** EMPLOYER: PLAINFIELD BOARD OF EDUCATION
ADDRESS: 186 WILLOWBROOK DRIVE NORTH BRUNSWICK NJ 08902

JOB RESTRICTIONS: EMPLOYER CAN ACCOMMODATE (ALL) (MOST) RESTRICTIONS.
OTHER: THE CLMT HAS A RESTRICTED DUTY TYPE OF JOB

DOCTOR'S NAME: Jeffrey M. Warshaver 908 3647801 PHONE: _____ FAX: 9082222757

DIAGNOSIS (NAME/ICD-9 CODE(S)) M24.611 Ankylosis

PROCEDURE PROPOSED (NAME/CPT CODE(S)): Arthroscopy (right) shoulder

ANY SPECIAL EQUIPMENT REQUIRED: w/ lysis of adhesives

***CO-SURGEON:** 29825

ADDRESS & PHONE (IF NOT AFFILIATED IN YOUR GROUP):

***PHYSICIAN ASSISTANT:** Heather Pedersen, PAC

ADDRESS & PHONE (IF NOT AFFILIATED IN YOUR GROUP): Same as DR.

***CO-SURGEON &/OR SURGICAL ASSISTANT WILL BE ALLOWED IF PROCEDURE CODE WARRANTS AN ASSISTANT.**

HOSPITAL / FACILITY WHERE PROCEDURE IS TO TAKE PLACE: The Ctr. for Amb. Sx. 1450 Rt. 22 W. Mountainside NJ 07092

SURGERY DATE: 6/7/23 LENGTH OF STAY: SDS

************ALL BILLS WILL BE PAID AT THE FMCO ALLOWABLE AMOUNT************

POST OP TREATMENT PLAN - ANTICIPATED LENGTH OF:

1. PT (IF APPLICABLE): _____
1. COMPLETE BED: _____
2. RETURN TO SEDENTARY DUTY: _____
3. RETURN TO LIGHT DUTY: _____
4. RETURN TO FULL DUTY: _____
5. ANTICIPATED MMI: _____

DOCTORS SIGNATURE: _____ **DATE:** _____

FOR D&H USE:

_____ DATE _____
PRE-CERTIFICATION SIGNATURE
CAROLINA SHELL
D&H ALTERNATIVE RISK SOLUTIONS
CLAIMS MANAGEMENT **973-940-1851**

State of New Jersey

PRESCRIPTION BLANK

HEATHER A. PEDERSEN, PA-C
INFINITY ORTHOPAEDICS, LLC
TEL. 908-364-7801 NPI #1619289824
LICENSE # 25MP00240600 DEA # MP2234920

JEFFREY M. WARSHAUER, D.O., SUPERVISING PHYSICIAN
1450 ROUTE 22 WEST, SUITE 200, MOUNTAINSIDE, NJ 07092
LICENSE # 25MB05525300 DEA #

☐ DELEGATED PHYSICIAN SUPERVISOR

LICENSE # TEL #

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE ☐
AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT Nabiliah Muhammad Ismail D.O.B.

ADDRESS DATE 5/22/23

☐ PIT
☐ SPO

Post-Operative

Sling shot Brace

RXZV90715000058

SUBSTITUTION PERMISSIBLE DO NOT SUBSTITUTE

DO NOT REFILL
REFILL ____ TIMES

SIGNATURE OF PRESCRIBER

Use a separate form for each controlled substance prescription

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW