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

Medical Claims Analysis

CASE INFORMATION

Injured Workers Name (First, Middle Initial, Last)			Date Referred / 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

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

RUSH Explanation

NOTES/SPECIAL HANDLING

DOCUMENTS NEEDED:

1. Notice of Injury
2. Adjuster Notes
3. Pay History
4. All Medical Records / Available Bills

Submit Form

(For Internal Use)
PRO MED File #:

Revised 12/20/07