Completed Form can be faxed to: (800) 735-1435

OR

Emailed to: 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 8/1/17