encova INSURANCE

REQUEST FOR INDEPENDENT MEDICAL EXAMINATION

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

1. Claimant name
2. Claim number
3. Social Security number
4. Date of injury
5. Body part(s) to be examined

I, (write your name) _____ request to be sent out for an independent medical examination for an evaluation and determination regarding permanent partial impairment.

Mailing address
Phone number (include area code)

Claimant signature	Date