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
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 ○	Adjuster Name	Tel. Number	E-mail Address	
	Carrier/TPA/Servicing Agent	Address		Office Location
Referring Party ○	Defense Attorney Name	Tel. Number	E-mail Address	
	Defense Firm Name	Address		
Please provide copies of report to: Carrier/TPA/Servicing Agent ☐ Defense Attorney ☐ Other; explain ☐				
Party Responsible for Invoice: Carrier/TPA/Servicing Agent ☐ Other; explain ☐				

INITIAL REVIEW & REPORT TIME FRAME

Routine Turnaround = 30 days	Normal Status ☐	RUSH Status ☐	RUSH Explanation (please type)
	Date RUSH Needed_____		

NOTES/SPECIAL HANDLING

(For Internal Use)

SUBMIT PRO MED file #