Go to Form

Instructions for Completing the

Application for a Division Independent Medical Exam (IME)

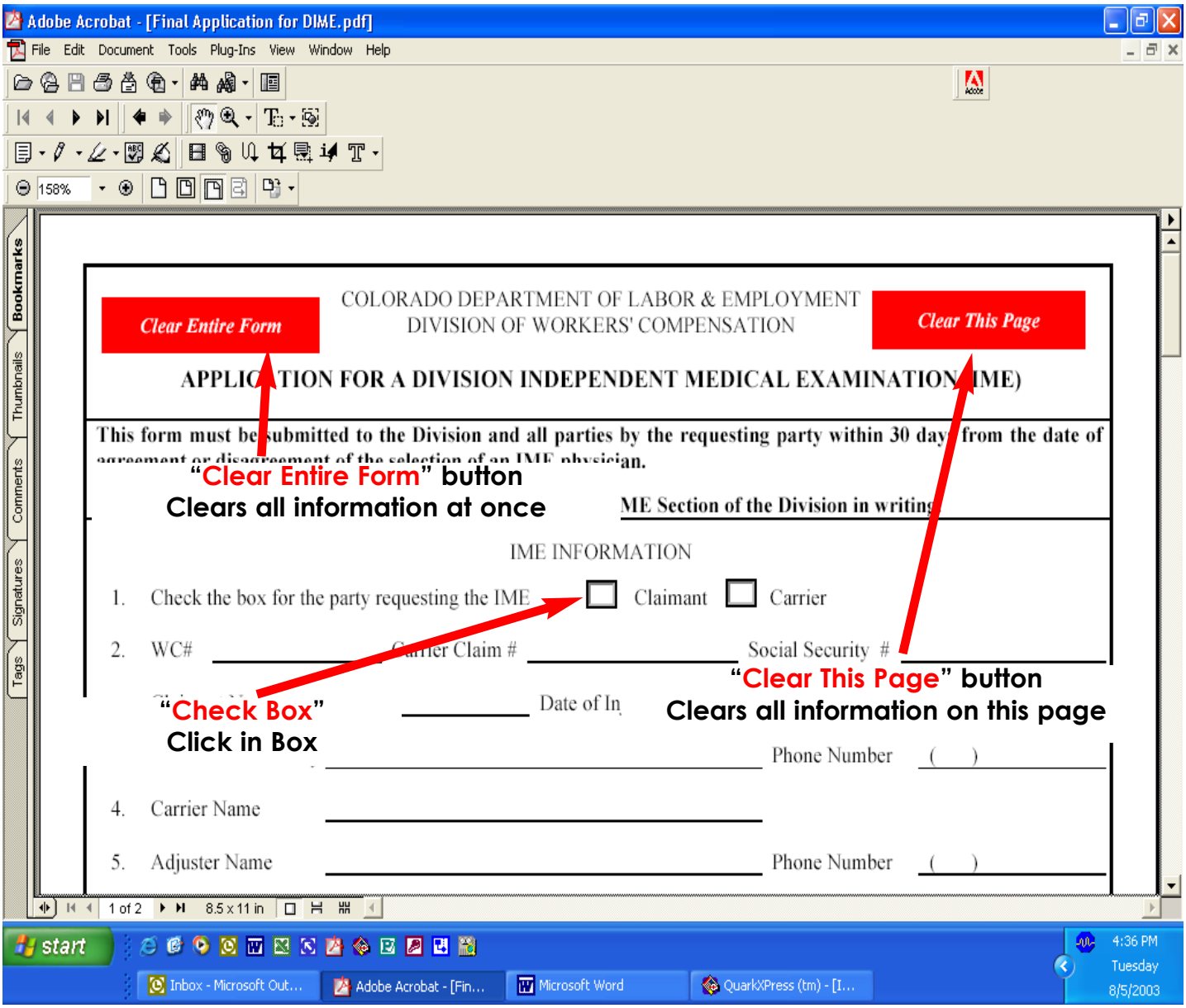
Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will *not* be able to save the form onto your computer's hard drive.

When you open the form, click in the appropriate check box (field), complete the information, and use the tab key to navigate to the next field. To fill in a check box, click inside the box with your mouse.Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you *cannot* continue to type information into a field if it doesn't fit into the space provided.

Use numbers only to fill in the fields for Social Security # and phone numbers. Do not use dashes or parentheses; when you tab out of the field, it will fill in automatically. The "Certificate of Mailing" fields are surrounded by a gray border. Type the information in the first field and tab to the next to enter more information.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To clear all information on a single page, click on the red "Clear This Page" button. To change the information in one field, use the backspace or delete key.


