PRECISION RESOLUTION

Medicare Set-Aside Allocation Letter of Engagement

Required Documentation.

Please forward the below documentation to intake@precisionlienresolution.com or upload to our secure server by *clicking here*.

1. Enclosed Precision Resolution New Case Intake Form.
2. Records/reports from your client's treating physician(s) for the past two (2) years of treatment or from the date of accident (whichever is shorter);
3. IME Reports for the past three (3) years or from the date of the accident (whichever is shorter);
4. Print out of payment history for medical benefits for the past 3 years, if it is readily available;
5. A copy of the Bill of Particulars (or other particularized pleading as to the negligence and injuries sustained); and
6. A list of current accident-related prescription medications (including dosage and frequency).

Fees.

Medicare Set-Aside Fee Schedule			
Service	**Production Time**	**Fee**	**Fees Due**
Medicare Set-Aside Allocation	*10 Business Days	$2,800	Upon Completion of Allocation

* 10 business days from receipt of all above referenced documentation. Expedited production time of 5 business days available for additional $1,200.00 fee.

Unless otherwise indicated on the enclosed intake form, no services other than the MSA allocation will be provided. Additional services requested relating to lien reporting and/or resolution will be subject to separate fees and/or retainer agreements.

Should you have any questions, please feel free to contact us.

Precision Resolution looks forward to assisting your firm and your client with this matter.

Very truly yours,

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PRECISION RESOLUTION, LLC

Do you have questions about this form? Call **888-961-LIEN** & we will walk you through our intake & engagement processes.

New Service Request Form

So that Precision Resolution may begin processing your file immediately, please submit this completed form, along with any additional authorization forms to:
intake@precisionlienresolution.com

Service Request Please select only the services that you wish Precision Resolution to engage in.

Date of Request: ____|____|____ Conference Call Requested after Submission? ◯ Yes ◯ No

◯	**Medicare Conditional Payment (Parts A/B)**	Medicare # _____ Entitlement Date ____|____|____ Has the case been reported? ◯ Yes ◯ No
◯	**Medicare Advantage Plan (Part C)**	Insurance Co. Name _____ Group/ID # _____ Has the case been reported? ◯ Yes ◯ No
◯	**Medicare Supplement Plan (Part D)**	Insurance Co. Name _____ Group/ID # _____ Has the case been reported? ◯ Yes ◯ No
◯	**Medicaid/Public Assistance**	State(s) _____ County(ies) _____ Has the case been reported? ◯ Yes ◯ No
◯	**ERISA, Private Health Plan, FEHBA or Other Lien Type**	Insurance Co. Name _____ Group/ID # _____ Has the case been reported? ◯ Yes ◯ No If Employer-based plan, specify employer name _____ Please provide Plan Document or Summary Plan Description, if available.
◯	**TRICARE or Veteran's Administration**	Treatment Facilities _____ Sponsor SSN_____ Has the case been reported? ◯ Yes ◯ No
◯	**Liability Medicare Set-Aside Allocation**	
◯	**Workers' Comp Medicare Set-Aside Allocation**	
◯	**Medicare Set-Aside Submission to CMS**	
◯	**Medicare Set-Aside Opinion Letter**	

Other Benefits If service not selected above, but benefits received, please indicate below.

Medicare Part A/B
Medicare # _____
Entitlement Date ____|____|____

Medicare Part C (Advantage Plan)
Insurance Co. _____
Group # _____

Medicaid/Public Assistance
State _____
County _____
ID # _____

Social Security Disability Insurance
Award Date _____
Application Date _____
Monthly Benefit $_____

Supplemental Security Income
Award Date _____
Application Date _____
Monthly Benefit $_____

Other/Private: _____

Claimant Information

Name _____ ◯ Female ◯ Male

SSN _____ DOB ____|____|____

Address _____

City _____ State _____ Zip _____

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

*If yes, list state(s)? _____

Name of Authorized Rep. or Administrator of Affairs _____

Attorney Information

Name _____

Attorney Email _____

Phone _____ Fax _____

Firm _____

Address _____

City _____ State _____ Zip _____

Paralegal/Associate Contact _____

Paralegal/Associate Email _____

If the claimant is deceased or party has POA, please forward certificate of death, and letters of administration, or executed POA. If the plaintiff is a minor, please forward birth certificate or parental affidavit.

Case Information ◯ Motor Vehicle ◯ Nursing Home Negligence ◯ Medical Malpractice ◯ Slip & Fall ◯ Product Liability ◯ Exposure ◯ Other_____

Date of Injury ____|____|____ Date of Death (if applicable)____|____|____ Still Treating? ◯ Yes ◯ No Date of Last Treatment ____|____|____

Specific Nature of Accepted Injuries | Please submit complaint, BOP or narrative summary

Pre-Existing Conditions | Please submit supporting medical records

Brief Accident Description | If plaintiff treated at hospital, please list facility names and dates, or submit records with this form.

Has the case settled?

◯ **YES** Date____|____|____ Gross Settlement $_____ Attorney Fee $_____ Case Expense $_____ Claimant Net $_____

◯ **NO** Mediation/Arbitration Date ____|____|____ Anticipated Settlement $_____ Anticipated Settlement Date____|____|____

Liability

Carrier Name _____

Policy Limit $_____

Policy # _____

SUM/UIM

Carrier Name _____

Policy Limit $_____

Policy # _____

Will there be more than one settlement for this date of injury? ◯ Yes ◯ No

No Fault ◯ Yes ◯ No

NF Denied? ◯ Yes ◯ No

NF Exhausted? ◯ Yes ◯ No

Carrier Name _____

Policy Limit $_____

Policy Remaining $_____

APIP ◯ Yes ◯ No

APIP Denied? ◯ Yes ◯ No

APIP Exhausted? ◯ Yes ◯ No

Carrier Name _____

Policy Limit $_____

Policy Remaining $_____

Comments

Reset Form