Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOLUTIONS
First Name: JESSICA
Last Name: LEMASSON
Main Phone: 973-940-1851
Ext.: 286
Fax: 973-940-1852
Email Address JLEMASSON@RISKSOLUTIONS.COM

Claimant

Request: PT
First Name: MARK
Last Name: MIGLIORE
Claim Number: [PJWC086859
Date of Injury: 1969-04-02
ICD Code
Describe Injury: LEFT SIDE/RIBS AREA

Working: YES
Occupation: LABORER
Date of Birth: 1969-04-02
Gender: MALE
Home Phone: (908)290-6232
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 131 WEST STREET
Address 2:
City: COLONIA
State: NJ
Zip: 07067
Preferred Language:

Employee

Company: BOROUGH OF ROSELLE
Phone Number: 908-245-2920

Contact:
Address 1: 210 CHESTNUT STREET
Address 2:
City: ROSELLE
State: NJ
Zip: 07203
PT - Schedule during work hours? YES
What hours does patient work? 5:30 AM- 2:00 PM, M-F

Referring Doctor

First Name: CLARA
Last Name: IRIZARRY, PA
Practice Name: MD URGENT CARE
Phone Number: 908-691-3800
Email Address:
Fax: 908-352-0505
Address 1: 637 WESTFIELD AVE
Address 2:
City: ELIZABETH
State NJ
Zip: 07208
Did patient have surgery? NO
Surgery Date:
DX: SPRAIN OF RIBS/ SIDE
Body Parts: LEFT SIDE/RIBS AREA
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD:

Special Instructions

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

LWINTER@RISKSOLUTIONS.COM

THANK YOU