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: DME
First Name: MAGALIZ
Last Name: GONZALEZ
Claim Number: PJWC085751
Date of Injury:
ICD Code
Describe Injury: RIGHT SHOULDER

Working: YES
Occupation: OFFICE CLERK
Date of Birth: 1962-01-25
Gender: FEMALE
Home Phone: (732)829-0405
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 5302 BRISTOL STATION CT
Address 2:
City: CARTERET
State: NJ
Zip: 07008
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?
What hours does patient work?

Referring Doctor

First Name: MATTHEW J.
Last Name: GARFINKEL, MD
Practice Name: EDISON-METUCHEN ORTHOPAEDIC GROUP
Phone Number: 732-494-6226
Email Address:
Fax: 732-494-8762
Address 1: 10 PARSONAGE ROAD
Address 2:
City: EDISON
State NJ
Zip: 08837
Did patient have surgery? YES
Surgery Date: 2024-02-12
DX: RT SHOULDER ARTHROSCOPY, RTC REPAIR
Body Parts: RIGHT SHOULDER
# 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