INDEPENDENT MEDICAL EXAMINATION REQUEST		
Page 1		
	CLIENT INFORMATION	
CLIENT		
CONTACT		Internal Notes:
EMAIL		
PHONE		
FAX		
REQUEST DATE		
l	CLAIMANT INFORMATION	
CLAIMANT		
ADDRESS		
PHONE		
SS#		
DOB		
LANGUAGE		
	CLAIM INFORMATION	
CARRIER		
ТРА		
EMPLOYER		
CLAIM #		
DOA		
WCB #		
PULL FROM ECASE		
ACCEPTED SITES		
ALLEGED SITES		
PARTIES OF INTEREST (WHO YOU WANT US TO COPY ON THE IME PAPERWORK)		
SERVICE REQUESTS	TYPE OF CLAIM	SPECIALTY REQUESTED
	Workers' Compensation(state)	
	□ Fit For Duty	
	□ No Fault	
	□ Other	

READ REPORTS MEDICAL REVIEW SERVICES

INDEPENDENT MEDICAL EXAMINATION REQUEST

Page 2		
CLAIMANT : REQUEST DATE:		
ISSUES TO BE ADDRESSED – CHECK ALL THAT APPLY		
DETAILED PAST HISTORY		
DETAILED ACCIDENT HISTORY		
DETAILED TREATMENT HISTORY		
DETAILED WORK HISTORY		
CAUSAL RELATION		
DIAGNOSIS		
PROGNOSIS		
SUBJECTIVE/OBJECTIVE		
WORK STATUS		
RETURN TO WORK		
DEGREE OF DISABILITY		
RESTRICTIONS/CAPABILITIES		
EPC FORM		
STATUS QUO ANTE		
MMI		
SLU/PERMANENCY		
NEED FOR TREATMENT		
REASONABLE, NECESSARY & RELATED		
DIAGNOSTIC TESTING		
SURGERY		
DURABLE MEDICAL EQUIP		
PHARMACEUTICALS		
NAP MTG QUESTIONS		
C4-AUTH		
MG-2		
DEADLINE		
SEND CARRIER QUESTIONNAIRE WITH IME-5		
OTHER		
SUMMARY OF CLAIM		