Completed Form can be [Faxed: **(800) 735-1435** or
Emailed: **hinesreferral@hinesassoc.com**]

Prescreen Request for Medical Peer Review

Date Submitted: ______________________

Requestor: ______________________

Company Name: ______________________

Address: ______________________

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Telephone: ______________________

Fax: ______________________

Policy #: ______________________

Dates of Service: ____________ to ____________

Total Billed Charges: ______________________

Diagnosis: ______________________

ICD-10, if available ______________________

Hines File No: ______________________

Claimant: ______________________

DOB: ______________________

Insured: ______________________

Relationship: ______________________

Address: ______________________

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Telephone: ______________________

Name of Group: ______________________

Provider Name: ______________________

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Accident Date, if applicable: ______________________

Type of Review Requested: ☐ **NEW** ☐ **RE-REVIEW**

☐ **Medical Necessity / Appropriate / Level of Care:**

Please specify referral issues. All medical records and current release of information should be attached.
Dental and chiropractic reviews should also include all x-rays, treatment plans and indication of any charges paid to date.

Specific Questions you wish Addressed:

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Special Instructions:

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ALL CANCELLATIONS OF REFERRALS MUST BE RECEIVED IN WRITING

REVISED 8/01/17