West Penn
Evaluation & Review
A division of West Penn I. M. E., Inc.
PO Box 210 • N. Versailles, PA 15137

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Initial Peer Review Request Form

Rev 3/2015

Send Report / Bill To

Claim Investigator's Name		Email Address (Recommended)	
Company Name (MUST BE UNDER CONTRACT WITH WEST PENN IME)		Phone	
Address		Fax (Optional)	
City	State	Zip	

Instructions:
Complete this form as thoroughly as possible. Mail, fax, or email it to us with a HIPAA compliant authorization to release medical records if available. You may phone in your referral by calling (800) 321-6853. Please promptly mail copies of the medical records/bills you have on file to PO Box 210, N. Versailles PA 15137. Should the provider under review fail to supply his chart, we will require your records.

Claim Information

Claimant (Full Name)			Claim No.
Address			Date of Injury
City	State	Zip	Social Security No. (Optional)
			Birth Date
Claimant's Attorney, Address, Phone Number (Optional)			Insured ☐ *Same as Claimant*

Provider Under Review #1

Full Name (SHOULD BE AN INDIVIDUAL, NOT A GROUP OR PRACTICE NAME)			Provider's Licensure (M.D., D.O., D.C., etc.; If Known)
Address			Provider's Specialty (If Known)
City	State	Zip	Diagnosis (Optional)
Dates and Treatment Under Review			Phone

Provider Under Review #2 *(attach additional pages as necessary)*

Full Name (SHOULD BE AN INDIVIDUAL, NOT A GROUP OR PRACTICE NAME)			Provider's Licensure (M.D., D.O., D.C., etc.; If Known)
Address			Provider's Specialty (If Known)
City	State	Zip	Diagnosis (Optional)
Dates and Treatment Under Review			Phone

Reviewer Should Consider...

- ☐ Considerable Lapse in Care
- ☐ Lack of Progress
- ☐ Treatment Exceeds Typical Standards
- ☐ Records Indicate MMI Obtained
- ☐ Passive Modalities Applied Beyond Acute Phase
- ☐ Equally Effective Alternative Setting Available
- ☐ Diagnosis Inadequate to Justify Treatment
- ☐ Other (explain below):

Explain/Notes...

X _____ Signature of Person Completing Form

_____ Print Name (if different from Claim Investigator)

_____ Date

For fastest service, email this form to westpennime@comcast.net or fax it to (412) 829-7320 to initiate PRO.