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: GARRETT
Last Name: ANDERSON
Claim Number: PJWC082744
Date of Injury: 2023-02-02
ICD Code M62.830 & S29.012A
Describe Injury: LEFT THORACIC / LUMBAR MUSCLE STRAIN

Working: YES
Occupation: SANITATION
Date of Birth: 1983-08-17
Gender: MALE
Home Phone: 201-275-7905
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 460 WEST 3RD AVENUE
Address 2:
City: ROSELLE
State: NJ
Zip: 07203
Preferred Language:

Employee

Company: BOROUGH OF ROSELLE
Phone Number: 908-241-2014

Contact: KHEESHA WALLS
Address 1: 210 CHESNUT STREET
Address 2:
City: ROSELLE
State: NJ
Zip: 07203
PT - Schedule during work hours? YES
What hours does patient work? 6AM - 11AM (M-F)

Referring Doctor

First Name: CHRISTINA
Last Name: MOORE, PA
Practice Name: MD CARE - URGENT CARE CENTER
Phone Number: 908-691-3800
Email Address:
Fax: 908-352-0505
Address 1: 637 WESTFILED AVE
Address 2:
City: ELIZABETH
State NJ
Zip: 07208
Did patient have surgery?
Surgery Date:
DX:
Body Parts:
# of Auth visits: 12
Freq/Duration: 3XS A WEEK FOR 4 WEEKS
Script: YES
Follow-up MD:

Special Instructions

Special Instructions: ANY QUESTIONS OR FURTHER CORRESPONDENCE PLEASE CONTACT DFORGIONE@RISKSOLUTIONS.COM

THANK YOU