NOTICE OF CLAIM STATUS
INDEPENDENT MEDICAL EVALUATION

Injured Worker:		Social Security Number:
Worker's Address:	City, State:	ZIP:
Date of Injury:		
Employer:		
Insurance Company:		Adjuster:

This is to notify you that an Independent Medical Evaluation has been scheduled for you on ___/___/____at__:____with_____. The exam location is _____.

This evaluation is requested under Idaho Code §72-433, which grants us the right, on behalf of your employer, to seek an independent medical evaluation of your medical status by a duly qualified physician at a reasonable time and place.

If attendance requires you to travel, you may be entitled to reimbursement for necessary expenses to include an allowance for mileage reimbursement[1], meals, and lodging. You are encouraged to track your mileage and retain receipts for submission of your reimbursement request. I can help you with travel arrangements if you are not able to drive your personal vehicle to the exam. If you miss work because of the exam, or because of travel necessary to attend the exam, you are entitled to reimbursement of such time lost from work at your current rate of pay; if you are not currently working, you will be entitled to payment for travel time and exam time at the applicable rate for total temporary disability (TTD).

Both you and the examining physician have the right to make an audio recording of the examination, but video recording requires consent of the examining physician. At your expense, you also have the right to bring a physician of your choosing with you to the exam, so long as he or she does not interfere with the exam.

Please notify me immediately if you are unable to attend this evaluation at the scheduled time and place. If you miss this appointment, you may suffer certain penalties prescribed by statute: your workers' compensation benefits may be stopped, and you may be denied the right to prosecute your workers' compensation claim. If you unreasonably fail to attend the scheduled exam, or otherwise obstruct it, we will seek the Industrial Commission's approval to impose these penalties.

Please advise within ten (10) days of receipt of this notice if you are unable to attend this scheduled appointment. You will be expected to provide reasonable alternative dates.

_____ _____
Signature of Insurance Company Adjuster Examiner Phone

1 A mileage reimbursement form is available online at https://iic.idaho.gov/find-a-form/