

Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOLUTIONS
First Name: CAROLINA
Last Name: SHELL
Main Phone: 9739401851
Ext.: 239
Fax: 9739401852
Email Address CSHELL@RISKSOLUTIONS.COM

Claimant

Request:
First Name: MICHAEL
Last Name: GWIZDZ
Claim Number: HST083711
Date of Injury: 2023-04-29
ICD Code S93.402A
Describe Injury: L ANKLE/ ROLLED WHILE WALKING DOWN FRONT STEP, EE TRIPPED

Working: NO
Occupation: PAID FIRE FIGHTER
Date of Birth: 1977-11-26
Gender: MALE
Home Phone: 9083585374
Cell Phone: 9083585374
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 234 OKLAHOMA DR.
Address 2:
City: BRICK
State: NJ
Zip: 08723
Preferred Language: ENGLISH

Employee

Company: TOWINSHIP OF HILLSIDE

Phone Number:
Contact:
Address 1: 395 HOLLYWOOD AVE
Address 2:
City: HILLSIDE
State: NJ
Zip: 07205
PT - Schedule during work hours?
What hours does patient work?

Referring Doctor

First Name: MAXWELL
Last Name: CASTOR
Practice Name: PA-C
Phone Number: 7325679980
Email Address:
Fax:
Address 1: 368 LAKEHURST RD
Address 2:
City: TOMS RIVER
State: NJ
Zip: 08756
Did patient have surgery?
Surgery Date:
DX:
Body Parts:
of Auth visits:
Freq/Duration:
Script:
Follow-up MD: 2023-05-25

Special Instructions

Special Instructions: