Medicare Set-Aside Referral Form

**[ ]  CARRIER [ ]  THIRD PARTY ADMINISTRATOR [ ]  SELF-INSURED EMPLOYER**

**Client Name:**

**Claims Adjuster:**

**Phone:**

**Email:**

**Address:**

**Employer:**

**Phone:**

**Email:**

**Address:**

**Injured Worker:**

**Phone:**

**DOB:**

**SSN:**

**Medicare Number:**

**Address:**

**Claim(s) #:**

**State of Jurisdiction:**

**WCAB Board and #:**

**DOI:**

**ACCEPTED BODY PART(S) / CONDITION(S):**

**DENIED BODY PART(S) / CONDITION(S):**

**ATTORNEYS:**

**Applicant Attorney:**

**Company Name:**

**Phone:**

**Email:**

**Fax:**

**Address:**      **Defense Attorney:**

**Company Name:**

**Phone:**

**Email:**

**Fax:**

**Address:**

**SERVICES:**

**[ ]  Medicare Set-Aside (MSA) [ ]  Non-Threshold MSA Allocation (NT-MSA)**

**[ ]  Future Medical Allocation (FMA) [ ]  Social Security/Medicare Eligibility Verification**

**[ ]  Future Medical Projection [ ]  Submission of MSA to CMS**

**[ ]  Physician Medical Review** *(Complex cases)* **[ ]  Expedited Referral** *(completed within 5 business days)*

**[ ]  Conditional Payment Investigation [ ]  Rated Age Quotation**

**[ ]  Other:**

***By typing my name below I am authorized to make this referral on behalf of the Carrier and agree to the pricing of the Billing Guidelines and the Referral Terms and Conditions as published on*** [***http://www.ekhealth.com/component/content/article/432***](http://www.ekhealth.com/component/content/article/432)

 **NAME:       DATE:**