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: LESLIE
Last Name: CUMMINGS
Claim Number: PJWC08199-01
Date of Injury: 2022-11-16
ICD Code M25.S12
Describe Injury: LEFT SHOULDER CONTRAST

Working: YES
Occupation: LABORER
Date of Birth: 1976-11-11
Gender: MALE
Home Phone: 908-532-7320
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 216 E. 8TH AVE
Address 2:
City: ROSELLE
State: NJ
Zip: 07203
Preferred Language:

Employee

Company: 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?
What hours does patient work? 6AM- 230PM MON - FRI

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? NO
Surgery Date:
DX:
Body Parts: LEFT SHOULDER CONTRAST
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD:

Special Instructions

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

THANK YOU

FOLLOW UP - AFTER MRI