Request for Information

Please complete the following fields to the best of your ability.
Contact our office if you have any questions or need assistance.

PHYSICIAN			
Last Name		First Name	
Cell Phone		Email Address	

SPECIALITY			
Specialty		Board Certified	
Year Certified		Expiration	
State		License #	

PAYMENT			
Payable to		Tax ID	
Address		City, State, Zip	

LOCATIONS - *ENCLOSE A SEPARATE ATTACHMENT IF ADDITIONAL LOCATIONS ARE AVAILABLE*			
Address			
City, State, Zip		County	
Phone		Fax	
Send Meds to			

FEES			
WC IME		Record Review	
Liability IME		1st No Show	
Auto IME		2nd No Show	
Other		3rd No Show	

DEPOSITION (BY TELEPHONE)			
Deposition Fee		Terms	

TESTIMONY (IN PERSON)			
Testimony Fee		Terms	

MALPRACTICE			
Carrier		Phone	
Policy Number		Period Covered	
Claim Amount		Aggregate	

LANGUAGES					
Language		☐ Speak	☐ Read	☐ Write	☐ Fluent
Language		☐ Speak	☐ Read	☐ Write	☐ Fluent

READ REPORTS
MEDICAL REVIEW SERVICES

PLEASE ANSWER ALL QUESTIONS

The following is an agreement between the provider and Read Reports. The nature of this agreement includes only non-treatment services such as independent medical evaluations, file reviews and other non-treatment related services. All information contained in this agreement, and in any referral that is sent to your office, is privileged and should be held in the strictest of confidence. Any disclosure and/or distribution to any party, other than an agent designated by you to act on your behalf, is prohibited.

Question	yes	no
Do you currently hold an active, valid, unrestricted license to practice medicine by the appropriate state licensing agency?	☐ yes	☐ no
Has your insurance company ever cancelled, declined, reduced, restricted or refused to renew your malpractice insurance? If yes, please attach an explanation.	☐ yes	☐ no
Has your license to practice medicine ever been limited, restricted, suspended or revoked for any reason? If yes, please attach an explanation.	☐ yes	☐ no
Have there been, or are there currently, any state licensing investigations, claims or actions against you? If yes, please attach an explanation.	☐ yes	☐ no
Have you ever been denied participation or renewal of participation, in any workers' compensation auto insurance, hospital or managed healthcare organizations? If yes, Please attach an explanation.	☐ yes	☐ no
Have you ever been reprimanded, disciplined or suspended by a health plan, Medicare/ Medicaid or professional state or federal board? If yes, please attach an explanation.	☐ yes	☐ no
Are you authorized by NYS to perform IME's? If yes, provide authorization number ________________	☐ yes	☐ no
Do you agree not to disclose confidential patient information or reports to any party other than Read Reports unless so authorized by Read Reports?	☐ yes	☐ no
Do you agree to be impartial, without bias, towards the claimant, referral source or any other party that holds interest?	☐ yes	☐ no
Are you aware that you are prohibited from discussing and giving treatment advice to the claimant?	☐ yes	☐ no
Do you agree to indemnify and hold Read-Reports, Inc., its client, sources and their respective officers, directors and employees harmless from all claims and damages arising directly or indirectly, from obligations concerning your performance of, or failure to perform, services as per this agreement?	☐ yes	☐ no
Do you agree that x-rays or additional diagnostic tests are not authorized at the time of the IME unless you have prior, written authorization from the offices of read reports?	☐ yes	☐ no
Do you understand that services performed under this agreement are solely to be performed as an independent contractor and not as a joint venture, employee or agent of Read Reports and that all rules, regulations and obligations of an independent contractor apply?	☐ yes	☐ no
Are you currently in active practice?	☐ yes	☐ no
How many independent medical examinations do you perform, on average, each week?	________ Exams	

ENDORSEMENT	
Name of Provider	
Provider's Signature	
Date Completed	

With this completed Request for Information, please forward copies of your:

- **CV**
- **License**
- **Malpractice**
- **W-9**
- **Sample Report (if possible)**