**REQUEST FOR INDEPENDENT MEDICAL EVALUATION**

FOR SCHEDULING REQUESTS:

**EVALONEPRO, LLC**

**2470 EAST FLAMINGO RD, SUITE C**

**LAS VEGAS, NV 89121**

E-fax this form to (626) 228-2980 or

email your request to m.white@evalonepro.com

**APPOINTMENT INFORMATION**

Appointment needed by:

Specialty:

Location:

How soon is this report needed:

Please mail, fax, or e-fax the medical records and cover letter to EVALONEPRO corporate office LV

**ADDITIONAL COMMENTS**

**SPECIFIC ISSUES TO BE ADDRESSED**

**MEDICAL RECORDS**

Will medical records be sent? [ ] Yes [ ] No

If Yes, how many inches?

**CLIENT INFORMATION**

Analyst:

Agency:

Address:

City /State/Zip:

Phone:

Fax:

**PRE-AUTHORIZE**

Reschedule of Appointment? [ ] Yes [ ] No

Reschedule of No-Show? [ ] Yes [ ] No

Diagnostic Studies? [ ] Yes [ ] No

**CASE INFORMATION**

Claim #

Date of Disability:

Diagnosis or Nature of Complaints:

Type of Claim

[ ] Long Term Disability [ ] Temp. Disability

[ ] Short Term Disability

[ ] Other

**PATIENT INFORMATION**

Last Name:

First Name:

Address:

City/State/Zip:

Phone:

DOB:

Employer:

Occupation:

If you need us to arrange for an interpreter, please specify

 language needed: