

Instructions for Completing the Notice and Proposal to Select an Independent Medical Examiner

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 “WC#” box (field), complete the information, and use the tab key to navigate to the next field. 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 #. Do not use dashes or parentheses; when you tab out of the field, it will fill in automatically. To fill in a **check box**, click inside the box with your mouse. 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 change the information in one field, use the backspace or delete key.

Adobe Acrobat - [Pages from WC4Final Admission.pdf]

File Edit Document Tools Plug-Ins View Window Help

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
NOTICE AND PROPOSAL TO SELECT AN INDEPENDENT MEDICAL EXAMINER

Clear Entire Form

Complete Sections I and II. Please read the information at the bottom of this form

SECTION I Notice and Proposal of Independent Medical Examiner

WC # _____ Carrier Claim # _____ Social Security # _____
Claimant Name _____ Date of Injury _____
I, the (check one) claimant respondent, disagree with the determination by Dr. _____, dated _____, and I request a Division IME. I understand that the Division IME will consider the issues of MMI, permanent impairment and apportionment, if relevant.

I propose any one of the following physicians to conduct the IME
physicians, as well as other information and forms, is available on
listed below.

"Check Box"
Click in Box

I understand that I _____; request. Once the negotiation process is completed, I must submit the Application for IME form to the Division and all parties.

Signature of Requester _____ Phone # _____

***Check here if you claim to be unable to pay [indigent] the cost of the IME. See Instruction No. 7, below.**

SECTION II Certificate of Mailing

Copies of this document were placed in the U.S. mail or delivered to the following parties this _____ day of _____, _____, _____ Address _____

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4:51 PM Tuesday 8/5/2003

*Check here if you claim to be unable to pay [indigent] the cost of the IME. See Instruction No. 7, below.

SECTION II 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:	<input type="text"/>	<input type="text"/>
Claimant's Attorney:	<input type="text"/>	<input type="text"/>
Carrier:	<input type="text"/>	<input type="text"/>
Carrier's Attorney:	<input type="text"/>	<input type="text"/>

Division of Workers' Compensation, 1515 Arapahoe Street, Tower 2, Suite 640, Denver, CO 80202-2117

By: _____
Signature

INFORMATIONAL SUMMARY

- The following is a brief summary of the circumstances and is not intended to be a complete statement of the facts. This information may not include all information listed below.
1. The party requesting this Notice must send this Notice to the other party. If you are the claimant, the other party is the insurance carrier. If you are the Insurance Carrier, the other party is the claimant or claimant's representative, if applicable.
 2. The parties have 30 calendar days to negotiate the selection of the Independent Medical Examiner (physician who will conduct the IME). The requester needs to obtain an Application for Independent Medical Examination (IME), Form WC77, during this time.
 3. If the parties agree on the Independent Medical Examiner, the requester must schedule the examination promptly with the physician. The requester must also complete the Application for IME form and submit this to the Division of Workers' Compensation, the physician, and the other party.
 4. If the parties do not agree on the Independent Medical Examiner, or there is no response to the Notice and Proposal, the insurance carrier must complete the Notice of Failed IME Negotiation, Form WC165. A copy must be sent to the Division and the claimant. The party requesting the IME shall have 30 days from the date of the failure to agree or respond to submit Application for Independent Medical Examination (IME) Form

“Gray Border”
Enter Information and tab to next field



COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
NOTICE AND PROPOSAL TO SELECT AN INDEPENDENT MEDICAL EXAMINER

Complete Sections I and II. Please read the information at the bottom of this form

SECTION I Notice and Proposal of Independent Medical Examiner

WC # _____ Carrier Claim # _____ Social Security # _____
Claimant Name _____ Date of Injury _____

I, the (check one) claimant respondent, disagree with the determination by Dr. _____, dated _____, and I request a Division IME. I understand that the Division IME will consider the issues of MMI, permanent impairment and apportionment, if relevant.

I propose any one of the following physicians to conduct the IME: **(The physician must be Level II accredited.)** A list of accredited physicians, as well as other information and forms, is available on the Division's web site. You may also call the Customer Service Unit listed below.

I understand that I need to talk to the other party to discuss this request. Once the negotiation process is completed, I must submit the Application for IME form to the Division and all parties.

Signature of Requester _____ Phone # _____

***Check here if you claim to be unable to pay [indigent] the cost of the IME. See Instruction No. 7, below.**

SECTION II 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 St., Suite 400, Denver, CO 80202-3626

By: _____
Signature

INFORMATIONAL SUMMARY

The following is a brief outline of the Division Independent Medical Examination (IME) process. This general information may not include all circumstances and is not meant as legal advice. Also refer to Rule 11. If you have any questions, contact the Customer Service Unit listed below.

1. The party requesting the IME (requester) must complete the Notice and Proposal for Independent Medical Examiner form. The requester must send this Notice to the other party. If you are the claimant, the other party is the insurance carrier. If you are the Insurance Carrier, the other party is the claimant or claimant's representative, if applicable.
2. The parties have 30 calendar days to negotiate the selection of the Independent Medical Examiner (physician who will conduct the IME). The requester needs to obtain an Application for Independent Medical Examination (IME), Form WC77, during this time.
3. If the parties agree on the Independent Medical Examiner, the requester must schedule the examination promptly with the physician. The requester must also complete the Application for IME form and submit this to the Division of Workers' Compensation, the physician, and the other party.
4. If the parties do not agree on the Independent Medical Examiner, or there is no response to the Notice and Proposal, the insurance carrier must complete the Notice of Failed IME Negotiation, Form WC165. A copy must be sent to the Division and the claimant.
 - a. The party requesting the IME shall have 30 days from the date of the failure to agree or respond to submit an Application for Independent Medical Examination (IME), Form WC77. Within 10 calendar days of receiving the Application, the Division will designate a panel of three qualified physicians from which the parties must select one physician pursuant to procedures stated in Rule 11-3. The parties will be notified in writing of the three-physician panel.
 - b. The form which provides the three-physician panel will contain additional instructions on how and when to strike a doctor from the list, and other options such as requesting from the physicians information regarding their business and financial interests. This may assist the parties in deciding which physician to strike from the list.
 - c. If the parties do not complete this process in 15 business days, the Division will select one name and notify the parties. Within 5 business days of the physician selection, the requesting party must telephone the physician and schedule the examination.
5. The carrier must submit medical records to the physician and other party at least 14 calendar days before the examination.
6. The claimant must notify the carrier if a language interpreter is needed at least 14 calendar days before the examination. The requester is responsible for paying the interpreter.
7. The requester must make the payment to the IME physician at least 10 calendar days before the examination. If you wish to assert that you are unable to pay for the IME, you must obtain and file an "Application for Indigent Determination (IME)", Form WC35 IME, within 20 days of the filing of this Notice and Proposal. Contact the Division Customer Service Unit or IME Unit to obtain the form or for further information.
8. The physician is required to mail the IME report to the parties and the Division within 20 calendar days of the examination.
9. If the requester wishes to cancel the IME process, contact the IME Section of the Division immediately.

If you have any questions, or need an Application for Independent Medical Examination (IME), Form WC77, or any other forms, contact the Division of Workers' Compensation Customer Service Unit at 303.318.8700 or toll free at 888.390.7936

(The top portion may be used for mailing purpose. This side of the form is optional.)

**NOTICE AND PROPOSAL TO SELECT AN INDEPENDENT MEDICAL EXAMINER
Form WC146**