



# Florida Claims Management

## PEER REVIEW FORM

Adjuster: \_\_\_\_\_  
Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

Date: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Claimant: \_\_\_\_\_  
Insured: \_\_\_\_\_

Claim #: \_\_\_\_\_  
Date Of Accident: \_\_\_\_\_

Type Of Physician Required: \_\_\_\_\_

Response Needed By: \_\_\_\_\_

**TESTING REVIEW**

Type of Test: \_\_\_\_\_ Date of Service: \_\_\_\_\_  
Type of Test: \_\_\_\_\_ Date of Service: \_\_\_\_\_  
Type of Test: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Review for necessity of tests. Referring Physician: \_\_\_\_\_  
Review of test results. Physician who performed test: \_\_\_\_\_

**FULL REVIEW OF THE FILE** needed for necessity of the treatment rendered, review of bills for reasonable and necessary treatment charges, and necessity of continued treatment.

**REVIEW OF ONLY THE FOLLOWING ITEMS** (Please indicate date of service):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SPECIFIC QUESTIONS/CONCERNS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ADJUSTER CODE: \_\_\_\_\_

DOCTOR CODE: \_\_\_\_\_