



Send completed form & documents to :

P.O. Box 941870
 Maitland, FL 32794
 T: 407-599-9122
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www.gopromed.com/forms

Florida Utilization Review Service Request

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

KEY CONTACT & BILLING INFORMATION <small>(Please select referring party)</small>			
Referring Party <input type="radio"/>	Adjuster Name	Tel. Number	E-mail Address
	Carrier/TPA/Service Agent	Office Location	Mailing Address:
Referring Party <input type="radio"/>	Defense Attorney Name	Tel. Number	E-mail Address
	Defense Firm Name	Address	
Referring Party <input type="radio"/>	Plaintiffs Attorney Name	Tel. Number	E-mail Address
	Firm Name	Address	

Please provide copies of the report & future reports/letters to:
 Carrier/TPA/Service Agent Defense Attorney Other; explain _____

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

FILE INFORMATION	
Full medical review, to include: <u>(Please check all that apply)</u>	
Medical necessity <input type="checkbox"/>	Causal relationship <input type="checkbox"/>
Review medications (specify) <input type="checkbox"/> _____	Treatment being provided (specify provider) <input type="checkbox"/> _____
Appropriateness of : Proposed Surgery <input type="checkbox"/>	Proposed Treatment <input type="checkbox"/> Ongoing Treatment <input type="checkbox"/>
Review for excessive charges:(specify provider) <input type="checkbox"/> _____	Other; See Special Handling <input type="checkbox"/>

INITIAL REVIEW & REPORT TIME FRAME <small>(Please select time frame)</small>	
Routine Turnaround = 45 days <input type="checkbox"/> Normal Status <input type="checkbox"/> RUSH Status <input type="checkbox"/>	RUSH Explanation
If RUSH requested, please provide date report is needed: _____	

NOTES/SPECIAL HANDLING	DOCUMENTS NEEDED:
_____	1. Entire file (to include Legal)

(For Internal Use)

PRO MED File #: _____