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: MRI
First Name: JAMES
Last Name: VITOLLO
Claim Number: IWC087340
Date of Injury: 2024-03-12
ICD Code
Describe Injury: LEFT SHOULDER

Working: YES
Occupation: PAID FIRE FIGHTER
Date of Birth: 1980-11-01
Gender: MALE
Home Phone: (973)908-5696
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 148 MOUNTAINVIEW ROAD
Address 2:
City: WARREN
State: NJ
Zip: 07059
Preferred Language:

Employee

Company: TOWNSHIP OF IRVINGTON
Phone Number: 973-399-6562

Contact:
Address 1: 1 CIVIC SQUARE
Address 2:
City: IRVINGTON
State: NJ
Zip: 07111
PT - Schedule during work hours?
What hours does patient work? 24 ON 72 OFF

Referring Doctor

First Name: DAVID S.
Last Name: KLEIN, DO
Practice Name: TRI COUNTY ORTHOPEDICS
Phone Number: 973-538-2334
Email Address:
Fax: 973-538-4081
Address 1: 197 RIDGEDALE AVE
Address 2: SUITE 300
City: CEDAR KNOLLS
State NJ
Zip: 07927
Did patient have surgery? NO
Surgery Date:
DX: LEFT SHOULDER CUFF TEAR
Body Parts: LEFT SHOULDER
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD:

Special Instructions

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

CSHELL@RISKSOLUTIONS.COM

THANK YOU