Medicare Set-Aside Allocation Intake Form

MSAIntake@allsupinc.com | fax: (618) 236-8599

Referrals can be placed online using full or abbreviated forms avaliable at http://www.allsupinc.com/workers-compensation.aspx

☐ Workers' Comp Claim ☐ Liability Claim

REFERRING COMPANY

Referring Company (Insurance carrier, TPA, Self Insured Employer)	Telephone Number	Fax Number

Contact Name	Email Address

Address

ALLSUP SERVICES REQUESTED

☐ **Medicare Verification ONLY** *(Determines SS and Medicare entitlement dates)*
Release forms: ☐ In file ☐ Already sent to Claimant ☐ Allsup to send forms to Claimant/Attorney

☐ **MSA Allocation with Medicare Verification** *(Proceed with writing the MSA allocation regardless)*
Due dates: Trial Date _____ Hearing Date _____ Need Date _____
☐ Include Submission of MSA to CMS *(WC claim only)*
☐ Include Medicare Lien Verification

☐ **Medicare Lien Verification ONLY** *(Contact Medicare to determine if there are any conditional payments. Additional claimant releases are required by CMS/MSPRC.)*

☐ **Medicare Lien Resolution** *(Assist in resolving Medicare Lien/Conditional Payment notice. Additional claimant releases are required by CMS/MSPRC.)*

CLAIMANT INFORMATION

Please attach the following information on each claimant.

Claimant Name (Last, First, Middle Initial)	Claim Number

Claimant Street Address	Date of Birth	Male/Female

City, State, Zip Code	Social Security Number	HICN Number

Employer Name or Defendant Name	Date of Injury/Date of Loss

Employer Address or Defendant Address	State Jurisdiction

Allsup
Life Reclaimed

DEFENSE ATTORNEY **If applicable.**

Defense Attorney Name	Phone Number	Fax Number

Address

CLAIMANT ATTORNEY **If applicable.**

Claimant's Attorney Name	Phone Number	Fax Number

Address

CLAIM INFORMATION

Is the claimant currently receiving Medicare benefits? ☐ Yes ☐ No ☐ Unknown

Have you received any notices regarding Medicare conditional payments related to this claim? ☐ Yes ☐ No

If YES, please provide a copy of any Medicare correspondence you have received regarding conditional payments.

Is the claimant currently receiving any Social Security benefits? ☐ Yes ☐ No ☐ Unknown

Has the claimant applied for or intend to apply for Social Security disability benefits in the near future? ☐ Yes ☐ No ☐ Unknown

Is the claimant competent? ☐ Yes ☐ No

If not, who is the legal guardian?

Can the legal guardian sign contracts, authorizations and/or other documents on behalf of the claimant? ☐ Yes ☐ No

What type of claim is this? (i.e. auto, general, etc.) *(Liability claim only)*

How many Plaintiffs are involved? *(Liability claim only)*

If more than one Plaintiff, please provide complete information on each Plaintiff

Does this referral encompass more than 1 injury? ☐ Yes ☐ No

Please list

Please note **accepted** claim(s) and Body Parts:

Please note **denied** claim(s) and Body Parts:

Has there been a settlement, judgment, or award? ☐ Yes ☐ No

Has the settlement been approved by the court? *(WC claim only)* ☐ Yes ☐ No

If Yes, what was the settlement amount paid out: *(WC claim only)* $ _____

If No, is there a proposed settlement? *(WC claim only)* ☐ Yes ☐ No

If Yes, what is the proposed settlement? *(WC claim only)* $ _____

Indemnity portion $ _____ Future medical portion $ _____

Can any amount be defined as a compromise settlement? *(WC claim only)*	☐ Yes	☐ No
Is there a life care plan prepared on this case?	☐ Yes	☐ No
Is there a rated age on the claimant?	☐ Yes	☐ No
Is the claimant at MMI?	☐ Yes	☐ No
Is there a physician report regarding future medical or lack of future medical?	☐ Yes	☐ No
Is the claimant taking prescriptions? If so, what are the current prescriptions?	☐ Yes	☐ No
(*Please list name and dosage of current prescriptions)*		

Referring person's signature _____

DOCUMENTATION NEEDED FROM YOUR FILE:

- First Report of Injury *(WC Claim only)*
- Medical reports that outline initial treatment and all subsequent treatment. *(if available for Liability claim.)*
- Medical reports that indicate current condition/status, Permanent & Stationary or MMI. Medical reports should be from the most recent two years of treatment, at least. *(if available for Liability claim.)*
- Prescription drug pay history. Prescription pay history should be from the last two years, at least. Please include report indicating specific prescription drugs and dosage the claimant is currently taking related to the claim(s).
- Physician's report regarding future medical treatment, if any.
- Any Medicare conditional payment correspondences you have received related to this claim.
- Life Care Plan—if applicable.
- Proposed settlement information.
- Payout pattern (loss run) for both indemnity and medical. If no indemnity or medical has ever been paid, please provide a statement on your letterhead indicating, "No medical and indemnity payments have ever been made on this claim." *(WC claim only)*
- If any part of the alleged injury is denied, please explain and include any medical documentation that supports the denial.
- Any payments made to date regarding medical treatment or prescription drugs related to this claim. If no payments have been made, please indicate this on your letterhead. *(Liability claim only)*
- Any other reports you feel would explain the injury, the reason for compromise or whether or not future medical treatment is needed (i.e. latest legal status letter from defense, depositions.)

PLEASE SEND COMPLETED FORM & DOCUMENTATION TO:

ALLSUP INC.
MSA Department
300 Allsup Place, Belleville, IL 62223-8626
Voice: (866) 477-7005 Fax: (618) 236-8599
email: MSAIntake@allsupinc.com

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