

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: _____

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: _____

Is an Interpreter Needed: ☐ Yes ☐ No

If yes, specify language: _____

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

Worker's Compensation ☐

If WC - Select One:

NY WC ☐ Federal WC ☐

Earliest Appointment Needed: _____