THE INDEPENDENT MEDICAL EVALUATION SPECIALISTS, INC

IME REQUEST FORM

PATIENT INFORMATION

Name: ____________________ Date of Loss: ____________________

Address: ____________________ Claim #: ____________________

____________________ Claim Type: ____________________

City: ____________________ *For W/C Only*

State: ____________________ Claim Accepted? YES NO

Zip: ____________________ Employer: ____________________

Phone: ____________________ Address: ____________________

DOB: ____________________ ____________________

SS #: ____________________ City: ____________________

Injury: ____________________ State: ____________________

Tx Dr: ____________________ Zip: ____________________

PATIENT ATTORNEY INFORMATION (if applicable)

Name: ____________________ Address: ____________________

Firm : ____________________ ____________________

Phone: ____________________ City: ____________________

Fax: ____________________ State: ____________________

Zip: ____________________

REFERRAL INFORMATION

Name: ____________________ Address: ____________________

Co : ____________________ ____________________

Phone: ____________________ City: ____________________

Fax: ____________________ State: ____________________

E-mail: ____________________ Zip: ____________________

The Independent Medical Evaluation Specialists, Inc.
15 East Uwchlan Avenue, Suite 404, Exton, PA 19341
Voice: 610.280.9122 Fax: 610.280.9129 E-mail: scheduling@timesime.com

THE INDEPENDENT MEDICAL EVALUATION SPECIALISTS, INC

IME REQUEST FORM

BILLING INFORMATION Check here if same as referral

Name: ____________________ Address: ____________________

Co : ____________________ ____________________

Phone: ____________________ City: ____________________

Fax: ____________________ State: ____________________

E-mail: ____________________ Zip: ____________________

DEFENSE ATTORNEY INFORMATION (if applicable)

Name: ____________________ Address: ____________________

Firm : ____________________ ____________________

Phone: ____________________ City: ____________________

Fax: ____________________ State: ____________________

E-mail: ____________________ Zip: ____________________

APPOINTMENT INFORMATION

Specialty or Physician Requested: ____________________

Location Requested: ____________________

Timeframe for appointment: ____________________

Would you like us to:

Notify Patient/Patient Atty?	YES	NO
Copy Defense Attorney?	YES	NO
Copy Billing Party?	YES	NO
Arrange Transportation?	YES	NO
Arrange An Interpreter?	YES	NO

COMMENTS OR SPECIAL REQUESTS:

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