MEDICAL EQUATION™

Pick Up Date: _____ **Due Date:** _____

Carrier: _____ **Adjuster:** _____

Phone: _____ **Fax:** _____

Address: _____

Email Address: _____

Requested Service

Review

- ☐ Peer Review
- ☐ EMG/NCV Review
- ☐ Medication Utilization Assessment (MUA)
- ☐ Addendum
- ☐ IR/DD Review
- ☐ Early Compensability Assessment (ECA)

Exam

- ☐ Post-DD-RME
- ☐ Required Medical Exam
- ☐ Independent Medical Exam

Reason for Exam:

- ☐ Extent of Injury
- ☐ Impairment Rating
- ☐ Maximum Medical Improvement
- ☐ Return to Work
- ☐ Return to Work for Sibs
- ☐ Disability – Direct Result
- ☐ Treatment
- ☐ Other: _____

Administrative

- ☐ Bill Review
- ☐ Claims File Analysis
- ☐ DWC Letter of Clarification (LOC) Requests
- ☐ 22 processing
- ☐ 32 processing
- ☐ Nurse Case Management

Designated Doctor: _____ **Date Of Exam:** _____

Claim #: _____ **Date of Injury:** _____

Claimant: _____ **Phone:** _____

Address: _____

Employer: _____

Attorney: _____

Are Benefits Provided Through a: ☐ [Political Subdivision] ☐ [Health Care Network] ☐ [N/A]

Network Name: _____

Compensable Injuries: _____

Disputed Injuries: _____