CHI Health
Company Care

CONSULT FORM

CONSULT INFORMATION

☐ Independent Medical Evaluation ☐ Medical File Review ☐ Second Opinion ☐ Other (disability, etc.)_____

Prior to scheduling an appointment, medical records will need to be reviewed. Once these records have been reviewed, Company Care will call to schedule an appointment.

EXAMINEE INFORMATION

Name: _____ Soc. Sec. #:_____

Address: _____ Date of Birth: _____

City: _____State:_____Zip:_____ Phone: _____

Job Title: _____

Date of Injury: _____ Type of Injury: _____

Employer at Time of Injury: _____ Attending Physician: _____

Employer Address _____ Referring Physician:_____

Employer City _____ State _____ Zip _____

CASE MANAGER/ATTORNEY INFORMATION

Name: _____

Company: _____

Address: _____

City: _____State:_____Zip:_____

Phone: _____Fax:_____

Claim #: _____

BILLING INFORMATION

If billing directly to Insurance Company please verify their IME Billing Process as it may not always be the same as work comp.

☐ Same as Case Manager/Attorney

Name:

FAX OR MAIL THIS COMPLETED FORM, ALONG WITH MEDICAL RECORDS TO COMPANY CARE FAX #: 402.742.8419. (Form must be completed prior to scheduling.)

If a patient has previously been seen/treated for this injury, medical record review will need to occur prior to scheduling an appointment for treatment.

- The fee is $350 per hour. This will include the visit time, records review time and report preparation after the visit.
- Cancellations made within 24 hours of the appointment time will be assessed a $200 cancellation fee plus $350 per hour for the time already spent on the medical review.
- Cancellations made with more than 24 hours' notice will have no cancellation fee but will be assessed the fee of $350 per hour for time already spent on review.
- No Shows will be assessed a $200 no show fee plus $350 per hour for the time already spent on the medical review.

Mailed_____Emailed_____Fax_____ Initials_____