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: LAQURAN
Last Name: JORDAN
Claim Number: IWC087551
Date of Injury: 2024-04-04
ICD Code
Describe Injury: INJ LOWER & UPPER BACK WHILE BLOWING LEAVES & DEBRIS, EE SLIPPED & FELL

Working: YES
Occupation: LABORER
Date of Birth: 1976-09-20
Gender: MALE
Home Phone: (862)230-1273
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 107 SOUTH HARRISON ST.
Address 2: APT.702
City: EAST ORANGE
State: NJ
Zip: 07108
Preferred Language:

Employee

Company: TOWNSHIP OF IRVINGTON

Phone Number: 973-399-6707
Contact:
Address 1: 1 CIVIC SQUARE
Address 2:
City: IRVINGTON
State: NJ
Zip: 07111
PT - Schedule during work hours?
What hours does patient work? 5AM-130PM, M-F, OFTEN WORKS SAT & SUN 5AM

Referring Doctor

First Name: JAY S.
Last Name: REIDLER
Practice Name: PREMIER ORTHOPAEDICS & SPORTS MEDICINE
Phone Number: 201-431-7703
Email Address:
Fax: 201-862-0095
Address 1: 403 GRAND AVE
Address 2:
City: ENGLEWOOD
State NJ
Zip: 07631-4104
Did patient have surgery? NO
Surgery Date:
DX: BACK PAIN
Body Parts: BACK
# 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