

Referral

Submitter

Company Name: DH ALTERNATIVE RISK SOLUTIONS
First Name: KRISTIN
Last Name: WILKINSON
Main Phone: 9739401851
Ext.:
Fax:
Email Address KWILKINSON@RISKSOLUTIONS.COM

Claimant

Request: MRI
First Name: DAVIS
Last Name: SALAZAR
Claim Number: [PJWC085781
Date of Injury: 2023-10-27
ICD Code S29.012A
Describe Injury: STRAIN OF MUSCLE AND TENDON OF BACK WALL OF THORAX,
INIT-S29.012A

Working: YES
Occupation: POLICE
Date of Birth: 1980-08-10
Gender: MALE
Home Phone: 848-242-0244
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 212 RARITAN ST
Address 2:
City: UNION BEACH
State: NJ
Zip: 07735
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY -PD

Phone Number: 732-826-0290
Contact: MARIA RIVERA
Address 1: 260 HIGH STREET
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08861
PT - Schedule during work hours?
What hours does patient work? 2PM -12AM

Referring Doctor

First Name: SHANTHI
Last Name: REDDY MD
Practice Name: CONCENTRA MEDICAL CENTER NJ
Phone Number: 732-248-0088
Email Address:
Fax: 732-248-4408
Address 1: 16 ETHEL ROAD
Address 2:
City: EDISON
State: NJ
Zip: 08817
Did patient have surgery?
Surgery Date:
DX:
Body Parts:
of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD: 2023-11-16

Special Instructions

Special Instructions: ANY QUESTIONS PLEASE CONTACT
KWILKINSON@RISKSOLUTIONS.COM