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: HUBERT
Last Name: JONES
Claim Number: PJWC086876
Date of Injury: 2024-02-06
ICD Code
Describe Injury: LEFT ELBOW

Working: YES
Occupation: LABORER
Date of Birth: 1981-06-07
Gender: MALE
Home Phone: (908)296-8549
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 309 MAPLE AVE
Address 2:
City: LINDEN
State: NJ
Zip: 07036
Preferred Language:

Employee

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

Contact: SHATERA SMITH
Address 1: 210 CHESTNUT STREET
Address 2:
City: ROSELLE
State: NJ
Zip: 07203
PT - Schedule during work hours? YES
What hours does patient work? 5:30AM ? 10:30AM (MON-FRI) PART-TIME

Referring Doctor

First Name: ANDREW A.
Last Name: WILLIS, MD
Practice Name: TRI COUNTY ORTHOPEDICS
Phone Number: 973-538-2334
Email Address:
Fax: 973-538-6498
Address 1: 160 EAST HANOVER AVE
Address 2:
City: MORRISTOWN
State NJ
Zip: 07962
Did patient have surgery? NO
Surgery Date:
DX: LEFT ELBOW
Body Parts: LEFT ELBOW
# of Auth visits: 8
Freq/Duration: 2X A WEEK/4 WEEKS
Script: YES
Follow-up MD:

Special Instructions

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

LWINTER@RISKSOLUTIONS.COM

THANK YOU