



Send completed form & documents to:

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 T: (407) 599-9122
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www.gopromed.com/forms

MEDICAL VALUATION SERVICE REQUEST

Settlement

Reserve setting

CASE INFORMATION			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

Referring Party	Name:	Office Location:	Telephone #:	Email Address:
	Carrier/TPA/Servicing Agent		Mailing Address:	

REPORT TIME FRAME

Routine Turnaround = 30 days	Normal Status <input type="checkbox"/>	RUSH Status <input type="checkbox"/>
IF Rush, please provide date report is needed:		

NOTES/SPECIAL HANDLING

RUSH Explanation:	<u>Documents Needed:</u>
	<ol style="list-style-type: none"> 1. <u>First report of injury</u> 2. <u>Payment history reflecting last 2 years of medical</u> 3. <u>All Medical records</u> 4. <u>1 year of Rx (<i>Listing name, dosage, frequency</i>)</u> 5. <u>Legal documents reflective of medical treatment</u>

PRO MED file #:

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(For Internal Use)