



Send completed form & documents to :

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

## RADIOLOGY SERVICE REQUEST

Number of films: \_\_\_\_\_

### CASE INFORMATION

Claimants Name (First, Middle Initial, Last)	Date Referred
	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	
Please provide copies of report to: Carrier/TPA/Service Agent <input type="checkbox"/> Defense Attorney <input type="checkbox"/> Other; explain <input type="checkbox"/>			
Party Responsible for Invoice: Carrier/TPA/Service Agent <input type="checkbox"/> Other; explain <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 #