



Send completed form & documents to :

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

## LIABILITY SERVICE REQUEST

Third Party Demand Package

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

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

Radiology Review  Third Party Bill Review Only

<b>CASE INFORMATION</b>		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		
<b>Please provide copies of report to:</b>				
Carrier/TPA/Service Agent <input type="checkbox"/> Defense Attorney <input type="checkbox"/> Other; explain <input type="checkbox"/>				
<b>Party Responsible for Invoice:</b>				
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 #