



Send completed form & documents to:

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[www.gopromed.com](http://www.gopromed.com)

# AIG MEDICAL COST PROJECTION SERVICE REQUEST

(Please choose one of the following)

Settlement Tool

Reserve Setting

Projected # of years: \_\_\_\_\_

## CASE INFORMATION

|   |       |                      |                        |
|---|-------|----------------------|------------------------|
| Claimant Name (First, Middle Initial, Last) |       |                      | Date Referred          |
| Address                                     |       |                      | Date of Birth          |
| City  | State | Zip Code             | Date of Injury         |
| Employer                                    |       | Jurisdictional State | Social Security Number |
|   |       |                      | Claim Number           |

## KEY CONTACT & BILLING INFORMATION (please choose referring party option)

|  |                           |                   |                   |                |
|--|---------------------------|-------------------|-------------------|----------------|
| Referring Party<br><input type="radio"/> | Adjuster Name             | Adjuster Location | Telephone Number  | E-mail Address |
|  | Carrier/TPA/Service Agent |                   | Mailing Address : |                |
| Referring Party<br><input type="radio"/> | Defense Attorney Name     |                   | Telephone Number  | E-mail Address |
|  | Defense Attorney Firm     |                   | Mailing Address : |                |
| Referring Party<br><input type="radio"/> | Plaintiff Attorney Name   |                   | Telephone Number  | E-mail Address |
|  | Plaintiff Attorney Firm   |                   | Mailing Address : |                |

Please provide copies of the allocation report to \_\_\_\_\_ (Explain)

Carrier/TPA/Service Agent  Defense Attorney  Plaintiff Attorney  Other

## Party Responsible for Invoice

Carrier/TPA/Service Agent  Other; explain

## REPORT TIME FRAME

|  |  |                                      |                                |
|--|--|--------------------------------------|--------------------------------|
| Routine Turnaround = 30 days <input type="checkbox"/>              | Normal Status <input type="checkbox"/> | RUSH Status <input type="checkbox"/> | RUSH Explanation (please type) |
| If RUSH is requested, please provide dated report is needed: _____ |  |                                      |                                |

## NOTES/SPECIAL HANDLING

|  |   |
|--|---|
| Controverted issues, deadlines, mediation/court date, etc. (please type) | <b>Documents Needed</b> (Please check all included documents)                       |
|  | 1. First Report of Injury <input type="checkbox"/>                                  |
|  | 2. Payment History reflecting last 3 years of medical <input type="checkbox"/>      |
|  | 3. Medical records and bills for last 3 years of Treatment <input type="checkbox"/> |
|  | 4. 1 year of RX (listing name, dosage & frequency) <input type="checkbox"/>         |

(For Internal Use)

PRO MED file # :