



MEDICARE SET-ASIDE
REFERRAL FORM

Send completed form via fax or email to:
FAX: 209-491-5199 or
Email: MSAreferal@ADMgmt.com

CASE INFORMATION

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

MSA SERVICE SELECTION (Select One Service Only - Call if Uncertain. *The Prescription Drug Review (PDR) may be selected with a MSA Allocation.)

<input type="checkbox"/> MSA Allocation: Limited	<input type="checkbox"/> MSA Allocation: Standard	<input type="checkbox"/> MSA Allocation: Complex
Example: extremity fractures without complications, pain resolved (not currently treating), non-surgical back strains.	Example: herniated disc injury, multiple trauma with healed fractures, chronic pain (no DCS or Morphine Pumps); stabilized knee injuries, carpal tunnel syndrome.	Example: traumatic brain injuries, paraplegia; quadriplegia; amputees; toxic exposure cases; complex RSD requiring DCS/Morphine pumps; major depression with psychiatric hospitalization

ADDITIONAL SERVICES

<input type="checkbox"/> Lien Research	<input type="checkbox"/> Lien Negotiation	<input type="checkbox"/> Prescription Drug Review (PDR)*	<input type="checkbox"/> Medicare/Social Security Verification
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KEY CONTACT & BILLING INFORMATION

<input type="checkbox"/> Referring Party	Adjuster Name (or Other Referring Contact)	Telephone Number	Fax Number	Email Address
	Insurance Carrier/TPA/Self-Insured/Other	Address		City, State, Zip
Note: TPAs/Insurers servicing another company's claims, please list company here:				
<input type="checkbox"/> Referring Party	Defense Attorney Name	Telephone Number	Fax Number	Email Address
	Defense Firm Name	Address		City, State, Zip
<input type="checkbox"/> Referring Party	Plaintiff Attorney Name	Telephone Number	Fax Number	Email Address
	Plaintiff Firm Name	Address		City, State, Zip
<input type="checkbox"/> Referring Party	Structured Settlement Broker	Telephone Number	Fax Number	Email Address
	Structured Settlement Brokerage Firm	Address		City, State, Zip
Party Responsible for Bill: <input type="checkbox"/> Insurance Carrier/TPA <input type="checkbox"/> Referring Party			Billing Address & Telephone Number (if different from above)	

FILE INFORMATION

1. Has the claimant applied, denied and/or appealing; or receiving Social Security Disability Payments?	<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 yes, please indicate issue in Notes section 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 <input type="checkbox"/> Not Known
6. Has a rated age been obtained? Please note preferred 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"/> ADM <input type="checkbox"/> Specialized Legal Counsel <input type="checkbox"/> Other

NOTES/SPECIAL HANDLING

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

Incomplete records or delayed receipt of the required documents may delay the processing of your file and may not serve your needs in a timely manner. We will notify you of any missing documentation upon receipt of the file. ADM reserves the right to change service selection based on injury type and volume of records upon review and notification to referring party.