

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: PT
First Name: JOSE
Last Name: RUIZ
Claim Number: PJWC087608
Date of Injury: 2024-04-08
ICD Code
Describe Injury: INJ WRIST, NECK & ARM WAS STRUCK BY ANOTHER VEHICLE WHEN MAKING L TURN

Working: YES
Occupation: SANITATION DRIVER
Date of Birth: 1955-05-06
Gender: MALE
Home Phone: (732) 207-1616
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 60 MADISON AVE.
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08861
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY

Phone Number: (732)826-0290
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? 5AM ? 12PM MON-FRI

Referring Doctor

First Name: YVONNE
Last Name: FARNACIO, MD
Practice Name: HACKENSACK MERIDIAN HEALTH
Phone Number: 732-362-3871
Email Address:
Fax: 732-362-3873
Address 1: 742 US-1N
Address 2:
City: ISELIN
State: NJ
Zip: 08830
Did patient have surgery? NO
Surgery Date:
DX: CERVICAL SPRAIN
Body Parts: CERVICAL
of Auth visits: 6
Freq/Duration: 2X A WEEK/3 WEEKS
Script: YES
Follow-up MD:

Special Instructions

Special Instructions: FOR FURTHER QUESTIONS OR CORRESPONDENCE, PLEASE CONTACT:

LWINTER@RISKSOLUTIONS.COM

THANK YOU