[Your Name/Company Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Vendor/Medical Group Name]
[Scheduling Department]
[Address]
[City, State, Zip Code]

RE: Letter of Instruction for Independent Medical Examination (IME)

Claimant Name: [Claimant Name]
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]
Case Type: [e.g., Workers' Compensation / Personal Injury]

To Whom It May Concern,

Please schedule an Independent Medical Examination for the above-referenced claimant with a physician specializing in [Specify Specialty, e.g., Orthopedic Surgery].

Examination Requirements:

- **Preferred Location:** [Specify Geographic Area or City]
- **Timeframe:** Examination to be completed by [Date]
- **Medical Records:** Enclosed are the relevant medical records for the physician's review.

Specific Questions for the Physician:

1. What is the formal diagnosis related to the incident of [Date]?
2. Is the current condition causally related to the reported injury?
3. Has the claimant reached Maximum Medical Improvement (MMI)?
4. Are the current treatment recommendations necessary and appropriate?
5. What are the claimant's specific physical restrictions or work capabilities?

Please confirm the appointment date, time, and location once scheduled. Forward the final narrative report and any billing statements to [Your Name/Email Address].

Thank you for your assistance in this matter.

Sincerely,

[Your Signature]

[Your Printed Name]
[Your Title]