



Send completed form & documents to:
 P.O. Box 941870
 Maitland, FL 32794
 T: (407) 599-9122
 F: (407) 599-1994
 TF: (866) 599-9122

COST PROJECTION SERVICE REQUEST

SETTLEMENT **RESERVE SETTING**
 Lifetime Other
 (If other, how many projected years) _____

www.gopromed.com/forms

CATISTROPHIC **NON-CATISTROPHIC**

Workers Comp Longshore Federal Liability

CASE INFORMATION			Date Referred
Injured Worker (First, Middle Initial, Last)			Date of Birth
Address			Date of Injury
City	State	Zip Code	Social Security Number
Employer		Jurisdictional State	Claim Number

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

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

Please provide copies of the allocation report to
 Carrier/TPA/Service Agent Defense Attorney Plaintiff Attorney Other (Explain)

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

REPORT TIME FRAME

Routine Turnaround = 14 days Normal Status RUSH Status
 If RUSH is requested, please provide dated report is needed: _____ RUSH Explanation

NOTES/SPECIAL HANDLING

Controverted issues, deadlines, mediation/court date, etc.	Documents Needed
	<ol style="list-style-type: none"> 1. First Report of Injury 2. Payment History reflecting last 3 years of medical treatment 3. Medical records and bills for last 3 years of treatment 4. 1 year of RX (listing name, dosage & frequency) <p>**** Rated age obtained whenever possible</p>

(For Internal Use)

PRO MED file # : _____