Independent Evaluations LLC
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IME SERVICES

APPOINTMENT REQUEST FORM

DATE: _____

CLIENT: _____

Address: _____

_____

ADJUSTER: _____

CLAIMANT: _____

Address: _____

_____

Phone #: _____

SS#: _____

CLAIMANT'S ATTORNEY: _____

Address: _____

_____

Phone #: _____

INSURED/EMPLOYER: _____

DATE OF ACCIDENT: _____

CLAIM #: _____

WCB #: _____ **WCB OFFICE:** _____

TREATING PHYSICIAN: _____

Address: _____

_____

Has Statewide previously scheduled and IME? Yes/No

If Yes, when? _____ **SW File #:** _____

Nurse case Mgr: _____

E-mail: _____

Tel: _____

SPECIALTY REQUIRED

☐ Internal Medicine	☐ Chiropractic	☐ Pulmonary	☐ Dental
☐ Orthopedic	☐ Radiology	☐ Psychiatry	☐ Acupuncture
☐ Neurology	☐ Plastic Surgery	☐ Physiatry (P.M. & R.)	☐ Other_____

TYPE OF COVERAGE

☐ **WORKERS' COMPENSATION**

Is this claim bound by the New York State Workers' Compensation Board? Yes/No

☐ **NO FAULT**

☐ **LIABILITY**

VENUE: _____

ISSUES TO BE ADDRESSED

☐ Can Patient Return to Usual Occupation?	☐ Diagnosis	☐ Apportionment
☐ RTW Full Duty or Light Duty with Restrictions?	☐ Casual Relationship	☐ Permanency
☐ Schedule Loss Evaluation	☐ Need for Treatment	☐ Other_____
☐ Impairment Rating	☐ Degree of Disability	_____
☐ ANCR_____	☐ M & S Issues **(NYS WC Only)**	

SPECIAL INSTRUCTIONS/PEER REVIEW INSTRUCTIONS

_____

_____

_____

_____

_____

_____

– OFFICE USE ONLY –

Date _____
Time _____
Doctor _____