IME PC

SERVICE ORDER FORM

Please Submit Completed Form
Email: info@imei.com
Fax: 231-929-4356

COMPANY INFORMATION

COMPANY		TELEPHONE #	
CONTACT NAME		FAX #	
EMAIL ADDRESS		TYPE OF CLAIM	
ADDRESS		PREFERRED METHOD OF COMMUNICATION	O TELEPHONE O OTHER O EMAIL O FAX
Additional Information:		SERVICE TYPE	O IME O LIABILITY O WORKERS COMP O DISABILITY O CHART REVIEW O AUTO

CLAIMANT INFORMATION

NAME		DATE OF BIRTH	
TELEPHONE #		DATE OF INJURY	
CLAIM #		CLAIM #	
ADDRESS:		SOCIAL SECURITY #	XXX-XX-
COMPLAINT / INJURY		Additional Information	

ADDITIONAL INFORMATION

SPECIALTY TYPE		TIMEFRAME (DEADLINE)	
AMA GUIDELINES	O YES O NO _____ EDITION	PROVIDER NAME	(IF YOU HAVE CHOSEN A SPECIFIC PROVIDER)
AMOUNT OF MEDICAL RECORDS		TRAVEL CONSTRAINTS	

PLEASE NOTE: ADDITIONAL INFORMATION MAY BE REQUIRED TO PROCESS YOUR REQUEST. IME, PC WILL BE IN CONTACT AFTER REVIEW