Online Referral Form

# Please email completed form to MSAreferral@bswllp.com.

# Rush Service

[ ]  3 BUSINESS DAYS OR LESS

[ ]  1 BUSINESS DAYS OR LESS

# Case Classification

[ ]  Workers' Compensation

[ ]  Liability

[ ]  No-Fault

[ ]  Longshore

[ ]  Jones Act

[ ]  Other Click here to enter text.

# \*Service Options

Please select the service(s) you are requesting:

[ ]  MSA allocation report with Medicare covered items/services only

[ ]  MSA allocation report with Medicare covered and NON-Medicare items/services

[ ]  MSA RUSH within 2 business days

[ ]  MSA RUSH within 5 business days

[ ]  Subsequent MSA revisions after 6 months of original MSA prepared by BSW MSA Solutions

[ ]  MSA revisions on reports written by other parties

[ ]  MSA Submissions to CMS

[ ]  Quality review of MSA written by other allocators

[ ]  Extended medical/research review

[ ]  Drug utilization review (DUR)

[ ]  Entitlement search

[ ]  Lien verification

[ ]  Lien negotiation with CMS

[ ]  Medical Cost Projection

[ ]  Social Security Verification

[ ]  Life Care Plan

[ ]  Other (Please specify in the 'Special Instructions' section at the bottom of this form)

# \*Who are you

To help facilitate the referral process, please specify your contact information for this referral:

|  |  |
| --- | --- |
| I am the: Choose an item.Please select your relationship to this referral. | Contact Name:Click here to enter text. |
| Email Address:Click here to enter text. | Phone Number: Click here to enter text. |

# Claimant Information

|  |  |  |
| --- | --- | --- |
| \*Claimant First NameClick here to enter text. | \*Claimant Middle InitialClick here to enter text. | \*Claimant Last NameClick here to enter text. |
| \*Claimant AddressClick here to enter text. | \*Claimant Address Line 2Click here to enter text. |  |
| \*CityClick here to enter text. | \*State/Providence/RegionClick here to enter text. | \*Postal / Zip CodeClick here to enter text. |
| \*Claimant Date of BirthClick here to enter text. | \*Claimant Social Security NumberClick here to enter text. |  |
| \*Date of InjuryClick here to enter text. | \*Claim NumberClick here to enter text. |  |

# Employer Information

|  |  |
| --- | --- |
| Employer Name: Click here to enter text. | Mailing Address: Click here to enter text. |
| Contact Name: Click here to enter text. | City: Click here to enter text. |
| Contact Email: Click here to enter text. | State: Click here to enter text. |
| Phone Number: Click here to enter text. | Zip Code: Click here to enter text. |
| Fax Number: Click here to enter text. |  |

# Defense Attorney Information

|  |  |
| --- | --- |
| Defense Attorney: Click here to enter text. | Mailing Address: Click here to enter text. |
| Email Address: Click here to enter text. | City: Click here to enter text. |
| Phone Number: Click here to enter text. | State: Click here to enter text. |
| Fax Number: Click here to enter text. | Zip Code: Click here to enter text. |

# Insurance Carrier and Claim Information

|  |  |
| --- | --- |
| Insurance Carrier Information: Click here to enter text. | Claim Information: Choose an item. |
| Insurance Carrier: Click here to enter text. | Claim Type: Click here to enter text. |
| Contact Name: Click here to enter text. | Stae of Jurisdiction: Click here to enter text. |
| Contact Email: Click here to enter text. |  |
| Mailing Address: Click here to enter text. |  |
| City: Click here to enter text. |  |
| State: Click here to enter text. |  |
| Zip Code: Click here to enter text. |  |
| Phone Number: Click here to enter text. |  |
| Fax Number: Click here to enter text. |  |

# Plaintiff Attorney Information

|  |  |
| --- | --- |
| Claimant Attorney: Click here to enter text. | Mailing Address: Click here to enter text. |
| Email Address: Click here to enter text. | City: Click here to enter text. |
| Phone Number: Click here to enter text. | State: Click here to enter text. |
| Fax Number: Click here to enter text. | Zip Code: Click here to enter text. |

# Adjuster Information

|  |  |  |
| --- | --- | --- |
| \*Referring Party NameClick here to enter text. | \*Referring CompanyClick here to enter text. |  |
| \*Referring Party AddressClick here to enter text. | Referring Party Address Line 2Click here to enter text. |  |
| \*CityClick here to enter text. | \*State / Province / RegionClick here to enter text. | \*Postal / Zip CodeClick here to enter text. |
| CountryClick here to enter text. | \*Referring Party PhoneClick here to enter text. | \*Referring Party EmailClick here to enter text. |
| \*Excess Carrier NameClick here to enter text. |  | Excess CarrierClick here to enter text. |

# Broker Information

|  |  |
| --- | --- |
| Annuity Company: Click here to enter text. | Method of Funding: Choose an item. |
| Broker Name: Click here to enter text. | Mailing Address: Click here to enter text. |
| Broker Email: Click here to enter text. | City: Click here to enter text. |
| Phone Number: Click here to enter text. | State: Click here to enter text. |
| Fax Number: Click here to enter text. | Zip Code: Click here to enter text. |

# Claimant Case Information

Claim Number:

Click here to enter text.

How did injury occur?

Click here to enter text.

Please give title and brief description of the Claimant’s job at the time of injury.

Click here to enter text.

Is Claimant currently receiving Social Security Disability benefits?

[ ]  Yes

[ ]  No

Is Claimant currently eligible to receive Medicare benefits?

[ ]  Yes

[ ]  No

If not, are any of the following true:

[ ]  The claimant has applied for social security disability benefits.

[ ]  The claimant is in the process of appealing and/or refiling for social security disability benefits.

[ ]  The claimant has end-stage renal disease but does not yet qualify for Medicare based upon end-stage renal disease.

What is the total amount of indemnity benefits paid to date?

Click here to enter text.

Wat is the total amount of medical benefits paid to date?

Click here to enter text.

Has a settlement been reached?

[ ]  Yes

[ ]  No

Please provide the estimated settlement amount or range.

Click here to enter text.

Please provide date of settlement:

Click here to enter a date.

How is set aside to be paid?

[ ]  Lump sum

[ ]  Structured

# Additional Information

Is liability in this case disputed

[ ]  yes

[ ]  no

Please list all accepted injuries/body parts:

Click here to enter text.

Please list all disputed/denied injuries/body parts:

Click here to enter text.

# Finalized Settlement Agreement

Has a settlement agreement been finalized?

[ ]  yes

[ ]  no

If yes, indicate finalized settlement amount

Click here to enter text.

# Pending Dates

Please list pending dates:

|  |  |
| --- | --- |
| Mediation | Click here to enter a date. |
| Trial | Click here to enter a date. |
| Other: | Click here to enter a date. |
| Click here to enter text. | Click here to enter a date. |
| Click here to enter text. | Click here to enter a date. |
| Click here to enter text. | Click here to enter a date. |

# Special Instructions

Please list any special instructions for this referral:

Click here to enter text.

# Documentation

Please provide the following documentation (not necessary for claim/lien research or SSD/Medicare verification only):

[ ]  Medical and prescription records from the most recent two years of treatment (if not available, note please why)

[ ]  Current claims payment history, including medications

[ ]  Draft or final settlement documents/Release, if available

[ ]  First Report of Injury for workers' compensation cases

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