CORPORATE OFFICE: 119 Littleton Road, Parsippany, NJ 07054 |Phone: 973-257-5200 |FAX: 973-257-2288
BRANCH OFFICE: 500 Office Center Drive, Suite 400, Fort Washington, PA 19034 |Phone: 800-247-3422 |FAX: 267-513-1984

ANCILLARY SERVICES

EMAIL or FAX FORM TO: IntakeDepartment@FirstMCO.com | 973-257-2282

DATE	

PURPOSE OF REQUEST			
☐ IME Examination Only	☐ Peer Review	☐ Bill Review	☐ Audit
☐ IME # of Reschedules	☐ FCE	☐ Film Review	☐ Cost Projection
☐ Impairment	☐ Permanency	☐ Reform Exam	☐ PRO

REPRESENTATIVE			CLAIMANT		
Name:			Name:		
Company:			Address:		
Address:			City:	State:	Zip:
City:	State:	Zip:	Phone:		
Phone:	Fax:		File/Policy #:		
Email Address:					

ATTORNEY			Date of Loss:	Date of Birth:	
Firm Name:			Insured:		
Contact Attorney:			Treating Physician:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:			Phone:		
EMPLOYER:			Insurance Type	☐ PIP ☐ WC ☐ BI ☐ LTD ☐ STD	

TYPE OF EXAM				
☐ Chiropractic	☐ Orthopedic	☐ Neurology	☐ Physical Medicine	☐ Internal Medicine
☐ Psychiatry	☐ Psychology	☐ Dental	☐ TMJ	☐ Other:

ITEMS WHICH NEED TO BE ADDRESSED		
☐ Need for Treatment	☐ Need for Physical Therapy	☐ Address MMI
☐ Ability to Work	☐ Causal Relationship	☐ Degree of Impairment
☐ Medical Necessity of:	☐ Permanency	☐ Other:

Please Complete the Following Section for Audit, Disability Case Management, Pre-Certification or Cost Projection Referrals Only			
☐ AUDIT Physician/Hospital			
Date of Bill:	Amount of Bill:	Audit Authorization Signature:	
☐ Medical Case Mgmt	☐ Vocational Mgmt	☐ Cost Projection	☐ Pre-Certification

Special Instructions: