IME Request - 207 Case

UMC Headquarters:
100 Elwood Davis Road, Suite 106 • North Syracuse, NY 13212
Phone • 877-862-4463 • Fax 315-453-2884

CLAIMANT INFORMATION:		REQUESTED BY:	
CLAIM NUMBER:		COMPANY NAME:	Date:
NAME:		NAME:	
ADDRESS:		TITLE:	
CITY/STATE:	ZIP:	ADDRESS:	
PHONE:		CITY/STATE:	ZIP:
SS#	DOB#	PHONE:	FAX:
EMPLOYER:		EMAIL ADDRESS:	
ATTORNEY INFORMATION:		**INJURY INFORMATION:**	
ATTORNEY NAME:		DATE OF INJURY/LOSS:	
ADDRESS:		ANCR/BODY PART(S):	
CITY/STATE:	ZIP:	207 FILE #:	
ATTORNEY PHONE:	FAX:	WAGE LOSS: ☐ YES ☐ NO	

ATTENDING PHYSICIAN INFORMATION:		ADDITIONAL PHYSICIAN INFORMATION:	
TREATING PHYSICIAN NAME:		PHYSICIAN NAME:	
ADDRESS:		ADDRESS:	
TREATING PHYSICIAN PHONE:		PHONE:	FAX:

SPECIALTY NEEDED:

☐ORTHOPEDIST ☐NEUROLOGIST ☐ CHIROPRACTOR ☐ NEUROSURGEON ☐PMR
☐OTHER: ☐NAME OF REQUESTED IME PHYSICIAN:

ISSUES TO BE IDENTIFIED:

☐PROGNOSIS
☐CAUSAL RELATIONSHIP TO INJURY
☐NEED FOR TREATMENT, TYPE & DURATION
☐ PERMANENCY RATING
☐ TREATMENT REASONABLE NECESSARY & APPROPRIATE
☐DEGREE OF DISABILITY
☐ ESTIMATED DURATION OF DISABILITY
☐NEED FOR SURGERY
☐MAXIMUM MEDICAL IMPROVEMENT
☐ ABILITY TO RETURN TO WORK

COMMENTS: