

CASE INFORMATION MEDICARE SET-ASIDE REFERRAL FORM

| | | | |
|---|-------|-----------------|------------------------|
| Claimant Name (First, Middle Initial, Last) | | | Date of Birth |
| Address | | | Social Security Number |
| City | State | ZIP Code | Date of Injury |
| Employer | | WC Jurisdiction | Claim Number |

MSA SERVICE SELECTION (Select One Service Only - Call if Uncertain)

| | | |
|--|---|---|
| <input type="checkbox"/> MSA Allocation – LIMITED | <input type="checkbox"/> MSA Allocation – STANDARD | <input type="checkbox"/> MSA Allocation - COMPLEX |
| Examples: fracture clavicle healed; back strain (no surgery) pain resolved and not currently treating; extremity fractures without complications | Examples: herniated disc injury; multiple trauma with healed fractures; chronic pain (no DCS or Morphine Pumps); stabilized knee injuries; carpal tunnel syndrome | Examples: traumatic brain injuries; paraplegia; quadriplegia; amputees; toxic exposure cases; complex RSD requiring DCS/Morphine pumps; major depression with psychiatric hospitalization |

KEY CONTACT & BILLING INFORMATION

| | | | | |
|---|-----------------|-------------------------------------|---|----------------|
| <input type="checkbox"/> | Referring Party | Adjuster Name | Tel. Number | E-mail Address |
| | | Insurance Carrier/TPA/Service Agent | Address | |
| <input type="checkbox"/> | Referring Party | Defense Attorney Name | Tel. Number | E-mail Address |
| | | Defense Firm Name | Address | |
| <input type="checkbox"/> | Referring Party | Plaintiff Attorney Name | Tel. Number | E-mail Address |
| | | Plaintiff Firm Name | Address | |
| <input type="checkbox"/> | Referring Party | Structured Settlement Broker | Tel. Number | E-mail Address |
| Please provide copies of the allocation report to: | | | | |
| <input type="checkbox"/> Carrier/TPA/Service Agent <input type="checkbox"/> Defense Attorney <input type="checkbox"/> Plaintiff Attorney <input type="checkbox"/> Structure Broker <input type="checkbox"/> Other _____ | | | | |
| Party Responsible for Bill | | | Billing Address & Tel. Number (if different from above) | |
| <input type="checkbox"/> Insurance Carrier/TPA/Service Agent <input type="checkbox"/> Referring Party | | | | |

FILE INFORMATION

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|--|---|
| 1. Has the claimant applied, denied and/or appealing; or receiving Social Security Disability payments? (If yes, please provide supporting documentation.) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known |
| 2. Is the claimant currently a Medicare Beneficiary? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known |
| 3. Have the releases been sent to plaintiff counsel/claimant? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known |
| 4. Are there any controverted issues? If so, please note in box below. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known |
| 5. Has this claim been settled? | <input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No |
| 6. Has a rated age been obtained? If yes, please broker above. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known |
| 7. Who will be handling your CMS submission? | <input type="checkbox"/> Gould & Lamb <input type="checkbox"/> Other _____ |

NOTES/SPECIAL HANDLING

(controverted issues, deadlines, mediation/court date, etc.)