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: PT
First Name: IVETTE
Last Name: RIOS
Claim Number: PJWC082691
Date of Injury: 2023-01-23
ICD Code S16.1XXA, S93.401A, S50.02XA, S29.012A & S46.912A
Describe Injury:

Working: YES
Occupation: CODE ENFORCEMENT OFFICER
Date of Birth: 1972-08-25
Gender: FEMALE
Home Phone: 848-207-8552
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 414 PADEREWSKI AVE
Address 2: 11C
City: PERTH AMBOY
State: NJ
Zip: 08861
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY
Phone Number: 732-771-2508

Contact: MARIA RIVERA
Address 1: 260 HIGH STREET
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08861
PT - Schedule during work hours? YES
What hours does patient work? 9AM - 5PM (M-F)

Referring Doctor

First Name: SHANTHI
Last Name: REDDY MD
Practice Name: CONCENTRA MEDICAL CENTER NJ
Phone Number:
Email Address:
Fax:
Address 1: 16 ETHEL ROAD
Address 2:
City: EDISON
State NJ
Zip: 08817
Did patient have surgery? NO
Surgery Date:
DX:
Body Parts:
# of Auth visits: 6
Freq/Duration: 3XS A WEEK FOR 2 WEEKS
Script: YES
Follow-up MD: 2023-02-03

Special Instructions

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

PLEASE SCHEDULE PT AT PERTH AMBOY PT

THANK YOU