

Concentra Medical Centers (NJ)

16 Ethel Rd Edison, NJ 08817
Phone: (732) 248-0088 Fax: (732) 248-4408

Service Date: 01/24/2023**Referral Queue ID:** 480507507**Patient Referral****Patient Information:**

Patient:	Rios, Ivette	Home Phone:	(848) 207-8552
SSN:	154-60-1735	Work Phone:	Ext:
Address:	414 Padewreski Ave 11c	DOI:	01/23/2023
	PERTH AMBOY, NJ 08861	DOB:	08/25/1972
		Cell Phone:	(848) 207-8552

Employer Contact:

Employer Location:	City of Perth Amboy-General	Contact:	Maria Rivera
Address:	260 High St	Role:	Additional Injury Contact
	Perth Amboy, NJ 088614451	Phone:	(732) 771-2508
Auth. by:		Ext.:	
		Fax:	

Program:**Billing Information:**

Carrier:	D&H Alternative Risk Solutions	Billing:	D&H Alternative Risk Solutions
Address:	PO Box 68	Address:	PO Box 68
	Newton, NJ 078600068		Newton, NJ 078600068
Phone:	(973) 940-1851	Claim #:	
Fax:	(908) 684-9911		
Notes:	Alt name, Dietz & Hammer		

****NOTE TO THE ABOVE FACILITY OR PHYSICIAN:**

Please send a copy of all reports on this patient to the payer and the center.

Referral Queue ID: 480507507

Patient Referral**Patient Information:**

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Therapy Referral Information:

Referral Status: Pending Referral Dept

REFERRAL PRESCRIPTION

Provider Type: Physical Therapist

Requested

Total Treatments:	6	Request Comments:
Treatments per Week:	3	Auto Generated
Treatment Duration:	2 Weeks	

Diagnosis

ICD9 Code	ICD10 Code	Description
847.0	S16.1XXA	STRAIN OF MUSCLE, FASCIA AND TENDON AT NECK LEVEL, INIT-S16.1XXA
845	S93.401A	SPRAIN OF UNSPECIFIED LIGAMENT OF RIGHT ANKLE, INIT ENC NTR-S93.401A
923.1	S50.02XA	CONTUSION OF LEFT ELBOW, INITIAL ENCOUNTER-S50.02XA
847.1	S29.012A	STRAIN OF MUSCLE AND TENDON OF BACK WALL OF THORAX, INIT-S29.012A
840.3	S46.912A	STRAIN UNSP MUSC/FASC/TEND AT SHLDR/UP ARM, LEFT ARM, INIT-S46.912A

Additional Notes

Auto Create - Physical Therapy Referral

Date: 01/24/2023

Referring Provider: Shanthi Reddy, MD
*** Provider Signature on File ***

Number of Visits to Date:0

Authorized

Total Treatments:	Auth Number:
Treatments per Week:	Effective Date:
Treatment Duration:	Expiration Date:
Authorization Comments:	Units Authorized:

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