

# SERVICE REQUEST

Online Request: [www.medfileco.com](http://www.medfileco.com)



Request Date: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Claim /File #: \_\_\_\_\_

Name _____	Title _____
Company _____	Email _____
Address _____	Phone _____
City/State/Zip _____	Fax _____
Claimant/Patient _____	Insured _____
Address _____	Phone _____
City/State/Zip _____	Client _____
<b>Attorney</b>	
Name _____ ( <input checked="" type="checkbox"/> one )	Plaintiff _____ Defense _____
Name _____ ( <input checked="" type="checkbox"/> one )	Plaintiff _____ Defense _____
( <input checked="" type="checkbox"/> one )	
Type: PIP ___ BI ___ WC ___ UM ___ Liability ___ Med Pay ___ Disability ___ LOP ___ Other ___	

## SERVICES

- \_\_\_\_\_ **Peer Review** - File Review with a written report on medical necessity, reasonableness and relatedness of care by a Peer Physician. When applicable, the Demand Letter is addressed.
- \_\_\_\_\_ **Diagnostic Test Review** – Review & Report by Peer Physician of Diagnostic Test impressions/results and “Raw Data” (i.e. films, waveforms/graphs etc)
- \_\_\_\_\_ **IME (Independent Medical Examination)** – File Review and a hands-on physical examination with a written report.
- \_\_\_\_\_ **IRR (Impairment Rating Review)** – File Review with a written report on the accuracy of the Impairment Rating.
- \_\_\_\_\_ **RDR (Required Documentation Request)** - A written report/chart of missing records, documentation and/or billing to request from each provider/facility.
- \_\_\_\_\_ **Scanning** - (see “Scanning Request” form)

### Instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL FILE CONSULTANTS, INC. (MFC)**

P.O. Box 623128  
Oviedo, FL 32762-3128

**407-359-0074**

866-MFC-2748 (toll free) 866-632-2748

Fax: 407-365-6536 / Email: [mfc@medfileco.com](mailto:mfc@medfileco.com)