

# Instructions for Completing the Notice of Failed IME Negotiation

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, “WC# box (field) 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. 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 - [Final Notice of Failed IME Negotiation.pdf]

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COLORADO DEPARTMENT OF LABOR & EMPLOYMENT  
DIVISION OF WORKERS' COMPENSATION

**NOTICE OF FAILED IME NEGOTIATION**

**Clear Entire Form**

The insurance carrier must submit this form to the Division as notification that the parties have failed in their attempt to negotiate the selection of an IME physician.

WC # \_\_\_\_\_ Carrier Claim # \_\_\_\_\_ Social Security # \_\_\_\_\_

Claimant Name \_\_\_\_\_

I hereby notify the Division that on this \_\_\_\_\_ day, \_\_\_\_\_, \_\_\_\_\_  
the parties were unable to agree upon a physician.

\_\_\_\_\_  
Signature Date

Name of Signer \_\_\_\_\_ Carrier Name \_\_\_\_\_

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

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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: \_\_\_\_\_

Employer: \_\_\_\_\_

Carrier's Attorney: \_\_\_\_\_

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

By: \_\_\_\_\_

Adjustor's Signature

**NOTICES**

NOTICE TO CARRIER: The carrier shall submit this notice within 30 days from the date of disagreement of the parties.

NOTICE TO REQUESTING PARTY: This notice is to advise you that you must submit an Application for a Division Independent Medical Examination (IME) form. Submit the application to the Division and to all parties within 30 days from the date of disagreement.

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

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10:37 AM Thursday 5/29/2003

COLORADO DEPARTMENT OF LABOR & EMPLOYMENT  
DIVISION OF WORKERS' COMPENSATION

**NOTICE OF FAILED IME NEGOTIATION**

**The insurance carrier must submit this form to the Division as notification that the parties have failed in their attempt to negotiate the selection of an IME physician.**

WC # \_\_\_\_\_ Carrier Claim # \_\_\_\_\_ Social Security # \_\_\_\_\_

Claimant Name \_\_\_\_\_ Date of Injury \_\_\_\_\_

I hereby notify the Division that on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
the parties were unable to agree upon a physician.

\_\_\_\_\_  
Signature Date

Name of Signer \_\_\_\_\_ Carrier Name \_\_\_\_\_

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:

Employer:

Carrier's Attorney:

Division of Workers' Compensation, 633 17th Street, Suite 400, Denver, CO 80202-3660

By: \_\_\_\_\_  
Adjustor's Signature

**NOTICES**

**NOTICE TO CARRIER:** The carrier shall submit this notice within 30 days from the date of disagreement of the parties.

**NOTICE TO REQUESTING PARTY:** This notice does not eliminate the requirement that the requesting party submit an Application for a Division Independent Medical Examination (IME) form. Submit the Application to the Division and to all parties within 30 days from the date of disagreement.

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 80202-3660  
303.318.8655  
Toll Free: 888.390.7936