RateFast Express PTP Impairment Rating Referral

Patient Information		
Name (Last, First, Middle):		
Date of Injury (MM/DD/YYYY):	Date of Birth (MM/DD/YYYY):	
Claim Number:	Employer:	
Claims Administrator Information		
Company Name:	Contact Name:	
Address:	City:	State:
Zip Code:	Phone:	Fax:
E-mail Address:		
Vendor Service Information		
Vendor Name: RateFast	Contact Name: Chris Hall	
Address: 125 S. Main Street, Ste. 409	City: Sebastopol	State: CA
Zip Code: 95472	Phone: (707) 484-5778	Fax: (707) 921-7924
E-mail Address: express@rate-fast.com		Tax ID Number: 46-1201548
Primary Treating Physician		
I have determined the body part(s) selected in Section 1 below to have reached MMI. I request RateFast to be authorized to create a comprehensive impairment rating report for this patient based on my medical findings and chart documentation.		
Practice Name:	Contact Name:	
Address:	City:	State:
Zip Code:	Phone:	Fax:
PTP name:	E-mail Address:	
PTP Signature:	Date:	

STEP 1: Select Body Part(S) For Rating

SPINE:	**UPPER EXTREMITIES:**	R	L	**LOWER EXTREMITIES:**	R	L	**HERNIA:**	R	L
☐ Cervical	Shoulder	☐	☐	Hip	☐	☐	Inguinal	☐	☐
☐ Thoracic	Elbow	☐	☐	Knee	☐	☐	Umbilical	☐	☐
☐ Lumbar	Wrist	☐	☐	Ankle	☐	☐			
	Thumb	☐	☐	Great Toe	☐	☐	Vision	☐	☐
☐ Skin	Index	☐	☐	Lesser Toe(s)	☐	☐			
	Middle	☐	☐				Hearing	☐	☐
☐ Psychiatric	Ring	☐	☐	Other Body Parts:					
	Little	☐	☐						
☐ Pulmonary/COVID									

STEP 2: Indicate severity of pain/symptoms based on impact Activities of Daily Living (ADLS). Check one below:

☐ **None**	☐ **Mild**	☐ **Moderate**	☐ **Severe**
No pain/symptoms or impact to ADLs.	Pain/symptoms occur during 3 or more ADLs, but no limitations.	Pain/symptoms limit 7 or more ADLs.	Pain/symptoms limit 13 or more ADLs.

STEP 3: PTP Office Action: Please securely email or fax this coversheet to RateFast Express:
RateFast Express Email: express@rate-fast.com Fax: (707) 921-7924