Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOULUTIONS
First Name: KRISTIN
Last Name: WILKINSON
Main Phone: 973-940-1851
Ext.:
Fax: 973-940-1852
Email Address KWILKINSON@RISKSOLUTIONS.COM

Claimant

Request: MRI
First Name: RANDOLPH
Last Name: WALKER
Claim Number: IWC056645
Date of Injury: 2016-11-11
ICD Code M25.512
Describe Injury: LEFT SHOULDER W/O CONTRAST

Working: YES
Occupation: POLICE
Date of Birth: 1975-12-14
Gender: MALE
Home Phone: 973-277-0319
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 1872 MANOR DR
Address 2: APT B
City: UNION
State: NJ
Zip: 07083
Preferred Language:

Employee

Company: IRVINGTON TOWNSHIP
Phone Number: 973-399-6710

Contact: CHRISTI KELLY
Address 1: 1 CIVIC SQUARE
Address 2:
City: IRVINGTON
State: NJ
Zip: 07111
PT - Schedule during work hours?
What hours does patient work?

Referring Doctor

First Name: GREGORY
Last Name: PINKOWSKY, MD
Practice Name: SUMMIT HEALTH MEDICAL GROUP
Phone Number: 973-669-5600
Email Address:
Fax: 973-669-0269
Address 1: 1500 PLEASANT VALLEY WAY
Address 2: 1ST FLOOR, SUITE 101
City: WEST ORANGE
State NJ
Zip: 07052
Did patient have surgery? NO
Surgery Date:
DX:
Body Parts:
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD: 2023-01-13

Special Instructions

Special Instructions: ANY QUESTIONS OR FURTHER CORRESPONDENCE PLEASE CONTACT CSHELL@RISKSOLUTIONS.COM

THANK YOU!