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.)