



Send completed form & documents to :  
 P.O. Box 941870  
 Maitland, FL 32794  
 T: 407-599-9122  
 F: 407-599-1994  
 TF: (866) 599-9122

## Medication Reduction Program Service Request

[Referral@gopromed.com](mailto:Referral@gopromed.com)

<b>CASE INFORMATION</b>			Date Referred
Injured Workers Name (First, Middle Initial, Last)			Date of Birth
Address			Date of Injury
City	State	Zip Code	Social Security Number
Insured		Jurisdictional State	Claim Number

### KEY CONTACT & BILLING INFORMATION

Adjuster Name	Tel. Number	E-mail Address
Carrier/TPA/Servicing Agent	Office Location	Mailing Address:
Defense Attorney Name	Tel. Number	E-mail Address
Defense Firm Name	Address	
Plaintiffs Attorney Name	Tel. Number	E-mail Address
Firm Name	Address	
<b>Can Plaintiff Attorney be contacted?</b>		
YES <input type="checkbox"/> NO <input type="checkbox"/>		

<b>Necessary Documents:</b>
1.) Prior MSA / LCP / CP / RX Review
2.) Two years of Medical Records
3.) Notice of Injury
4.) Complete Pay History
5.) Complete RX History

(For Internal Use)

PRO MED File #: **MR**