Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOLUTIONS
First Name: JENIFER
Last Name: SCHETTING
Main Phone: 9735347455
Ext.: 250
Fax: 9739401852
Email Address JSCHETTING@RISKSOLUTIONS.COM

Claimant

Request: OT
First Name: PETE
Last Name: DEGRAZIO
Claim Number: T43688
Date of Injury: 2002-07-13
ICD Code
Describe Injury: LEFT FINGER AMPUTATIONS

Working: NO
Occupation: RETIRED
Date of Birth: 1960-11-09
Gender:
Home Phone:
Cell Phone: 2017573645
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 505 MARTIN ROAD
Address 2:
City: TOMS RIVER
State: NJ
Zip: 08753
Preferred Language: ENGLISH

Employee

Company: PASSAIC VALLEY SEWERAGE COMMISSION
Phone Number: 973-344-1800

Contact:
Address 1: 600 WILSON AVE
Address 2:
City: NEWARK
State: NJ
Zip: 07105
PT - Schedule during work hours? YES
What hours does patient work? N/A EE RETIRED

Referring Doctor

First Name: VIRAK
Last Name: TAN MD
Practice Name: INSTITUTE FOR ARM AND HAND SURGERY
Phone Number: 973-947-4700
Email Address:
Fax:
Address 1: 345 MAIN STREET SUITE 202
Address 2:
City: MADISON
State NJ
Zip: 07940
Did patient have surgery?
Surgery Date: 2023-05-25
DX: PIP POST TRAUMATIC DJD, RING FINGER SEVERE HOOK NAIL, SKIN
Body Parts: LEFT HAND MIDDLE FINGER
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD: 2023-08-15

Special Instructions

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