

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: MRI
First Name: ANTHONY
Last Name: COLON
Claim Number: PJWC084730
Date of Injury: 2023-08-02
ICD Code
Describe Injury: LEFT KNEE WITHOUT CONTRAST MATERIAL
Working: YES
Occupation: POLICE OFFICER
Date of Birth: 1994-09-23
Gender: MALE
Home Phone: 848-250-3509
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 602 MISSISSIPPI STREET
Address 2:
City: TOMS RIVER
State: NJ
Zip: 08755
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY -PD
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? 5PM TO 3AM, 4 DAY ON/4 DAYS OFF

Referring Doctor

First Name: MAXWELL
Last Name: CASTOR
Practice Name: CONCENTRA MEDICAL CENTER NJ
Phone Number: 732-557-9980
Email Address:
Fax: 732-557-9985
Address 1: 638 LAKEHURT ROAD
Address 2: SUITE 205
City: TOMS RIVER
State: NJ
Zip: 08755
Did patient have surgery? NO
Surgery Date:
DX:
Body Parts: LEFT KNEE
of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD: 2023-08-15

Special Instructions

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

THANK YOU