Experience Claims Management, LLC.

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IME/PEER REVIEW REQUEST FORM

Coverage Type
☐ *PIP/NO-FAULT*
☐ *WORKER'S COMP.*
☐ *TORT/LIABILITY*
☐ *DISABILITY*
Other:

Specialties		
☐ Orthopedic	☐ Neurology	☐ Chiropractic
☐ PM&R	☐ Psychology	☐ Dental- TMJ
☐ Acupuncture	☐ Chiro/Acup	☐ PM&R/Acup
☐ Psychiatric	☐ Radiological Review	
☐ **PEER REVIEW**	☐ Others:	

Claim #:	**Policy #:**	**Attorney/Firm:**
Date of Loss:	**Tel.#:**	**Address:**
Insured:	**DOB:**	**City/St/Zip:**
Claimant:		**Tel.#:**
Address: **City/State/Zip:**		**Fax.#**

Specific Requests to be addressed in IME report:-

☐ Need for Treatment
☐ Frequency/Duration of Treatment
☐ Need For Diagnostic Testing
☐ Need for Durable Medical Equipment
☐ Target Return To Work Date
☐ *OTHER COMMENTS*:

☐ Causal Relationship
☐ Degree of Disability
☐ Need for Surgery
☐ Need for Transportation
☐ Loss of Wages

☐ Return to work status
☐ Prognosis
☐ Permanency
☐ Need for House Hold Help
☐ **PEER REVIEW ONLY**

Provider(s)	Date(s) of Service(s)	Amount ($)

☐ *You have previously done a peer review.*

☐ *You have previously done an IME.*

*Claims Examiner:*______________________________

*Date:*______________________

WHERE YOU CAN FIND TRUST & RELIABILITY