PRO MED
Kaleidoscope of Medical Review Services

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

www.gopromed.com/forms

COST PROJECTION SERVICE REQUEST

SETTLEMENT ☐ **RESERVE SETTING** ☐
Lifetime ☐ Other ☐
(If other, how many projected years) _____

CATISTROPHIC ☐ Injury ***NON-CATISTROPHIC*** ☐ Injury

Workers Comp ☐ Longshore ☐ Federal ☐ Liability ☐

CASE INFORMATION

Injured Worker (First, Middle Initial, Last)			Date Referred / Date of Birth
Address			Date of Injury
City	State	Zip Code	Social Security Number
Employer		Jurisdictional State	Claim Number

KEY CONTACT & BILLING INFORMATION (please choose referring party option)

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

Please provide copies of the allocation report to
Carrier/TPA/Servicing Agent ☐ Defense Attorney ☐ Plaintiff Attorney ☐ Other ☐ (Explain)

Party Responsible for Invoice
Carrier/TPA/Servicing Agent ☐ Other; explain ☐

REPORT TIME FRAME

Routine Turnaround = 14 days ☐ Normal Status	☐ RUSH Status		RUSH Explanation
If RUSH is requested, please provide dated report is needed:			

NOTES/SPECIAL HANDLING

Controverted issues, deadlines, mediation/court date, etc.	***Documents Needed***
	1. First Report of Injury
	2. Payment History reflecting last 3 years of medical treatment
	3. Medical records and bills for last 3 years of treatment
	4. 1 year of RX (listing name, dosage & frequency)
	**** Rated age obtained whenever possible

(For Internal Use)

Submit Form

PRO MED file # :

Revised 03/10/08