

**SEND CLAIMS TO:**

AMBR, Inc.  
PO Box 492710, Redding, CA 96049  
530.221.4759 TEL 530.224.3390 FAX  
Claims@AMBR.com



**Submission Cover Sheet**

**RUSH:** \_\_\_\_\_ (Same Day Return, \$15 added)

Date: \_\_\_\_\_ Number of Pages (Including Cover): \_\_\_\_\_ Client Number: \_\_\_\_\_

**How would you like your review(s) returned?**

By Mail: \_\_\_\_\_ By Fax: \_\_\_\_\_ By Email: \_\_\_\_\_ By Secure Website : \_\_\_\_\_ (need access code)  
Original Bills Mailed Back? Yes: \_\_\_\_\_ No: \_\_\_\_\_

<p><b>Case Type:</b>    <b>First Party:</b> _____    <b>Third Party:</b> _____</p> <p><b>Diagnosis Codes:</b>    1. _____    2. _____    3. _____    4. _____</p>
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**Check One or More:**

- 1. PPO: \_\_\_\_\_ (First Party)    Auto: \_\_\_\_\_    WC: \_\_\_\_\_    Group Health: \_\_\_\_\_
- 2. Medical Bill Review: \_\_\_\_\_
- 3. Hospital Bill Review: Line Item: \_\_\_\_\_ File Audit : \_\_\_\_\_ (*attach copies of medical records for File Audit*)

4. Insured: \_\_\_\_\_

5. Claimant: \_\_\_\_\_

6. Date of Injury: \_\_\_\_\_

7. File/Claim Number: \_\_\_\_\_

**CLAIMS REPRESENTATIVE:** \_\_\_\_\_    **EXT:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

Company: \_\_\_\_\_

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

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

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

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