IME REFERRAL FORM

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: ______________________________

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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: ______________________________

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County/Office Preferred: ______________________________

Doctor Preference: ______________________________

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

Worker's Compensation ☐

If WC - Select One:

Federal WC ☐

NY WC ☐

Earliest Appointment Needed: ______________________________