Referral Form

6600 Sugarloaf Parkway, Suite 400-108
Duluth, GA 30097
Office: (844) 415-4422
Fax: (832) 485-9302

Medicare Set-Aside Services

- ○ Workers' Compensation Medicare Set-Aside
- ○ Liability Medicare Set-Aside
- ○ Apportionment Medicare Set-Aside
- ○ Liability Medical Assessment
- ○ Medicare Cost Projection
- ○ CMS Submission

Claimant Information

Claimant Name: ____________ DOB: ____________
Gender: ○ Male ○ Female Phone: ____________
Address: ____________
City, St., Zip: ____________
SSN: ____________ Medicare HICN#: ____________
Claim #: ____________ Date of Injury: ____________

Conditional Payment Services

- ○ Medicare Conditional Payment (Dispute/Appeal/ Final Demand)
- ○ Medicaid Conditional Payment (Research/Negotiation)
- ○ Medicare Advantage Conditional Payment (Research/Negotiation)

Insurance Type (please choose one):
- ○ Workers' Compensation
- ○ Liability
- ○ Auto/No-Fault

Jurisdiction (please choose one):
- ○ State ________
- ○ Jones Act
- ○ USLH (Longshore)
- ○ DBA
- ○ FELA

Referring Party

○ Insurance Carrier ○ TPA ○ Self-Insured ○ Excess Carrier ○ Other: ____________
Referring Party Name: ____________
Contact: ____________
Phone: ____________ Fax: ____________ Email: ____________
Address: ____________ City, St., Zip: ____________
Responsible for the invoice? ○ Yes ○ No Is this the billing address? ○ Yes ○ No
Billing Address: ____________

Employer: ____________
Contact: ____________
Phone: ____________
Fax: ____________
Email: ____________
Address: ____________
City, St., Zip: ____________

Defense Attorney: ____________
Contact: ____________
Phone: ____________
Fax: ____________
Email: ____________
Address: ____________
City, St., Zip: ____________

Structured Settlement Broker: ____________
Contact: ____________
Phone: ____________
Fax: ____________
Email: ____________
Address: ____________
City, St., Zip: ____________

Plaintiff Attorney: ____________
Contact: ____________
Phone: ____________
Fax: ____________
Email: ____________
Address: ____________
City, St., Zip: ____________

Claim Information

Description of Claimed Injury or Condition ***(please identify conditions or care being denied / disputed / controverted)***

ICD 9/10 codes: ____________ Injury: ____________
Proposed Settlement Amount: $ ____________

Special Handling / Additional Information

Please send referrals to: **referrals@mesgroup.com**