ExamWorks ECS Compliance Solutions

Referral Form

1424 North Brown Road, Suite 100
Lawrenceville, GA 30043
Office: 866.270.2516
Fax: 770.407.8277

Account Executive Name:	**Person Entering Referral:**	**Date:**

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

Jurisdiction *(please choose one)*: ☐ State_____ ☐ USLH (Longshore) ☐ DBA ☐ FELA ☐ Jones Act

Claimant Name:	DOB:	Date of Injury 1	Claim 1 #
Address:	Gender (M/F):	Date of Injury 2	Claim 2 #
City, St., Zip:	Phone:	Date of Injury 3	Claim 3 #
Email:	SSN:	Medicare ID #	

Description of Alleged Injury or Illness or Harm

Describe Alleged Injury:	List Accepted body part(s):

Has the entire claim been disputed? ☐ Yes ☐ No (please explain specific condition or care that is being denied / disputed / controverted) Include all legal and medical reasons as well as supporting documents / records to support basis for denial of liability.

List Denied body part(s):

ICD:

Services

MSP Compliance Services Suite	**Medicare Status / Conditional Payment Services**	**Rx Program**
Medicare Set-Aside ☐ Worker's Comp (WCMSA) ☐ Liability (LMSA) ☐ with RxD ☐ with CMS Submission ☐ with iMSA Quote ☐ with Post-Settlement Administration (PSA) ☐ EBMSA ☐ Legal Nurse Review (LNR) ☐ with Medical Bill Review ☐ with Medical Bill Analysis ☐ Claim Settlement Allocation (CSA) ☐ Pre-MSA ☐ Life Care Plan (LCP) ☐ Medical Cost Projection (MCP) ☐ Resolution Service	☐ Medicare Eligibility Inquiry (MEI) ☐ Medicare/Social Security Verification ☐ Medicare Conditional Payment ☐ Research ☐ Dispute ☐ Final Demand ☐ Medicaid Conditional Payment ☐ Research ☐ Negotiation ☐ Medicare Advantage Conditional Payment ☐ Research ☐ Negotiation	☐ RxAnalysis ☐ RxAnalysis With Provider Outreach ☐ RxD Program

MSA Information

Proposed Settlement Amount: $_____

Administration of the MSA*: ☐ Self** ☐ Professional

Do you intend to submit this MSA to CMS? ☐ Yes ☐ No

Funding of the MSA*: ☐ Annuity** ☐ Lump Sum

Involved Parties *(please select one as the Referring Party)*

☐ **Insurance Carrier** ☐ **TPA** ☐ **Self-Insured** ☐ **Excess Carrier** ☐ **Other:**_____

Party Responsible for Invoice: ☐ Insurance Carrier/TPA ☐ Referring Party	Billing Address (Mailing Address):

Referring Adjuster:	**Insurer/Carrier:**	**Structured Settlement Broker:**
Contact:	**Contact:**	**Contact:**
Phone/Fax:	**Phone/Fax:**	**Phone/Fax:**
Email:	Email:	Email:
Address:	Address:	Address:
City, St., Zip:	City, St., Zip:	City, St., Zip:
Receive Copy of Reports ☐	Receive Copy of Reports ☐	Receive Copy of Reports ☐
Plaintiff Attorney:	**Employer:**	**Defense Attorney:**
Contact:	**Contact:**	**Contact:**
Phone/Fax:	**Phone/Fax:**	**Phone/Fax:**
Email:	Email:	Email:
Address:	Address:	Address:
City, St., Zip:	City, St., Zip:	City, St., Zip:
Receive Copy of Reports ☐	Receive Copy of Reports ☐	Receive Copy of Reports ☐

General File Information

1. Is the claimant a Medicare Beneficiary? (If yes, please provide supporting documentation.) Yes ☐ No ☐ Not Known ☐
2. Has the claimant applied for Social Security Disability benefits? Yes ☐ No ☐ Not Known ☐
3. For Liability MSA (LMSA), is there an associated Workers' Compensation claim involved? Yes ☐ No ☐ Not Known ☐

Notes / Special Handling *(Controverted Issues, Mediation / Court Dates, Etc.):*

Required Information **Default - will use this option unless instructed otherwise. Electronically submit records to referrals@ExamWorksCompliance.com.