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: MRI
First Name: ANGEL
Last Name: SOTO
Claim Number: PJWC082001
Date of Injury: 2022-11-19
ICD Code S43.402A & S50.02XA
Describe Injury: L SHOULDER W/CONTRAST & LEFT ELBOW W/O CONTRAST

Working: YES
Occupation: POLICE
Date of Birth: 1985-05-01
Gender: MALE
Home Phone: 848-459-1589
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 514 SAYRE AVENUE
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08661
Preferred Language:

Employee

Company:
Phone Number:

Contact:
Address 1:
Address 2:
City:
State:
Zip:
PT - Schedule during work hours?
What hours does patient work?

Referring Doctor

First Name: JEFFREY M.
Last Name: WARSHAUER, DO
Practice Name:
Phone Number: 908-364-7801
Email Address:
Fax: 908-222-2757
Address 1: 3 PROGRESS STREET
Address 2: SUITE 1
City: EDISON
State NJ
Zip: 08820
Did patient have surgery? NO
Surgery Date:
DX:
Body Parts:
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD: 2023-01-03

Special Instructions

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

THANK YOU!