MEDICAL SYSTEMS, INC.
independent medical evaluation services

2022 IME Network Application Form

Please return this form with copies of your Fee Schedule, CV, Sample Report, license(s) & certificate of insurance by e-mail to Carolyn@MedicalSystemsUSA.com or fax to 414-235-3361
PLEASE CALL US AT 1-800-261-3278, IF YOU HAVE ANY QUESTIONS!

Doctor's Name:	
Specialty Area(s): *Please note if there are any types of injuries/body parts you specialize in or if there are any you do NOT address*	
Practice Name (if applicable):	
Mailing Address (include city, state and ZIP code): Please state if this is NOT an exam location and see question #2 below.	
Telephone Number (include area code):	
Doctor's Cell Phone (if applicable - include area code):	
Pager Number (if applicable – include area code):	
Fax Number (include area code):	
Doctor's Email Address: (if applicable)	
Tax ID Number (please note if separate tax IDs are used for different services):	
Medical License(s) -include State(s) and numbers:	

1. Who should we contact to schedule Independent Medical Evaluations (IMEs) and Records Reviews (ROR)?

_____ _____
Name Phone/Extension/E-mail

Do you prefer that we e-mail or fax our written confirmation of an IME appointment once it is scheduled with you?

☐ E-mail _____ ☐ Fax _____

2. If you perform IMEs at locations other than the mailing address above, please list the full addresses here (including location name & phone number claimant can call for directions), or send us a list of your other IME locations. Please indicate if you need us to set up exam room rental for you at these locations or not.
(Our scheduling database searches for available specialists based on proximity of your exam locations to the examinee.)

☐ I do not have other set IME locations but will travel if needed. (Please note the cities or regions to which you travel for IMEs.) _____
_____

If you have set IME dates or travel dates that you would like to fill, be sure to let our scheduling staff know.

3. What types of cases would you like us to contact you for? *(Check all that apply)*

☐ Worker's Compensation
☐ Disability/Fitness for Duty

Please check all that apply:

☐ Personal Injury* (Civil)..... ☐ Deposition ☐ Testimony in court
☐ Medical Malpractice* ..... ☐ Deposition ☐ Testimony in court

***Must be willing to provide expert witness services for Personal Injury & Malpractice cases**

If you have any other preferences regarding the types of cases you will or will not accept, please let us know.
_____
_____

4. What types of evaluation services do you provide? *(Check all that apply)*

☐ Independent Medical Evaluations
☐ Record Reviews (no exam performed)
☐ Impairment Ratings ☐ AMA Guidelines ____ Edition
☐ Wisconsin Work Comp PPD Ratings
☐ Other _____
☐ Other Services (please specify, e.g., Medical Bill Review, FCEs, etc):
_____

5. RECORD SORTING & SENDING PREFERENCES

How you would like records organized?

☐ Chronological Order *(Oldest to newest)*
☐ Reverse Chronological Order *(Newest to oldest)*
☐ Do NOT sort records

NOTE: We combine all providers in chronological order unless otherwise instructed. Please specify if you want records separated by provider or have other instructions. (If you have your own record sorting instructions, please send them.)

How you would like records sent to you?

☐ Paper records
☐ Scanned (PDF format) records
☐ Sent via email or DropBox to email address(es): _____
☐ Mailed on disk or USB data stick

How far in advance of the IME do you need to receive records? _____

If records should be sent somewhere other than your mailing address listed on page 1, please let us know.

6. We offer use of our free 24-hour dictation service. Please let us know if you need a dictation ID number.

☐ I will use my own dictation service.
☐ I will use your dictation service and will need a dictation ID.
☐ I dictate into my own device but will need the sound files transcribed by your dictation service.

If using our dictation and/or transcription service:

How would you prefer we send your transcribed reports for you to sign off on?

☐ Email:_____ ☐ Fax:_____

Please sign inside the box to create your electronic signature if you are using our dictation:

7. What is your usual report turnaround time for IMEs and Record Reviews?

_____

8. What is your current practice status?

(Check all that apply. We request this information because some of our clients specify that they need to use a doctor who is in active practice or spends at least X% of time treating patients.)

☐ Active Clinical Practice ☐ Teaching ☐ Semi-Retired ☐ Retired

Can you give an approximate estimate of what percentage of your time is spent treating patients?
If you are retired from active practice, please let us know when you retired.

_____

9. Please note any health systems, doctors or practices, with which you have a conflict of interest for doing IMEs or Record Reviews on their patients:

_____
_____

10. May we include your name in our listings of doctors available to do IMEs and Record Reviews that we periodically send out to our clients?

☐ Yes ☐ No

If you have set IME dates or travel dates that you would like us to include on the calendar of upcoming IME dates that we send to clients, you can e-mail our scheduling department at Schedule@MedicalSystemsUSA.com.

11. Are you interested in providing 45 minute to 1 hour presentations at insurance companies and/or law firms? *(This is a <u>great</u> way to develop relationships with those scheduling IMEs!)*

☐ Yes ☐ No

If yes, what topics would you be interested in presenting on?

_____
_____

"All the information provided in this form and accompanying documentation is true and correct to the best of my knowledge. If any of the information shall change, I will do my best to notify Medical Systems and provide updated documentation."

Doctor's Signature: _____ Date: _____

Please let us know if you have any questions! Thank you for your time, and we look forward to working with you!

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