UMC

Independent Medical Examinations

IME Order Form

This is a Web-Submission Receipt for an order of an IME in a **Workers' Compensation** 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:						
WCB 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):		DOB:			
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:				
	Honorific	First Name	MI	Last Name
Claimant Attending Physician:				
Attending Physician Firm:				
Attending Physician Address:				
City:				
State:		ZIP:		
Attending Physician Phone:				
Claim Number:				
WCB Number:				
Date of accident:				
Employer:				

Part 3: Examination Requirements

If Re-examination, Prior Exam Date:	
Is this a "RUSH" Case?:	
Need report by date:	
Hearing Location / City:	
ANCR:	

Specialties Required:

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

Other:

Part 3: Examination Requirements

Render Specific Opinion For:

☐ Diagnosis	☐ Causal Relationship
☐ Prognosis	☐ Need for Surgery
☐ Further Treatment and Frequency	☐ Permanency Rating
☐ Degree of Current Disability	Has Prior Permanency Opinion been given? Yes ◯ No ◯
☐ Apportionment of Disability	If 'Yes' (above), Date of PPO Report:
☐ Has an end result / MMI been reached?	☐ M & S Statement (2nd Injury Law)
☐ Can claimant return to work?	☐ Can claimant perform light / modified duty?
☐ C-4 Authorization?	☐ Variance Exam?

☐ Specific Job Capabilities (attach job description or include in materials for pickup)

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

☐ File Review

☐ Film Review (List films to be reviewed below)

Special Instructions / Comments:

Attachments:

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