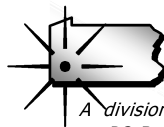

West Penn
Evaluation & Review
A division of West Penn I. M. E., Inc.
PO Box 210 • N. Versailles, PA 15137

Tel: (412) 829-7290
Toll Free: (800) 321-6853
Fax: (412) 829-7320
westpennime@comcast.net

Request for IME

Physical examination of patient including review of records, radiographs, and other pertinent materials

Insurance Information

	Adjuster or Primary Contact Name		
	Address (if different from left)		
	City	State	Zip
Email Address (optional)	Phone	Fax	

Legal Counsel for Insurer

Firm Name	
Attorney Name	City

This section is optional.
If you complete this section we will provide a copy of all correspondence to the law firm or attorney identified above. It is not necessary to provide an address, because we have addresses and phone numbers on file. We do ask that you indicate a city, because many firms have multiple offices.

Claim Information

Claimant Name			Coverage Type	Date of Birth	Social Security No.
Claimant's Address			Date of Injury	Insured	
City	State	Zip	Claim No.	Phone (only if not represented)	

Legal Counsel for Claimant

☐ None

Attorney Name (Requred Unless None)		
Firm Name		
Address		
City	State	Zip
Phone		

Requested Physician

First Choice	Spec (West Penn Use Only)
Second Choice	Appt (West Penn Use Only)

Mail all correspondence to: **West Penn Evaluation and Review**
PO Box 210
North Versailles, PA 15137-0210

Objectives/Other

- ☐ Diagnosis
- ☐ Objective findings/Subjective complaints
- ☐ Appropriateness and necessity of treatment
- ☐ Appropriateness and necessity of medications
- ☐ Appropriateness and necessity of referrals
- ☐ Disability from employment
- ☐ Disability from daily activities
- ☐ Disability from recreational activities
- ☐ Surgical recommendation
- ☐ Additional testing
- ☐ Maximum medical improvement
- ☐ Radiograph interpretation
- ☐ Estimate physical abilities (form provided by West Penn)
- ☐ Job description (please attach)
- ☐ Treatment recommendations
- ☐ Full recovery
- ☐ Causal relationship of complaints
- ☐ Causal relationship of treatment
- ☐ Causal relationship of disability
- ☐ Mechanism of injury
- ☐ Prognosis

☐ **Arrange transportation for claimant**

Other Comments

This section is optional.
You may instead provide a cover letter to the examiner. You should address your cover letter to the examiner c/o West Penn Evaluation and Review at the address above. If it is unclear what issues are germane to this case, someone will contact you. Thank you for choosing West Penn Evaluation and Review.

X

Signature of Person Completing Form | Date | Phone (if not provided above)