COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Follow-Up DIME

Instructions: This form must be submitted by the carrier when a claimant previously had a DIME and was determined to be 'not at MMI' and is now requesting a follow-up DIME. Per Rule 11, a follow-up DIME examination shall be scheduled with the same DIME Physician, unless he or she is unavailable or declines to perform the examination. If the previous DIME Physician is unable to perform the follow-up examination please notify the DIME Unit using this form. In the instance where the parties agree upon a new DIME Physician, the parties shall indicate the name of the new DIME Physician **and** the agreed upon fee. Agreed upon follow-up DIMEs must use this form and the agreement shall be signed by the new DIME Physician and all parties to the claim. If the parties have agreed upon the previous DIME Physician under 11-4(A)(2)(a)(i) but now wish to proceed under section 11-4(A)(5), the parties shall request a prehearing conference before an ALJ. Absent an agreement of the parties and the DIME Physician, or an order from an ALJ, the carrier shall pay any additional examination fees.

****Do not submit this form if the follow-up is for repeat range of motion. Notify the DIME Unit in writing of the date and time of the appointment.****

WC #:____________________________ Claimant Name: ____

Check the box that is applicable:

1. Previous DIME Physician will perform the follow-up examination.

Previous DIME Physician: ____

2. Previous DIME physician unavailable or declined. A revised DIME Physician Panel is requested pursuant to 11-7(B)(2)(a)

3. Physician unavailable or declined. Parties have agreed to a new DIME Physician pursuant to 11-7(B)(1)

Agreed upon DIME Physician: ____

Agreed upon DIME fee: ____

By signing below all parties agree to the DIME fee stated above:

Claimant/Attorney: ____

Carrier/Attorney: ____

DIME Physician: ____

4. Follow-up Appointment Date (if known): ____

CERTIFICATE OF MAILING: Copies of this document were sent to the Division and the following parties this _______ day of ________________, ________.

List names and addresses of all persons copied:

Division of Workers' Compensation, DIME Unit
633 17th St., Suite 400, Denver, CO 80202-3626
DIME Unit Email: imeunit@state.co.us | DIME Unit Fax: 303-318-8659

Claimant: ____

Claimant's Attorney: ____

Carrier: ____

Carrier's Attorney: ____

DIME Physician: ____