

Referral

Submitter

Company Name: DH ALTERNATIVE RISK SOLUTIONS
First Name: KRISTIN
Last Name: WILKINSON
Main Phone: 9739401851
Ext.:
Fax: 973-940-1852
Email Address KWILKINSON@RISKSOLUTIONS.COM

Claimant

Request: PT
First Name: NICHOLAS
Last Name: DORCH
Claim Number: PJWC086145
Date of Injury: 0023-11-30
ICD Code
Describe Injury: BACK

Working: YES
Occupation: LABORER - DPW
Date of Birth: 1991-05-17
Gender: MALE
Home Phone: 973-445-8916
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 220 PROSPECT ST
Address 2: APT B9H
City: EAST ORANGE
State: NJ
Zip: 07017
Preferred Language:

Employee

Company: BOROUGH OF ROSELLE
Phone Number: 908-241-2014

Contact: KHEESHA WALLS
Address 1: 210 CHESNUT STREET
Address 2:
City: ROSELLE
State: NJ
Zip: 07203
PT - Schedule during work hours? YES
What hours does patient work? 5AM -11AM (M-F)

Referring Doctor

First Name: CLARA
Last Name: IRIZARRY PA-C
Practice Name: MD CARE - URGENT CARE CENTER
Phone Number: 908-691-3800
Email Address:
Fax: 908-352-0505
Address 1: 637 WESTFILED AVE
Address 2:
City: ELIZABETH
State: NJ
Zip: 07208
Did patient have surgery? NO
Surgery Date:
DX:
Body Parts: LUMBAR
of Auth visits: 9
Freq/Duration: 3XS A WEEK FOR 3WEEKS
Script: YES
Follow-up MD:

Special Instructions

Special Instructions: ANY QUESTIONS PLEASE CONTACT
KWILKINSON@RISKSOLUTIONS.COM
PT MUST BE LATER IN THE WORK DAY