Independent Medical Review (IMR) Request Form

Date Submitted: _____ (MM/DD/YYYY) Date of Birth _____ (MM/DD/YYYY)

Date Received by the Department
(For Department use only)

Claimant Name: _____

Claim Administrator Claim No.: _____ Date of Injury: _____ (MM/DD/YYYY) Date of MMI if rendered: _____ (MM/DD/YYYY)

Parts of Body Injured: _____

Petitioner Name: _____

Address/City/State/Zip: _____

Phone: _____ Relationship to Claimant: _____

Insurer Name: _____
(if not the person submitting the request)

Address/City/State/Zip: _____

Phone: _____

Treating Physician Name: _____
(if not the person submitting the request)

Address/City/State/Zip: _____

Phone: _____ Contact Person: _____

Request being submitted by: ☐ Treating Physician ☐ Referred Physician

Preliminary diagnosis: _____

Subsequent diagnosis: _____

What is the nature of your dispute?

_____

What procedure or treatment are you requesting the Medical Director to review?

_____

Was your request for prior authorization of this procedure denied by the insurer? _____

What attempt have you made to resolve your dispute?

_____

What documentation have you submitted in support of your request?
(Please list and provide a copy of medical records to support your Medical Review request.)