

Medicare Set-Aside Allocation Intake Form

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

Referrals can be placed online using full or abbreviated forms available 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

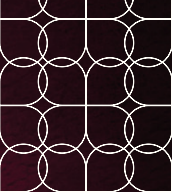
HICN Number

Employer Name or Defendant Name

Date of Injury/Date of Loss

Employer Address or Defendant Address

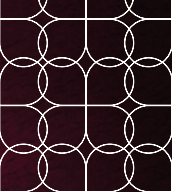
State Jurisdiction



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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
Have you received any notices regarding Medicare conditional payments related to this claim? <i>If YES, please provide a copy of any Medicare correspondence you have received regarding conditional payments.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the claimant currently receiving any Social Security benefits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
Has the claimant applied for or intend to apply for Social Security disability benefits in the near future?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
Is the claimant competent? <i>If not, who is the legal guardian?</i> <i>Can the legal guardian sign contracts, authorizations and/or other documents on behalf of the claimant?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What type of claim is this? (i.e. auto, general, etc.) (<i>Liability claim only</i>)		
How many Plaintiffs are involved? (<i>Liability claim only</i>) <i>If more than one Plaintiff, please provide complete information on each Plaintiff</i>		
Does this referral encompass more than 1 injury? <i>Please list</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please note accepted claim(s) and Body Parts:		
Please note denied claim(s) and Body Parts:		
Has there been a settlement, judgment, or award?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the settlement been approved by the court? (<i>WC claim only</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, what was the settlement amount paid out: (<i>WC claim only</i>)	\$ _____	
If No, is there a proposed settlement? (<i>WC claim only</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, what is the proposed settlement? (<i>WC claim only</i>)	\$ _____	
Indemnity portion \$ _____ Future medical portion \$ _____		



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

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

