Send completed form & documents to:
PO Box 941870
Maitland, FL 32794
T: (407) 599-9122
F: (407) 599-1994
TF: (866) 599-9122
www.gopromed.com/forms

# MEDICAL VALUATION SERVICE REQUEST

Settlement ☐ Reserve setting ☐

**CASE INFORMATION**

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

**KEY CONTACT & BILLING INFORMATION**

| | | | | |
|---|---|---|---|---|
| Referring Party | Name: | Office Location: | Telephone #: | Email Address: |
| | | | | |
| | Carrier/TPA/Servicing Agent | | Mailing Address: | |
| | | | | |

**REPORT TIME FRAME**

| Routine Turnaround = 30 days | Normal Status ☐ | RUSH Status ☐ |
|---|---|---|
| IF Rush, please provide date report is needed: | | |

**NOTES/SPECIAL HANDLING**

| RUSH Explanation: | **Documents Needed:** |
|---|---|
| | 1. First report of injury<br>2. Payment history reflecting last 2 years of medical<br>3. All Medical records<br>4. 1 year of Rx *(Listing name, dosage, frequency)*<br>5. Legal documents reflective of medical treatment |

Submit Form

PRO MED file #:

(For Internal Use)

Revised 12/14/07