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: DOMINGO
Last Name: CEPEDA
Claim Number: PJWC089861
Date of Injury: 2024-11-18
ICD Code
Describe Injury: INJ R SHOULDER FELT A POP WHEN THROWING A LEAF BAG INTO THE TRUCK

Working: YES
Occupation: LABORER
Date of Birth: 1975-04-13
Gender: MALE
Home Phone: (732)621-4810
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 384 PARK AVE.
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08861
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY

Phone Number: (732)934-0587
Contact:
Address 1: 260 HIGH STREET
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08861
PT - Schedule during work hours?
What hours does patient work?

Referring Doctor

First Name: DOROTA
Last Name: SOHAIL, APN
Practice Name: HACKENSACK MERIDIAN HEALTH
Phone Number:
Email Address:
Fax:
Address 1: 742 US-1N
Address 2:
City: ISELIN
State NJ
Zip: 08830
Did patient have surgery? NO
Surgery Date:
DX: MRI RIGHT SHOULDER W/OUT CONTRAST
Body Parts: RIGHT SHOULDER SPRAIN
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD:

Special Instructions

Special Instructions: FOR FURTHER QUESTIONS OR CORRESPONDENCE, PLEASE CONTACT

LWINTER@RISKSOLUTIONS.COM

THANK YOU