Adobe Acrobat - [Final Application for DIME.pdf]
File Edit Document Tools Plug-Ins View Window Help
Clear Entire Form
COLORADO DEPARTMENT OF LABOR & EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
Clear This Page
APPLICATION FOR A DIVISION INDEPENDENT MEDICAL EXAMINATION (IME)
This form must be submitted to the Division and all parties by the requesting party within 30 days from the date of
"Clear Entire Form" button
Clears all information at once
ME Section of the Division in writing
IME INFORMATION
1. Check the box for the party requesting the IME Claimant Carrier
2. WC# Carrier Claim # Social Security #
"Check Box"
Click in Box
Date of In
"Clear This Page" button
Clears all information on this page
Phone Number ( )
4. Carrier Name
5. Adjuster Name
Phone Number ( )
1 of 2
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QuarkXPress (tm) - [I...
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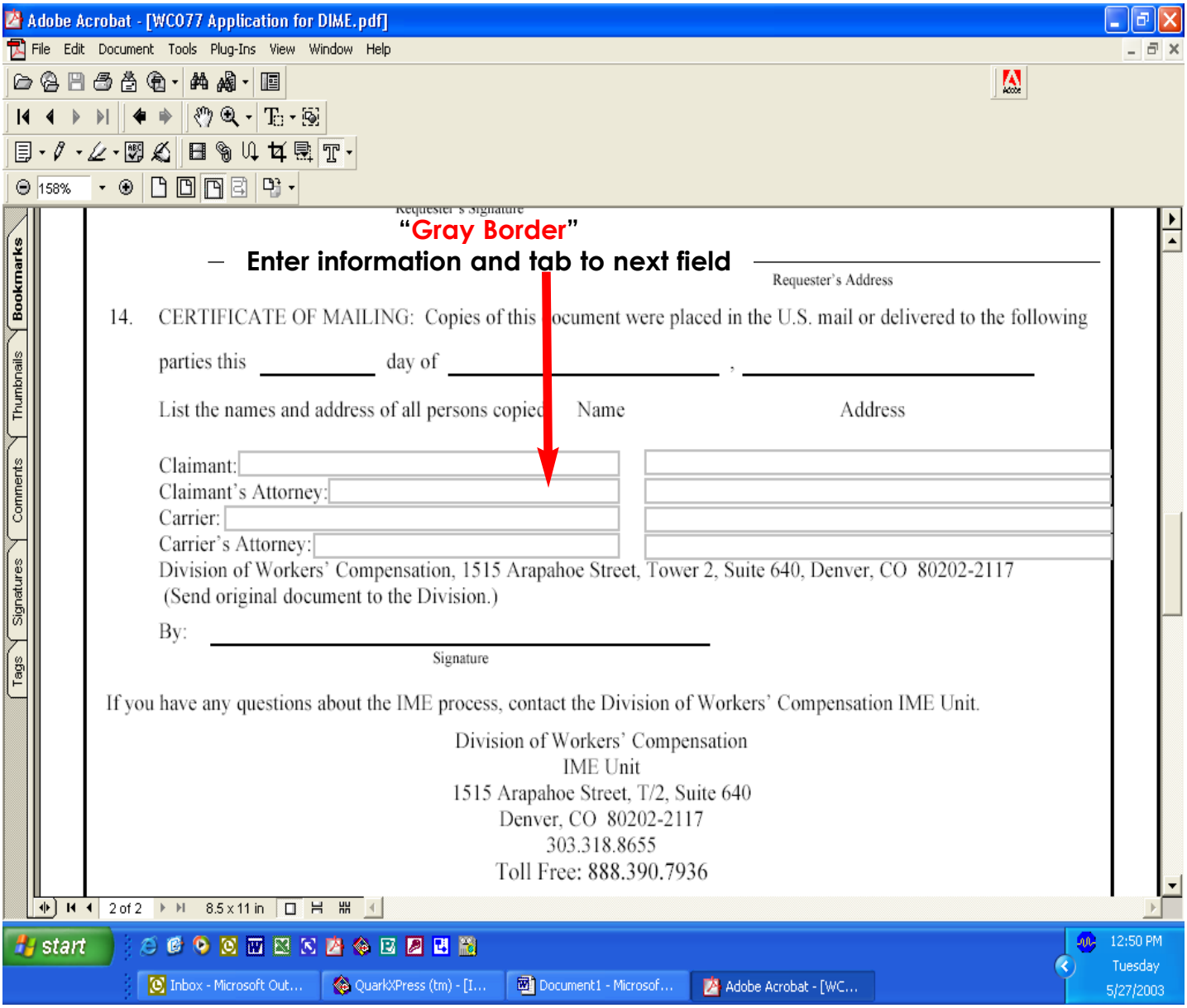
Tuesday
8/5/2003


