

Instructions for Completing the Notice and Proposal to Select an Independent Medical Examiner

Please read all pages

This form is “**fillable**.” That means you can type the information onto the form from your computer and print the form. You will not be able to save the form onto your computer’s hard drive.

When you open the form, click in the “WC#” box (field), complete the information, and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you cannot continue to type information into a field if it doesn’t fit into the space provided.

Use numbers only to fill in the fields for Social Security #. Do not use dashes or parentheses; when you tab out of the field, it will fill in automatically. To fill in a **check box**, click inside the box with your mouse. The “Certificate of Mailing” fields are surrounded by a **gray border**. Type the information in the first field and tab to the next to enter more information.

To clear or delete all the information you have typed onto the form, click on the red “**Clear Entire Form**” button. To change the information in one field, use the backspace or delete key.

Adobe Acrobat - [Pages from WC4Final Admission.pdf]

File Edit Document Tools Plug-Ins View Window Help

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
NOTICE AND PROPOSAL TO SELECT AN INDEPENDENT MEDICAL EXAMINER

Clear Entire Form

Complete Sections I and II. Please read the information at the bottom of this form

SECTION I Notice and Proposal of Independent Medical Examiner

WC # _____ Carrier Claim # _____ Social Security # _____
Claimant Name _____ Date of Injury _____
I, the (check one) claimant respondent, disagree with the determination by Dr. _____, dated _____, and I request a Division IME. I understand that the Division IME will consider the issues of MMI, permanent impairment and apportionment, if relevant.

I propose any one of the following physicians to conduct the IME
physicians, as well as other information and forms, is available on
listed below.

"Check Box" Click in Box

I understand that I _____; request. Once the negotiation process is completed, I must submit the Application for IME form to the Division and all parties.

Signature of Requester _____ Phone # _____

*Check here if you claim to be unable to pay [indigent] the cost of the IME. See Instruction No. 7, below.

"Clear Entire Form" button Clears all information at once

SECTION II Certificate of Mailing

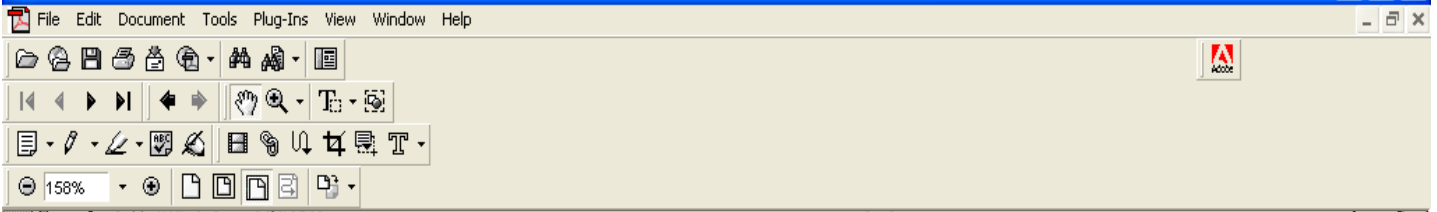
Copies of this document were placed in the U.S. mail or delivered to the following parties this _____ day of _____, _____.

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4:51 PM Tuesday 8/5/2003



*Check here if you claim to be unable to pay [indigent] the cost of the IME. See Instruction No. 7, below.

SECTION II Certificate of Mailing

Copies of this document were placed in the U.S. mail or delivered to the following parties this _____ day of _____,

List the names and address of all persons copied:	
Name	Address
Claimant: _____	_____
Claimant's Attorney: _____	_____
Carrier: _____	_____
Carrier's Attorney: _____	Claimant's Attorney Address

Division of Workers' Compensation, 1515 Arapahoe Street, Tower 2, Suite 640, Denver, CO 80202-2117

By: _____
Signature

INFORMATIONAL SUMMARY

The following is a brief summary of the circumstances and is not intended to be a complete summary of the information. Information may not include all information listed below.

“Gray Border”
Enter Information and tab to next field

1. The party requesting this Notice must send this Notice to the other party. If you are the claimant, the other party is the insurance carrier. If you are the Insurance Carrier, the other party is the claimant or claimant's representative, if applicable.
2. The parties have 30 calendar days to negotiate the selection of the Independent Medical Examiner (physician who will conduct the IME). The requester needs to obtain an Application for Independent Medical Examination (IME), Form WC77, during this time.
3. If the parties agree on the Independent Medical Examiner, the requester must schedule the examination promptly with the physician. The requester must also complete the Application for IME form and submit this to the Division of Workers' Compensation, the physician, and the other party.
4. If the parties do not agree on the Independent Medical Examiner, or there is no response to the Notice and Proposal, the insurance carrier must complete the Notice of Failed IME Negotiation, Form WC165. A copy must be sent to the Division and the claimant. The party requesting the IME shall have 30 days from the date of the failure to agree or respond to submit Application for Independent Medical Examination (IME) Form

(The top portion may be used for mailing purpose. This side of the form is optional.)

**NOTICE AND PROPOSAL TO SELECT AN INDEPENDENT MEDICAL EXAMINER
Form WC146**