[Sender Name]
[Sender Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Doctor Name]
[Clinic/Facility Name]
[Address]
[City, State, Zip Code]

RE: Independent Medical Examination

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Claim Number: [Claim Number]
Date of Injury: [Date]

Dear Dr. [Doctor Last Name],

This letter serves to formally request an Independent Medical Examination (IME) for the individual named above. The purpose of this examination is to obtain an objective medical opinion regarding the patient's current physical condition and its relationship to the reported injury.

Please evaluate the patient and provide a detailed written report addressing the following points:

- Confirmation of the diagnosis and its causality to the incident.
- Current clinical findings and objective evidence of impairment.
- Appropriateness of the current treatment plan.
- The patient's current work capacity and any specific physical restrictions.
- Whether the patient has reached Maximum Medical Improvement (MMI).
- Prognosis for future recovery or permanent disability rating, if applicable.

Enclosed are the relevant medical records and diagnostic imaging reports for your review prior to the appointment. The examination has been scheduled for:

Date: [Appointment Date]
Time: [Appointment Time]
Location: [Office Location]

Please send the completed report and your invoice for services to my attention at the address listed above. If you have any questions, please contact me directly.

Sincerely,

[Signature]
[Typed Name]
[Title/Company Name]