UOA
University Orthopaedic Associates

2 Worlds Fair Dr.
Somerset, NJ 08873
732-537-0909

4810 Belmar Blvd.
Wall, NJ 07753
732-938-6090

211 North Harrison St.
Princeton, NJ 08540
609-683-7800

www.UOANJ.com

Worker's Comp: Rose Rosenman, ext: 2207
Fax 732-564-9032

☐ **Evaluation & Treatment** ☐ **IME/NFT 99456 ($1,500)** ☐ **NFT by treating MD 99455 ($1,000)**
☐ **Second Opinion surgical 99244 ($850.00)**

Our office follows strict procedures in our IME protocol. All medical records and pre-payment must be sent to our Somerset office prior to any appointment scheduling. If you do not indicate a specific physician we will appoint one based on the physician's sub-specialty. Our fee for an IME is $1,500.00 for the examination, report and 1 hour of record review. If our physician needs to take x-rays to complete his examination, there will be an additional charge and payable within 30 days of the date of examination. A fee of $750.00 will be charged to you if your client does not show or you or your client cancels the IME appointment with less than 24 hours notice and $350 for second opinion. If you agree with our protocol, please complete and sign this form. . *Medical records should be sorted by the following categories: Hospital records; previous IME's; office notes (grouped by physician in reverse chronological order); physical therapy (grouped by facility in reverse chronological order); radiology reports (in reverse chronological order); legal documents; miscellaneous.* A separate page with anything you want to be address specifically in the report. Forward a copy of this form with the medical records. We will contact you to schedule the appointment.

✦ ✦

Injured Name:_____ **Date of Birth**_____ **Date of Injury**_____

Address: _____ **City, State, Zip:** _____

Phone #:_____ **Last 6 digits Social Security #**_____**Body part injured** _____

Insurance Carrier:_____ **Contact:**_____

Carrier Address:_____

Claim Number_____ **Phone#**_____ **Fax #:**_____

Employer's Name:_____

Hand and Upper Extremity
Timothy P Leddy, MD
Christopher Doumas, MD
James T Monica, MD

Sports Medicine
Jeffrey R Bechler, MD
Charles J Gatt, Jr., MD
Kenneth G Swan, Jr., MD
Patrick S Buckley, MD

Traumatology
Mark S Butler, MD
Carlos A Sagebien, MD
David A Polonet, MD
Sergei A Pushilin, MD

Spine Surgery
Gino Chiappetta, MD
Matthew McDonnell, MD

Reconstructive Rearfoot/Ankle
Justin J Fleming, DPM

Adult Reconstruction
David A Harwood, MD
Stephen A Kayiaros, MD
William A Baione, MD

Appointment requested with _____ **M.D. in your** _____ **office.**
(Our physician's name) (Princeton/Somerset/Wall)

By signing this form I agree to accept University Orthopaedic Associates, LLC protocol for IME examinations. I also agree that by completing this form that I have authorized any x-rays needed to complete the examination and understand that payment for these x-rays must be made within 30 days of the examination.

_____ _____
Print your name **Title** **Date**

Additional Comments:

jwa