UMC

Independent Medical Examinations

IME Order Form

This is a Request Form for an order of an IME in a **Liability** case.

Part 1: Claim Information

Date:					
	First Name	MI	Last Name		
Requested by:					
Company:					
Address 1:					
Address 2:					
City:		State:		ZIP:	
Phone:		FAX:			
e-mail:					
Name of insured:					
Name of claims adjuster:		Phone #:			
Claim Adjuster's e-mail:					
Claim office:					
Bill to:	Requester (above) ◯	Third Party ◯			
Company:		Reference #:			
	First Name	Last Name			
Name:					
Address 1:		Phone #:			
Address 2:					
	City	State	Zip		
Locale:					

Part 2: Examinee Information

	Honorific	First Name	MI	Last Name
Claimant Name:				
Claimant SSN (last 4 digits):				
	Honorific	First Name	MI	Last Name
Plaintiff Attorney:				
Attorney Firm:				
Attorney Address:				
City:				

Part 2: Examinee Information (continued)

State:		ZIP:	
Attorney Phone:			
Claim Number:			
File Number:			
Date of accident:			
Venue:			

Part 3: Examination Requirements

Specialties Required:

☐ Ortho	☐ Neuro	☐ Neuro Surgical	☐ Surgeon
☐ Psychiatric	☐ ENT	☐ Internal Medical	☐ Dental
☐ Oral Surgery	☐ Cardiology	☐ Acupuncture	

Other:

Render Specific Opinion For:

☐ Diagnosis	☐ Discussion of Findings	☐ Prognosis
☐ Causal Relationship	☐ Need for Surgery	
☐ Ability to Work	☐ Treatment	

☐ Medical Necessity of Testing Performed (Specify test type and date below)

☐ File Review

☐ Film Review (List films to be reviewed below) ☐ RoM with instrument noted

☐ Indicate RoM & Norms	☐ Pre-existing Conditions	☐ Treatment R, N & A

Special Instructions / Comments:

Attachments:

☐ Bill of Particulars	☐ Medicals	☐ Other (specify below)
☐ Please schedule pickup of record materials		