Send completed form & documents to:
P.O. Box 941870
Maitland, FL 32794
T: 407-599-9122
TF: 866-599-9122
F: 407-599-1994
www.gopromed.com/forms

MEDICAID REPORTING SERVICE REQUEST

CASE INFORMATION

Claimant Name (First, Middle Initial, Last)		Date of Birth	Date Referred
Address		Social Security #	Medicaid Number
City	State		Medicaid Effective Date
Zip Code	Jurisdictional State		Court Number (pending claim)
			Docket Number (pending claim)

KEY CONTACT & BILLING INFORMATION

Adjuster Name	Adjuster Location	Telephone Number	E-mail Address
Carrier/TPA/Servicing Agent		Mailing Address :	
Defense Attorney Name		Telephone Number	E-mail Address
Defense Attorney Firm		Mailing Address :	
Plaintiff Attorney Name		Telephone Number	E-mail Address
Plaintiff Attorney Firm		Mailing Address :	

Injuries resulting from accident	
1	
2	
3	
4	
5	
6	
7	
8	

Documents Needed:

1. Signed General release Form

(For Internal Use)

PRO MED file # : **MED**

Revised 07/08/09