

**New File Referral Form**

**CLAIMANT INFORMATION:**

Claimant name: \_\_\_\_\_

Street address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

Medicare No.: \_\_\_\_\_

Medicare Entitlement Date (shown on Medicare card): \_\_\_\_\_

**CLAIMANT ATTORNEY:**

Name: \_\_\_\_\_

Street address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**INJURY INFORMATION:**

Date of Injury: \_\_\_\_\_

Description of Injury: \_\_\_\_\_

\_\_\_\_\_

**DEFENSE ATTORNEY:**

Name: \_\_\_\_\_

Firm: \_\_\_\_\_

Phone: \_\_\_\_\_

**CLAIM INFORMATION:**

Name of defendant: \_\_\_\_\_

Insurer for defendant: \_\_\_\_\_

Type of claim (WC/Liab/No fault): \_\_\_\_\_

Name of adjuster: \_\_\_\_\_

Address of adjuster: \_\_\_\_\_

\_\_\_\_\_

**SETTLEMENT:**

Actual or estimated settlement date: \_\_\_\_\_

Actual or estimated settlement amount: \_\_\_\_\_

Actual or estimated attorney fee: \_\_\_\_\_

Actual or estimated costs: \_\_\_\_\_

**Our Medicare conditional payment and lien resolutions services (flat prepaid fee of \$500):**

- We report the claim to Medicare as required by federal regulations.
- We obtain a letter from Medicare showing any conditional payments made.
- We audit conditional payment claim for accuracy and challenge any payments for treatment unrelated to claim settlement.
- We negotiate a lien compromise when requested and when appropriate.
- We provide settlement information and procurement costs to Medicare for appropriate reductions in the lien amount.
- We obtain a final payment demand from Medicare and guide client on closing case with Medicare.