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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| http://inside.cbs.state.or.us/docs/branding/logos/wcd/en/JPEG/WCD-logo-black.jpg | | | | | | |  | | | | Insurer’s Request forDirector Approval of an Additional Independent Medical Examination | | | | | | | | | |
| Worker information | | | | | | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Worker name: | | | |  | | | | | | | | | Phone: | | |  | | | | |
| Address: | |  | | | | | | | | | | | | | | | | | | |
| Date of injury: | | | | |  | Insurer: | | |  | | | | | Claim no.: | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | |
| INDEPENDENT MEDICAL EXAMINATION (IME) INFORMATION | | | | | | | | | | | | | | |  | | | | | |
|  | | | | | |
| 1. | State the reasons you are requesting an additional IME and the conditions you want to have evaluated. **Note:** Include any medical documentation you want to have considered in this matter. *(Use the back of this form or attach additional sheets, if necessary.)* | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | |
| 2. | What was the date of the last IME to evaluate this condition? Date: | | | | | | | | | | |  | | | | | | |  | |
| 3. | How many IMEs has the worker attended since the claim was last opened? | | | | | | | | | | | | | |  | | | | | |
| 4. | Attach copies of previous IME notification letters for this open period. If you **cannot** provide copies, list all examinations in chronological order, with the names of the examiners, time, date, place, and conditions evaluated. *(Use the back of this form or attach additional sheets, if necessary.)* | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | |
| 5. | What was the purpose of the previous IMEs? | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Certification statement | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | |
| By signing below, I certify that I: | | | | | | | | | | | | | | | | | | | | |
| * Have answered all questions to the best of my ability. | | | | | | | | | | | | | | | | | | | | |
| * Have attached sufficient documentation to support the request (See [Bulletin 252](https://wcd.oregon.gov/Bulletins/bul_252.pdf)). | | | | | | | | | | | | | | | | | | | | |
| * Will provide a copy of this request to the worker and the worker’s attorney (if represented). | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Signature: | | |  | | | | | | | | | | | | | | Date: | | |  |
| ***Send a completed and signed copy of this form and all accompanying documents to:*** Workers’ Compensation Division, Medical Resolution Team350 Winter St. NE, P.O. Box 14480Salem, OR 97309-0405 | | | | | | | | | | | | | | | | | | | | |
| Notice to the worker | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| If you object to the request for an additional independent medical examination (IME), send your objections within 10 days from the date of this request to: Workers’ Compensation Division, Medical Resolution Team  350 Winter St. NE  P.O. Box 14480  Salem OR 97309-0405  The director will approve or deny the insurer’s request based only on available information.  ***For more information, contact the Medical Resolution Team at* 503-947-7606*, email*** [***wcd.medicalquestions@dcbs.oregon.gov***](mailto:wcd.medicalquestions@dcbs.oregon.gov)***, or visit our website:*** [***www.wcd.oregon.gov***](http://www.wcd.oregon.gov)***.*** | | | | | | | | | | | | | | | | | | | | |
| 440-2333 (6/25/DCBS/WCD/WEB) | | | | | | | | | | | | | | | | | | | | |