



Intervention RX™

Complete all required information, print the form and fax to the Clinical Services Department at 614-839-5397.

**\*\*Please note - if prescription records are unavailable, an Intervention RX™ cannot be completed.**

1. Date submitted:
2. Injured Party Information:
  - a. Name
  - b. Date of birth
  - c. Address
  - d. Phone number
  - e. Social Security number
  - f. Employer's name
  - g. Job title/description
3. Claim Information:
  - a. Claim number
  - b. Claim type  Workers' Compensation  Auto No-Fault
  - c. Date of injury
  - d. State of jurisdiction
  - e. Accident description
  - f. Diagnosis/Allowed conditions
  - g. Restrictions
  - h. Non-compensable conditions
4. Claims Professional information:
  - a. Name
  - b. Insurance company
  - c. Address
  - d. City, State, Zip code
  - e. Phone number
  - f. E-mail address
  - g. Fax number

250 Progressive Way  
Westerville, Ohio 43082  
(800) 777-3574 (614) 794-3300  
e-mail: [progressive@progressive-medical.com](mailto:progressive@progressive-medical.com)  
[www.progressive-medical.com](http://www.progressive-medical.com)





**Please include the following with your request**

- Completed referral form
- Medical records from the original injury (i.e., First report of injury and initial treatment provided)
- Medical history over the past 12-24 months
  - Healthcare provider's notes, plans of treatment, lab results, etc.
  - Independent Medical Evaluations or Peer Reviews completed for the claim (regardless of date of exam)
- Complete current pharmacy records over the past 12-24 months (**must** include name of medications, strength, quantity dispensed, days supply, refill information, physician name and pharmacy name)
- List of all compensable conditions (related diagnosis and additional allowances)
- List of all non-compensable conditions (unrelated diagnosis)
- History of present illness

**Submit the request**

Complete all the required information, print the form and submit to the Clinical Services department via the fax number listed on the form. Required documents should be sent in the following manner:

- If there are 1-25 pages, fax to 1-614-839-5397
- If there are more than 25 pages, mail to:

**Progressive Medical, Inc.**  
Attention: Clinical Services Department  
250 Progressive Way  
Westerville, OH 43082

-OR-

- Upload electronic documents to:  
<ftp.progressive-medical.com>  
Contact the Clinical Services Department at 866-742-7676 for user name and password

250 Progressive Way  
Westerville, Ohio 43082  
(800) 777-3574 (614) 794-3300  
e-mail: [progressive@progressive-medical.com](mailto:progressive@progressive-medical.com)  
[www.progressive-medical.com](http://www.progressive-medical.com)



FOR INTERNAL USE ONLY – DO NOT COMPLETE

1. Date request received:
2. Date request for information sent to claims professional:
3. Date information received:
4. Date Intervention RX™ completed and mailed:
5. Date of confirmation of receipt of Intervention RX™:
6. Miscellaneous information: