

Account Representative
Referral Date (mm/dd/yy)

### Case Information

Claimant/Applicant Full Name				
Claimant/Applicant Telephone Number	Gender (M/F)	Date of Birth (mm/dd/yy)	Social Security #	Jurisdiction State
Claimant/Applicant Address		City	State	Zip Code
<b>1</b>	Date Of Injury (mm/dd/yy)	Claim Number	<b>2</b>	Date Of Injury (mm/dd/yy) Claim Number

### Insurance Type (Select one only)

<input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> Longshore
<input type="checkbox"/> Liability
<input type="checkbox"/> Auto
<input type="checkbox"/> Other _____

### Requested Service (Select all that apply)

<input type="checkbox"/> Professional Administration
<input type="checkbox"/> MSA (Medicare Allowable portion)
<input type="checkbox"/> MCA (Non-Medicare Allowable portion)
<input type="checkbox"/> Self-Administration Kit

### Contact / Billing Information

Send Professional Administration Contract Copies to: <input type="checkbox"/> Adjuster <input type="checkbox"/> Defense Attorney <input type="checkbox"/> Plaintiff Attorney <input type="checkbox"/> Broker <input type="checkbox"/> Other: _____				
Party Responsible for Invoice: <input type="checkbox"/> Adjuster <input type="checkbox"/> Defense Attorney <input type="checkbox"/> Plaintiff Attorney <input type="checkbox"/> Broker <input type="checkbox"/> Other: _____				
Adjuster Name		Company		Referring Party <input type="checkbox"/>
Telephone Number	Fax Number	Email Address		
Address		City	State Zip Code	
Defense Attorney Name		Company		Referring Party <input type="checkbox"/>
Telephone Number	Fax Number	Email Address		
Address		City	State Zip Code	
Plaintiff Attorney Name		Company		Referring Party <input type="checkbox"/>
Telephone Number	Fax Number	Email Address		
Address		City	State Zip Code	
Structured Settlement Broker Name		Company		Referring Party <input type="checkbox"/>
Telephone Number	Fax Number	Email Address		
Address		City	State Zip Code	

## Funding Arrangements

How is the Medicare Set-Aside Account being funded?

Single lump sum deposit at time of settlement  
 Amount \$ \_\_\_\_\_

Structured settlement with periodic payments

OR

Life Company: \_\_\_\_\_

Initial Funding \$ \_\_\_\_\_

Annual Annuity Payment \$ \_\_\_\_\_

How is the Medical Custodial Account being funded?

Single lump sum deposit at time of settlement  
 Amount \$ \_\_\_\_\_

Structured settlement with periodic payments

OR

Life Company: \_\_\_\_\_

Initial Funding \$ \_\_\_\_\_

Annual Annuity Payment \$ \_\_\_\_\_

## Coverage, Restrictions & Exclusions

Indicate the specific future medical expenses covered under this agreement:

Indicate any restrictions OR exclusions to coverage:

## Account Duration/Term

State the duration/term of the agreement:

## Beneficiary Information

Upon the death of the Claimant/Applicant, who will receive any remaining account funds?

Beneficiary Name		Date of Birth (mm/dd/yy)	Social Security #	
Beneficiary Address	City	State	Zip Code	

## Account Reversion

If the account is reversionary to the Payor, please provide the following information:

% Reversionary to Payor: \_\_\_\_\_

Payor Tax ID: \_\_\_\_\_-\_\_\_\_\_