GARRETSON
RESOLUTION GROUP
Phone 704.559.4300 www.garretsongroup.com

Case Intake Form

Date _____

Claimant Information

Party Representing Plaintiff

Your Case Number / Reference Code _____

Name _____ Gender Male

SSN _____ DOB _____

Address _____

City _____ State Zip _____

Phone _____

Has claimant lived in another state since date of injury? ◯ Yes* ◯ No

*If yes, what state?

Email (optional) _____

Injury Information

DOI* _____ DOD* (if applicable) _____

*Date of accident/date of exposure/date of ingestion/date of injury

Actual / Projected Date of Completed Treatment _____

Injuries Sustained

Pre-Existing Conditions

Injury-Related Medical Expenses (to date) $_____

Is injury-related care anticipated post-settlement? ◯ Yes ◯ No

Past/future injury-related hospitalization or surgery? ◯ Yes ◯ No

Claimant's Out-of-Pocket Expenses $_____

Client Information

Attorney / Contact Name _____

Phone _____ Fax _____

Firm / Company _____

Firm Address _____

City _____ State Zip _____

Attorney / Client Email _____

Paralegal / Assistant Name _____

Paralegal / Assistant Email _____

Case Type (please check all that apply)

- ☐ Motor Vehicle Accident — No Fault Policy? ◯ Yes ◯ No
- ☐ Medical Malpractice
- ☐ Nursing Home Negligence
- ☐ Workers' Compensation
- ☐ Exposure — Please Specify _____
- ☐ Product Liability — Please Specify _____
- ☐ Other — Please Specify _____

Applicable Claims/Actions (please check all that apply)

- ☐ Wrongful Death — State Filed _____ Court Allocated? ◯ Yes ◯ No
- ☐ Derivative (Loss of consortium, etc.)
- ☐ Survivor
- ☐ Personal Injury — Please Specify _____

Resolution

Resolved? ◯ Yes ◯ No

Defendant _____

Actual / Projected Resolution Date _____

Actual / Projected Gross Award _____

Claimant Benefits & GRG Requested Services

Benefit Types	Claimant Applied For	Claimant Receiving (past/present)	Agency Notified	GRG Service Requested	Additional Information Needed if GRG is Engaged
Medicare Parts A/B (Traditional)		☐	☐	☐	HIC # _____ Entitlement Date _____
Medicare Parts C/D (Advantage/Prescription/ Supplemental)		☐	☐	☐	Insurance Company Name _____ Group/ID # _____
Future Medicals Evaluation				☐	*Initial step performed for all Future Medical engagements.*
Medicaid (Tort Recovery)		☐	☐	☐	Medicaid # _____ State _____
Private Health Plan (ERISA, Non-ERISA)		☐	☐	☐	Insurance Company Name _____ Group/ID # _____ If Employer-based Health Plan, specify employer name _____ *Please provide plan document if available.
Provider Direct (Doctor or Hospital)			☐	☐	Name of Provider(s) (Doctor or Hospital) _____
Other Government Plan: VA Tricare Indian Health Services		☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	Treating Facilities _____ Sponsor's SSN (if different than claimant's SSN) _____
SSDI (Social Security Disability Insurance)	☐	☐			*Income replacement based on disability and work history (relates to Medicare)*
SSI (Supplemental Security Income)	☐	☐			*Income replacement based on disability and/or age and financial need (relates to Medicaid)*
Workers' Compensation	☐	☐	☐	☐	Carrier/TPA _____ File/Board # _____

Next Steps: Please email GRG Case Intake Form and all relevant healthcare authorizations to intake@garretsongroup.com.