



American Medical Bill Review  
Review Request Form

(Check One) **Record Review**  or **IME**  **In- State Provider**

**Please perform Bill Review on the bills provided: Yes**  **No**

*Bill Review Fees are discounted when submitted with Record Reviews or IMEs*

Submission Date: \_\_\_\_\_ If this case is time sensitive, put "return by" date here: \_\_\_\_\_

Claims Representative: \_\_\_\_\_

Company: \_\_\_\_\_ Client Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

TEL: \_\_\_\_\_ FAX: \_\_\_\_\_

E-mail: \_\_\_\_\_

If you are a Law Firm or TPA who is your client: \_\_\_\_\_

Claims Person Name and Title if different from above: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Name of Patient/Claimant : \_\_\_\_\_

Address (If IME is Requested): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

TEL: \_\_\_\_\_

Represented by (If IME Requested):

Lawyer: \_\_\_\_\_ Firm: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

TEL: \_\_\_\_\_ FAX: \_\_\_\_\_

**Provider Information**

Type of Provider treating patient: \_\_\_\_\_ (MD, DC, DDS) Specialty: \_\_\_\_\_

Type of Medical Consultant requested: \_\_\_\_\_ (MD, DC, DDS) Specialty: \_\_\_\_\_

**Facts about the case**

Specific complaints by patient: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did injury occur: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If auto accident, please describe the location of the damage of each vehicle and the severity of damage: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you aware of any pre-existing conditions or injuries? If yes, please describe the pre-existing conditions and/or the type of prior injury and the date it occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In as much detail as possible, explain what occurred in the accident. How much time did the patient miss from work? Is the patient still being treated?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please circle the letters corresponding to the questions you would like specifically addressed:**

- a. Are the injuries and complaints a direct result of the accident? Are there degenerative conditions involved?
- b. Are the diagnoses appropriately based on the objective tests and medical documentation?
- c. Do the medical records indicate any pre-existing conditions? If so, were any treatments aimed at preexisting conditions? Did pre-existing conditions affect the severity of injuries, the treatment rendered, or the duration of care?
- d. Does the treatment and modalities appear to be reasonable and necessary? Was the duration and frequency of care reasonable and necessary? Please explain.
- e. Were there any permanent disabilities sustained from the accident? Is there any need for future treatment?

Additional questions you would like addressed:

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*Please note: medical providers are not permitted to comment on the reasonableness of the treatment costs. A Bill Review will compare the charges with reasonable and customary allowances in the geographic area where services were rendered, and reduce the bill accordingly.*

Time Frame: Be advised Record Reviews can take up to 30 days after we receive the case for analysis. IMEs can take 45 days or longer. We will keep you informed to the status of the file.

Send File to:

Brigitte DeShields  
AMBR, Inc.  
1160 Industrial Street  
Redding, CA 96002  
530.221.4759 TEL  
530.224.3390 FAX  
[bdeshields@ambr.com](mailto:bdeshields@ambr.com)

**Review Return Instructions**

Please return completed review by: (Check all that apply) Mail  Email  Fax

Originals need to be returned: Yes  No