UMC

Independent Medical Examinations

IME Order Form

This is a Request Form for an order of an IME in a **No Fault** 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 claims adjuster:					
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):				
Claimant Address:				
Claimant City:				
Claimant State:		Claimant ZIP:		
Claimant Phone:				

Part 2: Examinee Information (continued)

	Honorific	First Name	MI	Last Name
Claimant Attorney:				

Attorney Firm:			
Attorney Address:			
City:			
State:		ZIP:	
Attorney Phone:			
Claim Number:			
File Number:			
Date of accident:			
Insured:			

Part 3: Examination Requirements

If Re-examination, Prior Exam Date:

Specialties Required:

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

Other:

Render Specific Opinion For:

☐ Diagnosis	☐ Causal Relationship
☐ Prognosis	☐ Need for Surgery
☐ Ability to work	☐ Need for Household Help
☐ Further Treatment and Frequency	☐ Need for Diagnostic Testing
☐ Need for Special Transportation	☐ Need for Durable Medical Equipment

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

☐ File Review	☐ Arrange Transportation to IME

☐ Film Review (List films to be reviewed below)

Part 3: Examination Requirements (continued)

Special Instructions / Comments:

Attachments:

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