Workers' Compensation Division
Department of Consumer and Business Services

Insurer's Request for Director 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).
- 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 Team
350 Winter St. NE, P.O. Box 14480
Salem, 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, or visit our website: www.wcd.oregon.gov.