Florida Utilization Review Service Request

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

TIER II ☐ TIER III ☐

CASE INFORMATION

			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 (Please select referring party)

Referring Party ○	Adjuster Name	Tel. Number	E-mail Address
	Carrier/TPA/Servicing Agent	Office Location	Mailing Address:
Referring Party ○	Defense Attorney Name	Tel. Number	E-mail Address
	Defense Firm Name	Address	
Referring Party ○	Plaintiffs Attorney Name	Tel. Number	E-mail Address
	Firm Name	Address	

Please provide copies of the report & future reports/letters to:
Carrier/TPA/Servicing Agent ☐ Defense Attorney ☐ Other; explain ☐

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

FILE INFORMATION

Full medical review, to include: (Please check all that apply)

Medical necessity

Causal relationship

Review medications (specify) ☐

Treatment being provided (specify provider) ☐

Appropriateness of :
Proposed Surgery ☐ Proposed Treatment ☐ Ongoing Treatment ☐

Review for excessive charges:(specify provider) ☐

Other; *See Special Handling* ☐

INITIAL REVIEW & REPORT TIME FRAME (Please select time frame)

Routine Turnaround = 45 days ☐ Normal Status ☐ RUSH Status

RUSH Explanation

If RUSH requested, please provide date report is needed: ________

NOTES/SPECIAL HANDLING

(For Internal Use)

PRO MED File #:

Revised 12/20/07