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: PT
First Name: ELIUD
Last Name: MALAVE
Claim Number: PJWC084413
Date of Injury: 2023-07-05
ICD Code S69.91XA & W19.XXXA
Describe Injury: RIGHT WRIST/HAND AND FINGERS; INIT ECOUNTER

Working: YES
Occupation: MAINTENANCE
Date of Birth: 1982-01-01
Gender: MALE
Home Phone: 848-333-8957
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 262 SILZER STREET
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08861
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY
Phone Number: 732-826-0290

Contact: MARIA RIVERA
Address 1: 260 HIGH STREET
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08861
PT - Schedule during work hours? YES
What hours does patient work? 7AM 3PM M-F

Referring Doctor

First Name: SHANTHI
Last Name: REDDY MD
Practice Name: CONCENTRA MEDICAL CENTER NJ
Phone Number: 732-248-0088
Email Address:
Fax: 732-248-4408
Address 1: 16 ETHEL ROAD
Address 2:
City: EDISON
State NJ
Zip: 08817
Did patient have surgery? YES
Surgery Date:
DX:
Body Parts: RIGHT WRIST/HAND/FINGERS
# of Auth visits: 6
Freq/Duration: 3XS A WEEK FOR 2 WEEKS
Script: YES
Follow-up MD: 2023-07-14

Special Instructions

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