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: DME
First Name: ANGEL
Last Name: SOTO
Claim Number: PJWC087553
Date of Injury: 2024-04-07
ICD Code
Describe Injury: INJ R BICEP FELT PAIN WHILE MOVING GRILL BACK TO IT'S LOCATION

Working: YES
Occupation: POLICE
Date of Birth: 1985-05-01
Gender: MALE
Home Phone: (848)459-1589
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 514 SAYRE AVENUE
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08861
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY

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?

Referring Doctor

First Name: ANDREW A.
Last Name: WILLIS, MD
Practice Name:
Phone Number: 973-538-2334
Email Address:
Fax:
Address 1: 197 RIDGEDALE AVE
Address 2:
City: CEDAR KNOLLS
State NJ
Zip: 07927
Did patient have surgery? YES
Surgery Date: 2024-04-26
DX: RIGHT ELBOW DISTAL BICEPS REINSERTION
Body Parts: RIGHT ELBOW
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD:

Special Instructions

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

LWINTER@RISKSOLUTIONS.COM

THANK YOU