IME REFERRAL FORM

www.ime-plus.com
833-277-3828

PLEASE CALL 833-277-3828 TO SCHEDULE OR COMPLETE THIS REFERRAL FORM AND EMAIL TO SCHEDULING@IME-PLUS.COM

Referring Company: _____

Name , Contact Phone # and email: _____

_____

Do you represent the defense or the plaintiff? _____

Claimant's Name: _____

Claimant's DOB: _____

Claim Number: _____

DOL: _____

Body parts to be examined: _____

Name, Phone# and Email for person responsible for payment/invoice: _____

_____

County/Office Preferred: _____

Doctor Preference: _____

Type of Claim: ☐ **PIP** ☐ **Liability** ☐ **Disability** ☐ **Other**

Worker's Compensation ☐

If WC - Select One:

Federal WC ☐

Federal WC Scheduled Award ☐

NY WC ☐

Earliest Appointment Needed: _____