

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: PAUL
Last Name: ALVARDO
Claim Number: HST081818
Date of Injury: 2022-10-28
ICD Code S60.11A & S67.01XA
Describe Injury: CONTUSION OF RIGHT THUMB

Working: YES
Occupation: LABORER
Date of Birth:
Gender: MALE
Home Phone: 908-875-9384
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 145 VALLEY VIEW ROAD
Address 2:
City: HILLSIDE
State: NJ
Zip: 07205
Preferred Language:

Employee

Company: HILSIDE TOWNSHIP
Phone Number: 973-926-1110

Contact: SCOTT ANDERSON
Address 1: 1409 LIBERTY & HILLSIDE AVE
Address 2:
City: HILLSIDE
State: NJ
Zip: 07205
PT - Schedule during work hours? YES
What hours does patient work? 730AM - 4PM M-F

Referring Doctor

First Name: CHE
Last Name: LUI, MD
Practice Name: CONCENTRA MEDICAL CENTER NJ
Phone Number: 908-289-5646
Email Address:
Fax: 908-351-1099
Address 1: 615 DIVISION ST
Address 2:
City: ELIZABETH
State: NJ
Zip: 07201
Did patient have surgery? NO
Surgery Date:
DX:
Body Parts:
of Auth visits: 6
Freq/Duration: 3XS A WEEK FOR 2 WEEKS
Script: YES
Follow-up MD: 2022-11-14

Special Instructions

Special Instructions: ANY QUESTIONS OR FURTHER CORRESPONDENCE PLEASE
CONTACT DFORGIONE@RISKSOLUTIONS.COM

THANK YOU!