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.
Please call 713-292-5099, ext. 105 for instructions for submission and pricing. Thank You.