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 ☐ 303.675.4406/866.677.6717
 Fax 303.297.0856

MEDICARE SET-ASIDE REFERRAL FORM

THE INFORMATION REQUESTED IN THE FOLLOWING FORM MAY ALSO BE PROVIDED BY LETTER OR EMAIL									
1. Claimant/Plaintiff Information:									
First Name		MI		Last Name					
Address									
City		State		Zip Code					
Phone				Birth Date					
SSA No.				HICN (Medicare) No.					
Is Claimant/Plaintiff a current Medicare beneficiary?				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
2. Employer Information:									
Name				Contact Person					
Address									
Phone					Email Address				
3. Insurance Carrier:									
Name				Adjuster					
Address									
Phone		Fax		Email Address					
4. Third Party Administrator:									
Name				Adjuster					
Address									
Phone		Fax		Email Address					
5. Claimant's Or Plaintiff's Counsel:									
Name									
Address									
Phone		Fax		Email Address					
6. Respondents' Or Defendants' Counsel:									
Name									
Address									
Phone		Fax		Email Address					
7. Counsel For Any Other Party:									
Name									
Address									
Phone		Fax		Email Address					
8. Please Advise As To Whether A Particular Structured Settlement Broker Must Be Used. If So, Please Provide:									
Name									

Address				
Phone		Fax		Email Address

9. Accident And Injury Information:

Date of Accident		Claim No.	
Brief Description of Accident			
Injuries Sustained in Accident:	a. Admitted Injuries, Medical Conditions and Diagnosis:		
Injuries Sustained in Accident:	b. Contested Injuries, Medical Conditions and Diagnosis:		

10. Procedural Status Of Case:

A. Set forth any issues currently set to be adjudicated:	
B. Set forth any issues which were set to be adjudicated, but have been withdrawn, due to settlement of the case:	
C. Status of Settlement Negotiations:	
D. Indicate any Orders or Stipulations which might affect liability for Past and/or Future medical treatment:	

11. Please Provide The Following Documentation:

A. Last 3 years of medical records. . (If injury is more than three years old, include first medical record reporting injury, surgery records, and last two years of medical records.)
B. Printout of medical payment history for the last 3 years.
C. Any orders or stipulations which might affect liability for past and/or future medical treatment.
D. Any IME's or depositions which might affect liability for future medical treatment?

12. Referring Party:

Name				
Address				
Phone		Fax		Email Address

13. Party Responsible For Payment:

Name				
Address				
Phone		Fax		Email Address