



Independent Medical Examination Scheduling Form

Client Information

Name of Company Requesting Exam:		Name of Person Requesting Exam:	
Telephone #	Fax #	Email Address	

Claimant / Claim / Exam Information

Claimant Name		Claimant SS#	Claim #	DOB
Claimant Address		City	State	Zip
Claimant Phone #	Allowed Conditions			
Date of Injury	Specialty Requested		Hearing Date	
Type of Exam	<input type="checkbox"/> IME	<input type="checkbox"/> ADR IME	<input type="checkbox"/> C92	<input type="checkbox"/> File Review
Do you want MRG to review the file and create the exam letter to the physician			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Claimant's Attorney's Name		Name of Law Firm		
Attorney Address	City	State	Zip	

If MRG is creating the exam letter to the physician please check issues to be addressed

Extent of Disability	Necessity of Additional Treatment
Maximum Medical Improvement	Appropriateness of Treatment Provided to Date
Return to Work and/or Work Restrictions	Allowance (Claim is Being Contested)
Percentage of Permanent Partial Impairment	Temporary Total Disability
Permanent Total Disability	
Additional Allowance (Claimant has requested additional allowance) Please list allowances being requested:	

Additional Information / Instructions: