MEDICUSRX

Texas Workers' Compensation TPA

PEER REVIEW Referral Form

Today's Date:	
Injured Employee Info Name: Mailing Street Address: City, State, Zip Code: Date of Birth: Date of Injury:	**Carrier Info** Carrier Name (Insurance Comp): Adjuster/Claim Examiner: Employer: Claim Number: Contact Email Address:
Treating Provider Info Name: Street Address: City, State, Zip Code: Phone: Contact Email: Fax #: Tax ID: NPI:	**Attorney Info (if applicable)** Name of Law Firm: Name of Attorney: Street Address: City, State, Zip Code: Contact Name/Email Address: Fax #:
Specialty of Reviewer being Requested:	**State of Jurisdiction**:
Please list questions for Peer Review Physician Reviewer:	

PLEASE NOTE THE FOLLOWING:

Supporting documentation must accompany the request in order to process for services review request.

Submission of Form:

Fax Request form with supporting documentation to 281-407-6309

OR

Email request form with supporting documentation to medicusrx.ur@zmail.datacareservices.com

The sender of request will receive an email confirmation of receipt, if you do not receive an email confirmation, Please call 713-292-5099, ext. 105

If you have any questions or concerns, please call 713-292-5099, ext. 105