

# Read ✓ Reports

## MEDICAL REVIEW SERVICES



### 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		1 <sup>st</sup> No Show	
Auto IME		2 <sup>nd</sup> No Show	
Other		3 <sup>rd</sup> No Show	

#### DEPOSITION (BY TELEPHONE)

Deposition Fee		Terms	
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#### TESTIMONY (IN PERSON)

Testimony Fee		Terms	
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#### MALPRACTICE

Carrier		Phone	
Policy Number		Period Covered	
Claim Amount		Aggregate	

#### LANGUAGES

Language		<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write	<input type="checkbox"/> Fluent
Language		<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write	<input type="checkbox"/> Fluent



# Read Reports

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### 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.

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)

