MARKER 28
REFERRAL FORM

Service(s) Requested: (Check all that apply)

☐ WCMSA ☐ LMSA ☐ Non-Submittal MSA ☐MCP ☐ LNR ☐LNR/MBR
☐CMS Submissions ☐CP Investigation ☐CP Dispute ☐Appeal ☐Final Demand
☐RUSH Assignment Date Rush assignment needed by: _____

Today's date:				
CLAIMANT INFORMATION:				
Claimant's Last name:	Claimant's First Name:	Middle Initial:	DOB:	Gender: ☐ Male ☐ Female
Street Address:	City, State, Zip:			
SSN:	HICN:	Phone number:		
Medicare Beneficiary? ☐ Yes ☐ No ☐ Unknown	Receiving SSDI benefits? ☐ Yes ☐ No ☐ Unknown			
CLAIM INFORMATION:				
Employer:	Insurer:	RRE:		
Insurance Type: ☐ Workers' Comp. ☐ General Liability ☐ Auto/No-Fault	State of Jurisdiction:			
Date of Injury:	Claim #:	Accepted ICD Codes:		
INVOLVED PARTIES:				
TPA/Insurance Carrier:				
Company Name:	Contact Name:	☐Referring party		
E-mail:	Phone:	Fax:		
Address:	City, State, Zip:			
Defense Attorney:				
Company Name:	Contact Name:	☐Referring party		
E-mail:	Phone:	Fax:		
Address:	City, State, Zip:	OK to contact? ☐ Yes ☐ No		
Plaintiff Attorney:				
Company Name:	Contact Name:	☐Referring party		
E-mail:	Phone:	Fax:		
Address:	City, State, Zip:	OK to contact? ☐ Yes ☐ No		

*****Please check Billable party: ☐ TPA/Adjuster ☐ Defense Attorney**

444 Broadway, Suite 306
Saratoga Springs, NY 12866

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SUBMISSIONS INFORMATION: *(If applicable)*		
Proposed settlement amount: $		
Administration of MSA: ☐ Self ☐ Professional		
Funding of the MSA: ☐ Annuity ☐ Lump Sum		
Structured Settlement Broker:		
Company Name:	Contact Name:	
Email:	Phone:	Fax:
Address:	City, State: Zip:	OK to contact? ☐ Yes ☐ No

SPECIAL INSTRUCTIONS:
Accepted conditions:
Pre-existing conditions:
Denied conditions:
Special Instructions: *(If multiple DOI's, please list the additional dates here)*

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Saratoga Springs, NY 12866