



Send completed form & documents to :

P.O. Box 941870
Maitland, FL 32794
T: (407) 599-9122
F: (407) 599-1994
TF: (866) 599-9122

THIRD PARTY BILL REVIEW SERVICE REQUEST

Referral@gopromed.com

(Please select appropriate calculation method(s): Usual/Customary PIP Medicare

CASE INFORMATION	Date Referred
	Claimants Name (First, Middle Initial, Last)
	Date of Injury
	Claim Number
	Insured

KEY CONTACT & BILLING INFORMATION (please select referring party)

Referring Party <input type="radio"/>	Adjuster Name	Tel. Number	E-mail Address	
	Carrier/TPA/Service Agent	Address		Office Location
Referring Party <input type="radio"/>	Defense Attorney Name	Tel. Number	E-mail Address	
	Defense Firm Name	Address		

Please provide copies of report to:
Carrier/TPA/Service Agent Defense Attorney Other; explain

Party Responsible for Invoice:
Carrier/TPA/Service Agent Other; explain

SERVICE REQUESTED

Review for excessive charges (specify provider) <input type="checkbox"/>	Other (please explain) <input type="checkbox"/>	<small>(please type)</small>
Analysis of medical records for:		
Prep for court <input type="checkbox"/>		
Settlement Negotiations <input type="checkbox"/>		
Clarifying complex medical issues <input type="checkbox"/>		

INITIAL REVIEW & REPORT TIME FRAME

Routine Turnaround = 30 days	Normal Status <input type="checkbox"/>	RUSH Status <input type="checkbox"/>	RUSH Explanation <small>(please type)</small>
Date RUSH Needed _____			

NOTES/SPECIAL HANDLING

(For Internal Use)

PRO MED file #