



# MSA Services, LLC

## The Leader In MSP Compliance

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### REFERRAL FORM

#### CLAIMANT INFORMATION

Claimant's Name (First, Middle, Last)	Date of Birth
Claimant's Address	Claimant's Phone #
Claimant's Counsel Name, Address Phone #	Medicare # (or SS# if N/A)

#### RESPONDENT INFORMATION

Respondent-Employer	Respondent-Insurer	Name of Insurance Adjuster
Respondent-Employer Address	Respondent-Insurer Address	Adjuster's Phone #
Name of Respondent's Counsel	Insurance Claim #	Adjuster's e-mail address

#### CLAIM INFORMATION

List All DOI Included in Settlement	Has Claim Been Accepted	List All Accepted Injuries	List All Denied Aspects of Claim
List All Claim Numbers for All DOI	List Amount of Settlement (or last offer)	List All Rx Associated With Claim	Name of Treating Physician

#### MEDICARE STATUS

<input type="checkbox"/> On SSDI & Medicare	<input type="checkbox"/> On SSDI but not Medicare	<input type="checkbox"/> SSDI Application or Appeal Pending	<input type="checkbox"/> Age 63 or Older	<input type="checkbox"/> End Stage Renal Disease
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#### MSA SERVICE SELECTION

<input type="checkbox"/> MSA Allocation (No Submission to CMS) COST: \$1,250.00	<input type="checkbox"/> MSA Allocation w/Submission to CMS COST: \$1,750.00
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#### ADDITIONAL SERVICES

<input type="checkbox"/> Conditional Payments/Medicare Lien Search Cost: \$250.00	<input type="checkbox"/> Soc. Security Offset/MSA Trust Language for Settlement Docs Cost: \$500.00
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#### ADMINISTRATION OF MSA

Type of MSA Administration <input type="checkbox"/> Self-Administered <input type="checkbox"/> Professionally Administered	MSA Funding Method <input type="checkbox"/> Lump Sum <input type="checkbox"/> Structured
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**CASE REFERRAL INFORMATION**

Name of Referring Party  <input type="text"/>	Name of Firm or Company  <input type="text"/>	Phone #  <input type="text"/>
Fax #  <input type="text"/>	Address of Referring Party  <input type="text"/>	E-mail  <input type="text"/>

**In order for the analysis to be performed and submitted to CMS, you will need to provide us with a copy of the following documentation:**

1. **Proposed settlement agreement (If available).**
2. **Payment history from respondent insurer for last two years.**
3. **All medical records for at least the last two years of treatment (complete set of records preferred).**
4. All independent medical exam and commissioner's exam reports.
5. Printout from pharmacy of prescription drugs taken over last two years.
6. **Copy of Medicare card if applicable.**
7. Letter from workers' compensation insurer that no medical or indemnity payments have been paid on any denied body parts or conditions. (Necessary to keep any denied conditions out of MSA).

**IF THE CLAIMANT HAS BEEN ON MEDICARE AT ANY POINT DURING THE PENDANCY OF THE CLAIM, IT IS STRONGLY RECOMMENDED THAT A CONDITIONAL PAYMENTS LIEN SEARCH BE COMPLETED.**

**PLEASE USE THIS SPACE FOR ADDITIONAL INFORMATION AND/OR SPECIAL HANDLING INSTRUCTIONS.**

By signing this document, you hereby agree that this matter was referred to MSA Services, LLC for the sole purpose of completing the services requested above. You hereby acknowledge that MSA Services, LLC and Gregory F. Lisowski did not represent any of the parties in any legal capacity and that an attorney client relationship does not exist between MSA Services, LLC, Gregory F. Lisowski and any of the parties. By signing this agreement you are agreeing to pay for the services requested above, at the time of billing, whether or not the case settles or money is recovered.

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Signature of Party Financially Responsible for Fees (Print Name Below)