Professional Medical Copies, Inc.

UTILIZATION REVIEW SERVICE REQUEST

Injured party: Phone:

Employer: Date of Injury:

Claimant Address:

City/State: Zip:

Insurance Company:

Claim Number: W.C. Number:

Claim Representative: Phone:

Email: Fax:

Defense Counsel: Phone:

Email: Fax:

Mailing Address:

City/State: Zip:

Claimant Attorney: Phone:

Email: Fax:

Mailing Address:

City/State: Zip:

Provider Under Review: Phone:

Specialty:

Mailing Address:

City/State: Zip:

Please provide First Report of Injury, all Orders and Admissions, and all medical records available for this case.

You may transmit your records to us electronically via encrypted email to mary@promedcopies.com, or via **secure upload link**.

Special Instructions or concerns:

PMC Signature: _____ Date: _____ Page Count: _____

Mailing Address: P.O. Box 4518, Parker, CO 80134♦Shipping: 8108 Oak Briar Way, Castle Pines, CO 80108
Phone (303) 850-9594 ♦ Fax (303) 850-9598

https://promedcopies.com