ExamWorks Clinical Solutions

Referral Form

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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 Set-Aside
☐ Worker's Comp (WCMSA) ☐ Liability (LMSA)
☐ with RxD ☐ with CMS Submission ☐ with iMSA Quote
☐ with Post-Settlement Administration (PSA)
☐ EBiMSA
☐ with RxD ☐ with Post-Settlement Administration (PSA)
☐ Legal Nurse Review (LNR) ☐ LiabilityWorks
☐ with Medical Bill Review
☐ with Medical Bill Analysis
☐ Life Care Plan (LCP)
☐ Medical Cost Projection (MCP)
☐ Resolution Service

Medicare Status / Conditional Payment Services

☐ 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

Case Management

☐ Medical Case Management
☐ Vocational Case Management
☐ Catastrophic* Case Management
☐ Telephonic Case Management
☐ Task

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

Rx Program

☐ 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 Party:	**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 please send at referrals@examworks-cs.com.