Adobe Acrobat - [WC077 Application for DIME.pdf]
File Edit Document Tools Plug-Ins View Window Help
158%
Bookmarks
Thumbnails
Comments
Signatures
Tags
"Gray Border"
– Enter information and tab to next field
Requester's Address
14. CERTIFICATE OF MAILING: Copies of this document were placed in the U.S. mail or delivered to the following
parties this _____ day of _____ , _____
List the names and address of all persons copied Name Address
Claimant:
Claimant's Attorney:
Carrier:
Carrier's Attorney:
Division of Workers' Compensation, 1515 Arapahoe Street, Tower 2, Suite 640, Denver, CO 80202-2117
(Send original document to the Division.)
By: _____
Signature
If you have any questions about the IME process, contact the Division of Workers' Compensation IME Unit.
Division of Workers' Compensation
IME Unit
1515 Arapahoe Street, T/2, Suite 640
Denver, CO 80202-2117
303.318.8655
Toll Free: 888.390.7936
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Tuesday
5/27/2003

Clear Entire Form

COLORADO DEPARTMENT OF LABOR & EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

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APPLICATION FOR A DIVISION INDEPENDENT MEDICAL EXAMINATION (IME)

This form must be submitted to the Division and all parties by the requesting party within 30 days from the date of agreement or disagreement of the selection of an IME physician.

If the requester wishes to cancel the IME process, notify the IME Section of the Division in writing.

Back to Instructions

IME INFORMATION

1. Check the box for the party requesting the IME ☐ Claimant ☐ Carrier

2. WC# _____ Carrier Claim # _____ Social Security # _____

   Claimant Name _____ Date of Injury _____ Phone Number ( ) _____

3. *Claimant's Attorney _____ Phone Number ( ) _____

4. Carrier Name _____

5. Adjuster Name _____ Phone Number ( ) _____

6. *Carrier's Attorney _____ Phone Number ( ) _____

7. If Agreed Upon IME Physician

   Physician _____ Phone Number ( ) _____

   Address _____

   IME Appointment Date _____ Appointment Time _____

8. If Unable to Agree Upon IME Physician

   Preferred Location 1st Choice _____ 2nd Choice _____

9. List specific part(s) of the body and all conditions to be evaluated, including psychiatric where appropriate.

   _____

   _____

   _____

10. **The physician shall consider the following issues if relevant**: Maximum medical improvement, permanent impairment, and apportionment.

11. List any concerns to be addressed by the IME Physician (for example, further need for surgery).

    _____

    _____

    _____

*If the claimant and/or insurer is/are represented by an attorney, all Division correspondence will be mailed only to the attorney(s) listed.

12. MEDICAL PROVIDER HISTORY

Clear This Page

List name AND address of each physician who has evaluated or treated the claimant for this and/or any other relevant medical condition or injury. If a physician assigned an MMI date or an impairment rating, list the information. At least one MMI date must be listed for an IME to proceed. Attach additional pages, if needed. The Division and the IME physician use this information to assure there is no conflict of interest.

Physician Name	Physician Address (Street Address, City, State and Zip Code)	MMI Date	% Rating (WP or Extremity)

13. CERTIFICATE OF PAYMENT FOR IME

I hereby certify that I will be responsible for payment of the Division of Workers' Compensation Independent Medical Exam. I understand that this payment MUST be made to the selected physician's office at least ten (10) calendar days before the scheduled exam. ****Check Here____ if the claimant is the requester and has received a determination of indigence by order of an administrative law judge, or if an indigence proceeding is pending. If there has been an order granting indigence the insurance carrier or employer must advance the funds to pay for this IME, regardless of whether the claimant signs below**. It is requested that a copy of the judge's order be attached to this application.

By: _____

Requester's Signature

_____ _____

Requester's Name Requester's Address

14. CERTIFICATE OF MAILING: Copies of this document were placed in the U.S. mail or delivered to the following parties this _____ day of _____ , _____

List the names and address of all persons copied: Name Address

Claimant:
Claimant's Attorney:
Carrier:
Carrier's Attorney:
Division of Workers' Compensation, 633 17th Street, Suite 400, Denver, CO 80202-3626
(Send original document to the Division.)

By: _____

Signature

If you have any questions about the IME process, contact the Division of Workers' Compensation IME Unit.

Division of Workers' Compensation
IME Unit
633 17th Street, Suite 400
Denver, CO 80202-3626
303.318.8655
Toll Free: 888.390.7936