



Send completed form & documents to:

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

## LIFE CARE PLAN SERVICE REQUEST

<b>CASE INFORMATION</b>			Date Referred:
Injured Worker ( <i>First, Middle Initial, Last</i> ):			Date of Birth:
Address:			Date of Injury:
City:	State:	Zip Code:	Social Security #:
Employer:		Jurisdictional State:	Claim Number:

### KEY CONTACT & BILLING INFORMATION (Please select referring party)

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	Mailing Address:	
Referring Party <input type="radio"/>	Plaintiffs Attorney Name	Tel. Number	E-mail Address
	Firm Name	Mailing Address:	

### NOTES/SPECIAL HANDLING

Controverted issues, deadlines, mediation/court date, etc.  	<p><b><u>Documents Needed:</u></b></p> <p>1. Entire File Material</p>
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(For Internal Use)

PRO MED file #: