

# PEER REVIEW REQUEST

Date: \_\_\_\_\_

Insurance Company \_\_\_\_\_

**SPECIALTY:**  ORTHO  NEURO  CHIRO

PM&R  INTERNIST

OTHER(s): \_\_\_\_\_

Claims Examiner: \_\_\_\_\_

Claimant's Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Claim Number: \_\_\_\_\_

*Dear Sir/Madam,*

Working with  
**ARROW**  
**CLAIMS**  
**SERVICES, Inc.**  
Tel. # (718) 460-6900  
Fax # (718) 460-6924  
[www.arrowclaims.com](http://www.arrowclaims.com)

We request that a review be conducted pertaining to the following health provider bills below and determine their reasonableness and necessity:

PROVIDER	DATE(S) of SERVICE	BILL AMTS.
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Supporting report(s) and/or record(s), supplied by the health provider(s), are enclosed. Please review for medical necessity the services performed and include all proper **codes** and **fees** in accordance with the NYS No-Fault Fee Schedule.

If any additional information is needed, please notify me immediately.

**PLEASE CHECK THE BOXES BELOW THAT APPLY:**

You have previously done a peer review.

You have previously done an IME.

We received the above mentioned bill(s) on \_\_\_\_\_. Thirty (30) days from this date have been allotted to determine whether this claim is to be paid or not. We request that you provide us with a report within this time frame.

Thank you for your prompt attention on this urgent matter.

*Claim Examiner:* \_\_\_\_\_

*Date:* \_\_\_\_\_