

PROSPECTIVE NEW CLIENT GUIDE - MEDICARE SET-ASIDE

Thank you for your interest in our services. To help us assist you please note the following.

- 1. New File Referral form:** Before we can begin work on your matter we need the enclosed New File Referral Form completed and returned to us.
- 2. CMS Authorization Form:** Before we can communicate with the Centers for Medicare and Medicaid Services (CMS) we need to provide CMS with a signed CMS authorization form, a blank copy of which is attached. Please have the claimant sign the form and return to us at the address or fax or email address shown at the bottom of this page.
- 3. Our Medicare Set-Aside Services:**
 - We analyze the injury, claim and medical data and prepare a summary of the case and a projection of the future Medicare-covered lifetime medical treatment for the underlying injury or disease. Our report and recommendation is prepared by a team consisting of an attorney specializing in Medicare secondary payer law and a nurse case manager certified in both life care planning and Medicare set-aside preparation.
 - We submit the proposed Medicare set-aside and required support documentation to Medicare for approval.
- 4. Our fee:** We charge a flat fee of \$2,000 for our Medicare set-aside services. The fee is billed at the time we send our Medicare set-aside report and recommendation and before the proposed set-aside is submitted to CMS for approval.
- 4. What we need from you:**
 - A completed **New File Referral** form (see form attached).
 - A signed **CMS Authorization** form (see form attached).
 - A copy of all **medical records** related to the injury involved in the claim.
 - A printout of all **medical payments** (if any) paid by the insurer or self-insured claim respondent.

Medicare Set-Aside Intake 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 set-aside services include the following,
for which we charge a flat fee of \$ 2,000 billed after preparation of our report and recommendation and
prior to submission to Medicare for approval:**

- We analyze the injury, claim and medical data and prepare a summary of the case and a projection of the future Medicare-covered lifetime medical treatment for the underlying injury or disease. Our report and recommendation is prepared by a team consisting of an attorney specializing in Medicare secondary payer law and a nurse case manager certified in both life care planning and Medicare set-aside preparation.
- We submit the proposed Medicare set-aside and required support documentation to Medicare for approval.

CMS/Medicare Authorization for Release of Information

The Privacy Act of 1974 (Public Law 93-579) prohibits the government from revealing information from personal files without the express written permission of the person involved. Disclosure of personal records to an attorney or other representative who is acting on behalf of another person is prohibited, unless the individual to whom the record pertains has consented.

I, _____, hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to disclose, discuss, and/or release, orally or in writing, information related to my injury and/or settlement to the individual(s) and/or firm(s) listed below. This consent is for my current personal injury claim and is on an ongoing basis. An additional consent to release form will not be necessary unless or until I revoke this authorization (which must be in writing).

PLEASE CHECK:

- Claimant's attorney: _____
(Name and/or firm)
- Lien resolution attorney: **Gullen & Associates pllc**
(Name and/or firm)
- Insurer: _____
(Name and/or firm)
- Other: _____
(Name and/or firm)

Claimant's Signature

Date Signed

Date of Injury

Social Security Number

Medicare (HICN) Number

Medicare Entitlement Date (shown on Medicare card)

Return to: Gullen & Associates pllc
P.O. Box 80457
Rochester, MI 48308

Fax: 877.571.7871