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: DME
First Name: EMERSON
Last Name: THOMAS
Claim Number: GSCR083521
Date of Injury: 2023-03-01
ICD Code S43.431A
Describe Injury: SUPERIOR GLENOID LABRUM LESION (SLAP), RIGHT

Working: NO
Occupation: DPW WORKER
Date of Birth: 1972-10-24
Gender: MALE
Home Phone: 908-463-6932
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 916 BRACHELLER AVE.
Address 2:
City: LINDEN
State: NJ
Zip: 07036
Preferred Language:

Employee

Company: CITY OF RAHWAY
Phone Number: (732) 827-2022

Contact: KARIN NAPIER
Address 1: ONE CITY HALL PLAZA
Address 2:
City: RAHWAY
State: NJ
Zip: 07065
PT - Schedule during work hours?
What hours does patient work?

Referring Doctor

First Name: ANTHONY V.
Last Name: PETROSINI
Practice Name: ORTHOPAEDIC INSTITIUTE BRIELLE
Phone Number: 732-800-9000
Email Address:
Fax:
Address 1: 2035 LINCOLN HIGHWAY
Address 2: SUITE 1050
City: EDISON
State NJ
Zip: 08817
Did patient have surgery? NO
Surgery Date:
DX:
Body Parts:
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD:

Special Instructions

Special Instructions: ANY QUESTIONS PLEASE CONTACT KWILKINSON@RISKSOLUTIONS.COM