



Send completed form & documents to :

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www.gopromed.com/forms

LIABILITY SERVICE REQUEST

Third Party Demand Package

Review (Both Medical & Bill Review) Third Party Medical Record Review Only

Radiology Review Third Party Bill Review Only

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 <input type="checkbox"/> Defense Attorney <input type="checkbox"/> Other; explain <input type="checkbox"/>				
Party Responsible for Invoice:				
Carrier/TPA/Service Agent <input type="checkbox"/> Other; explain <input type="checkbox"/>				

SERVICE REQUESTED

Review for excessive charges (specify provider) <input type="checkbox"/>	Other (please explain) <input type="checkbox"/>	(please type)
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 (please type)
Date RUSH Needed _____			

NOTES/SPECIAL HANDLING

(For Internal Use)

PRO MED file #