Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOLUTIONS
First Name: ANGELA
Last Name: MONTGOMERY
Main Phone: 9739401851
Ext.: 241
Fax: 973-940-1852
Email Address AMONTGOMERY@RISKSOLUTIONS.COM

Claimant

Request: CT
First Name: KENNETH
Last Name: FINZI, JR
Claim Number: W890820339
Date of Injury: 2024-08-01
ICD Code
Describe Injury: NECK, LT SHOULDER, LT RIBS, LT ELBOW, LT WRIST, LOWER BACK, MUSCULO & NERVOUS SYSTEM

Working:
Occupation: HEAVY EQUIPMENT OPERATOR
Date of Birth: 1968-10-26
Gender: MALE
Home Phone: (570) 352-7142
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 200 HIGH STREET
Address 2:
City: CRANFORD
State: NJ
Zip: 07016
Preferred Language:

Employee

Company: HILLSIDE TWP

Phone Number: 973-926-3000
Contact: DEBORAH KARLSSON
Address 1: LIBERTY& HILLSIDE AVENUES
Address 2:
City: HILLSIDE
State: NJ
Zip: 07205
PT - Schedule during work hours?
What hours does patient work? 8AM TO 4:30PM

Referring Doctor

First Name: JEFFREY
Last Name: ABRAMS
Practice Name: PRINCETON ORTHOPEDIC ASSOC
Phone Number: 609-924-8131
Email Address:
Fax: 609-924-8532
Address 1: 325 PRINCETON AVENUE
Address 2:
City: PRINCETOIN
State NJ
Zip: 08540
Did patient have surgery? YES
Surgery Date: 2016-09-28
DX: LEFT SHOULDER DEGENERATIVE ARTHRITIS.
Body Parts: LT. SHOULDER
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD: 2024-10-07

Special Instructions

Special Instructions: BELONGS TO LUCIA