

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: SHEILA
Last Name: LEE
Claim Number: PLB089792
Date of Injury: 2024-11-11
ICD Code
Describe Injury: INJ L FINGER JAMMED IT WHEN REMOVING THE COVER WITH ASSIST
Working: YES
Occupation: CUSTODIAN
Date of Birth: 1970-07-17
Gender: FEMALE
Home Phone: (973)445-7273
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 20 A RIVERSIDE AVE.
Address 2:
City: NEWARK
State: NJ
Zip: 07104
Preferred Language:

Employee

Company: PLAINFIELD BOARD OF ED

Phone Number: (908)731-4323
Contact: WENDY HARDY
Address 1: 1200 MYRTLE AVE
Address 2:
City: PLAINFIELD
State: NJ
Zip: 07063
PT - Schedule during work hours?
What hours does patient work?

Referring Doctor

First Name: GREGORY S.
Last Name: GALLICK, MD
Practice Name:
Phone Number: 908-686-6665
Email Address:
Fax: 908-687-7507
Address 1: 2780 MORRIS AVE
Address 2: STE 2C
City: UNION
State: NJ
Zip: 07083
Did patient have surgery? NO
Surgery Date:
DX: CONTUSION LEFT WRIST/LEFT HAND
Body Parts: LEFT HAND
of Auth visits: 6
Freq/Duration: 3X A WEEK/ 2 WEEKS
Script: YES
Follow-up MD:

Special Instructions

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

CSHELL@RISKSOLUTIONS.COM

THANK YOU