



American Medical Bill Review  
Review Request Form

**This case is: Record Review  or IME  In- State Provider Mandatory: Yes**

**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 Name: \_\_\_\_\_

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

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

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

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

Claimant Name: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Date of Loss: \_\_\_\_\_

Claimant address (*Only If IME is Requested*): \_\_\_\_\_

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

Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Represented by (*Only If IME Requested*):

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

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

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

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

## Facts about the Accident

How did this injury occur?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

## Facts about the Injury

What **body parts** or **condition** is claimed to be the result of this accident?: \_\_\_\_\_

\_\_\_\_\_

Are you aware of any **pre-existing** conditions?: No:  Yes:  If so, what are they?: \_\_\_\_\_

\_\_\_\_\_

## Questions about the Treatment

Do you question whether any of the injuries or conditions are **related** to the accident? No:

Yes:  Explain which injuries/conditions and why: \_\_\_\_\_

\_\_\_\_\_

Is the issue **duration** of care?: Yes:  No:

If a surgery was performed or is being claimed to be needed, do you question if it was **medically necessary**?: No:  Yes:  Explain why: \_\_\_\_\_

\_\_\_\_\_

Do you question whether any of the medical care is due to a **pre-existing** condition? No:

Yes:  If yes, do you need an apportionment to the accident?: No:  Yes:

If **future care** is claimed, do you question the medically necessity or amount claimed?: No:  Yes:

If there is a **lost wage** claim, do you question the length of time the claimant was off work? No:

Yes:  If yes, describe the nature of the claimant's job duties as specifically as possible: \_\_\_\_\_

If a **permanent impairment** rating is claimed, do you question it?: No:  Yes:

Additional questions you would like addressed. In other words, what specifically do you want to know about the medical treatment not already asked above:

**Please note: Consultants are not permitted to comment on the reasonableness of the treatment costs. AMBR can provide a bill review audit consistent with the recommendations of the consultant. This allows the adjuster to align the medical bills with the consultant's report. If not previously requested at the top of this form, but you would like us audit the bills, provide the billing statements and check here:**

**Time Frame:** AMBR strives to complete these reviews within two weeks of receipt. However, depending on the size of the case and complexity, reviews may take up to 30 days. IMEs can take up to 45 days due to scheduling with the claimant/claimant attorney. If the case is missing pertinent, relevant, or necessary medical records, you will be notified by letter of what is needed in order for AMBR to submit the case for consultant review. Once the missing information is received, we will complete according to our stated timeframes.

**Send this form and file contents by mail to:**

AMBR, Inc.  
1160 Industrial Street  
Redding, CA 96002  
530-221-4759

**By Email to:** [claims@ambr.com](mailto:claims@ambr.com)

**By Fax to:** 530-224-3390

\*AMBR has a **secure web-based upload site** that can be utilized for file transmission. If your company does not already have access to this site, please contact our office to gain access.

### **Review Return Instructions**

Please return completed review by: *(Check all that apply)* Mail  Email  Fax  Secure upload site (need access code)

Originals need to be returned: Yes  No