



MEDICARE SET - ASIDE SERVICE REQUEST

Send completed form & documents to:

P.O. Box 941870
 Maitland, FL 32794
 T: 407-599-9122
 TF: 866-599-9122
 F: 407-599-1994

www.gopromed.com/forms

WORKERS COMP **LONGSHORE** **LIABILITY** **FEDERAL**
 (Please choose appropriate service/s)

Complete MSA Allocation Report Only
 (Allocation report with Submission)
 Lien Research Reopen Update
 **Date of Last report: _____

CASE INFORMATION

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

KEY CONTACT & BILLING INFORMATION (please choose referring party option)

Referring Party <input type="radio"/>	Adjuster Name	Adjuster Location	Telephone Number	E-mail Address
	Carrier/TPA/Service Agent		Mailing Address :	
Referring Party <input type="radio"/>	Defense Attorney Name		Telephone Number	E-mail Address
	Defense Attorney Firm		Mailing Address :	
Referring Party <input type="radio"/>	Plaintiff Attorney Name		Telephone Number	E-mail Address
	Plaintiff Attorney Firm		Mailing Address :	

Please provide copies of the allocation report to
 Carrier/TPA/Service Agent Defense Attorney Plaintiff Attorney Other (Explain)

Party Responsible for Invoice
 Carrier/TPA/Service Agent Other; explain

FILE INFORMATION

1. Social Security Benefits Status	Claimant Applied <input type="checkbox"/>	Denied <input type="checkbox"/>	Appealing <input type="checkbox"/>	Receiving <input type="checkbox"/>
2. Is the claimant currently a Medicare Beneficiary?	YES <input type="checkbox"/>	NO <input type="checkbox"/>		UNKNOWN <input type="checkbox"/>
3. Have the releases been sent to plaintiff attorney/ claimant?	YES <input type="checkbox"/>	NO <input type="checkbox"/>		UNKNOWN <input type="checkbox"/>
4. Are there any controverted issues? If so, Please note in box below	YES <input type="checkbox"/>	NO <input type="checkbox"/>		UNKNOWN <input type="checkbox"/>
5. Has this file been settled? (if yes how much)	YES <input type="checkbox"/>	\$ _____		NO <input type="checkbox"/>
6. Has a rated age been obtained? If yes broker name below	YES <input type="checkbox"/>	NO <input type="checkbox"/>		UNKNOWN <input type="checkbox"/>
7. Who will be handling CMS submission?	PRO MED <input type="checkbox"/>			OTHER <input type="checkbox"/>

REPORT TIME FRAME

Routine Turnaround = 14 days Normal Status RUSH Status

If RUSH is requested, please provide dated report is needed: _____

Preferred Structure Company Contact Number

PLEASE PROVIDE ANY SPECIAL HANDLING INSTRUCTIONS BELOW:	Documents Needed:
	<p>PHASE I</p> <p>1. First Report of Injury</p> <p>2. 2 years of Medical records</p> <p>3. 2 year of RX</p> <p>4. 2 years of Medical bills</p> <p>5. 2 years of Payment History</p> <p>PHASE II</p> <p>6. Social Security document?</p> <p>7. Settlement Documents or signed agreement</p> <p>8. Signed releases</p> <p>9. Copy of Medicare Card</p>

(For Internal Use)

PRO MED file # : _____