ExamWorks Clinical Solutions

ExamWorks Clinical Solutions Referral Form

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ExamWorks Clinical Solutions Account Executive	Person Entering Referral	
Name:	Name:	Date:

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

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

Nature of Assignment*

- ☐ WC Medicare Set-Asides (WCMSA)
  - ☐ With RxD
- ☐ Liability Medicare Set-Asides (LMSA)
- ☐ *i*MSA
- ☐ MSA CMS Submission
- ☐ Legal Nurse Review (LNR)
  - ☐ With Medical Bill Analysis (MBA)
- ☐ Life Care Plan (LCP)
- ☐ Medicare Cost Projection (MCP)
- ☐ Resolution Services
- ☐ RxAnalysis
- ☐ RxAnalysis With Provider Outreach
- ☐ RxD Program
- ☐ 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
- ☐ Medical Case Management
- ☐ Vocational Case Management
- ☐ Catastrophic* Case Management
- ☐ Telephonic Case Management
- ☐ Task

***Place hospital locations for CAT claimant in comment section below or CALL CAT Hotline (888) 877-7115**

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

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

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

Company:	**Contact:**	☐ Referring Party ☐ Copies of Reports
Phone:	Fax:	Email:
Address:	City, St., Zip:	
Employer:	**Contact:**	
Phone:	Fax:	Email:
Address:	City, St., Zip:	
Defense Attorney:	**Contact:**	☐ Referring Party ☐ Copies of Reports
Phone:	Fax:	Email:
Address:	City, St., Zip:	
Plaintiff Attorney:	**Contact:**	☐ Referring Party ☐ Copies of Reports
Phone:	Fax:	Email:
Address:	City, St., Zip:	
Structured Settlement Broker:	**Contact:**	☐ Referring Party ☐ Copies of Reports
Phone:	Fax:	Email:
Address:	City, St., Zip:	
Party Responsible for Invoice: ☐ Insurance Carrier/TPA ☐ Referring Party	Billing Address (Mailing Address):	

MSA Information

Proposed Settlement Amount: $_____

Administration of the MSA*: ☐ Self** ☐ Professional Funding of the MSA*: ☐ Annuity** ☐ Lump Sum

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
4.	Has the entire claim been disputed?	☐ Yes	☐ No	☐ Not Known

5. List accepted body part(s): _____
6. List any denied conditions: _____

Description of Alleged Injury or Illness or Harm *(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.	Injury:
	ICD:

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

Required Information **Default - will use this option unless instructed otherwise to electronically submit records please send to: referrals@examworks-cs.com