CMS Referral Request

CMS Review Thresholds

A workers' compensation settlement *may* qualify for referral to The Centers for Medicare & Medicaid Services (CMS) under the following review threshold criteria. Note that at present there are no published liability settlement review thresholds.

1. A referral to CMS is indicated if the Claimant is a *current* Medicare beneficiary *and* the "total settlement amount" is equal to or greater than \$25,000.

Total settlement amount includes attorney fees, indemnity payments for lost time, disfigurement, permanent partial impairments, mileage, past medical services and prescription drug expense reimbursement or payment, future Medicare covered *and* non Medicare covered medical services and prescription drug expenses, and any Medicare conditional payments or group health liens to be satisfied from the settlement proceeds. Any previously settled portion of the claim must be included in computing the total settlement amount. The annuity lifetime or guaranteed payout totals over the entire term of any annuity contract which is used to fund the settlement, whether indemnity and/or medical, rather than the cost or present cash value of the annuity is used to calculate the value of the annuity for total settlement amount purposes.

Claimants are generally eligible to receive Medicare benefits if, they are sixty-five (65) years of age, or if they have been receiving Social Security Disability benefits for at least twenty-four (24) months. Individuals found eligible for SSDIB benefits due to end stage renal disease or Lou Gehrig's disease (ALS)will qualify for Medicare earlier than 24 months.

OR

2. A referral to CMS is indicated if the Claimant is *not* a current Medicare beneficiary but there is a "reasonable expectation" that the Claimant will be Medicare entitled within thirty (30) months of the date of the settlement *and* the total settlement amount exceeds \$250,000.00.

A Claimant can "reasonably" expect to become a Medicare beneficiary within thirty (30) months, if at the time of settlement: (a) is at least 62 ½ years of age; (b) has applied for or has received SSDIB benefits; (c) has been denied SSDIB benefits but anticipates appealing the decision, or (d) has end stage renal disease or Lou Gehrig's (ALS) disease

Fee Schedule

The fee to refer a settlement for CMS approval is a flat \$1,000 which includes making the referral, following-up with periodic status inquires and obtaining CMS approval. CMS may reply to the CMS referral with a "counter" proposal. While there is no direct right of appeal to a counter proposal received from CMS the counter proposal may be "challenged". This usually involves providing CMS with counter medical evidence or other evidence supportive of the original proposed Medicare Set-aside figure. Fees may be higher should a "challenge" be filed to a counter CMS proposal. Before any additional fees are incurred my office will discuss in advance what is required. These additional fees are billed at the hourly rate of \$395.00 over the initial fee.

All fees are the responsibility of the submitting party and are not contingent upon any contractual relationship between the submitting party and client or upon the ultimate settlement or approval of settlement. All fees are due and payable in advance. Interest of 1.5% per month is charged for all outstanding invoices.

Additional Services

My office can provide additional services including (1) Medicare Set-aside analysis, (2) Medicare Conditional Payment Investigation and Reconciliation and (3) Settlement Document Preparation including Social Security offset, Informed Consent as to Medicare Set-aside/Medical Costs and Consequences of Your Settlement forms. To learn more about these services please visit my web site at www.sevarino.lawoffice.com.

The submitting attorney or party warrants to Angelo Paul Sevarino, Esq. that s/he has explained to his or her client that (a) no attorney-client relationship is being established between their client and Angelo Paul Sevarino, Esq., and (b) their client consents to Angelo Paul Sevarino, Esq. reviewing the submitted documents and communicating with the Social Security Administration or The Centers for Medicare & Medicaid Services as may be required. Further, the Submitting attorney or party warrants to Angelo Paul Sevarino, Esq. the accuracy of all the information contained herein.

The signature of the Client or authorized representative below is <u>required before</u> the referral to CMS may be made, as well as, the completion of the CMS Request Worksheet and two (2) attached authorizations.

Client	Submitting Attorney/Party
Date:	Date:

CMS Referral Request Worksheet

1. General Information:
Case Type: [] Workers' compensation [] Liability
State of Jurisdiction: [] Connecticut [] Other:
Date of Injury/Illness: Note, if more than one date of injury or illness provide specific details as to nature of injury/illness, who the responsible insurance carrier(s)/employer/defendants are and how the settlement proceeds are allocated to each injury or illness.
Body Part(s)/System(s):
Claimant Name:
Address: SSN/HICN: Telephone: Date of Birth:
If Spouse/Dependents are payees under the settlement please provide specifics.
Claimant's Attorney:
Address: Telephone :
Employer/Defendant:
Address: Telephone:
Insurer:
Address:
Telephone: Claim Number:
Employer/Insurer's Attorney: Address:
Address: Telephone:

2. Settlement

Total Settlement Amount: If not yet known provide	de best estimate.
Proposed Settlement Date:	
Indemnity Settlement Type:	[] lump sum
	[] structured. Please provide quotation summary. Please indicate if you need assistance in obtaining structured settlement quotations.
Medical Settlement Type:	[] lump sum
	[] structured. Please provide quotation summary. Please indicate if you need assistance in obtaining structured settlement quotations.
3. Medicare Entitlement Dat	e:
part (Parts A, B, C	t <i>is</i> on Medicare indicate the month and year for each coverage or D). Dates may differ per coverage part. If not known check ovide a copy of the Medicare card(s).
B. If Claimant is not y	vet Medicare entitled indicate:
below and submit to obtain this informa \$150.00. [] has applied [] has applied [] appealed an [] is 62½ year [] end stage re	complete the SSA Request For Information authorization found to the local Social Security Office. Should you wish my office to tion please return the sighed authorization along with a fee of for SSDIB been denied SSDIB but anticipates an appeal d/or re-filed for SSDIB

4. Medicare Set-aside:

A Medicare Set-aside analysis is necessary as part of the submission to CMS if future medical services or prescription drug therapy charges are part of the settlement. Indicate:
[] A Medicare Set-aside has been completed within the last 4 months and is attached.
[] I am requesting a Medicare Set-aside be completed. Please download and submit the MSA Request from http://sevarino.lawoffice.com
5. MSA Administration:
[] Self-administered
[] Professional administered by:
6. Medicare Conditional Payments:
If your client is on Medicare at the time of the settlement a Medicare conditional payment search and reconciliation must be undertaken.
[] A Medicare Conditional Payment search has already been done and is not being requested as part of this service. Please indicate amount of Medicare conditional payments to be repaid: \$
[] I am requesting a Medicare Conditional Payment investigation and/or reconciliation be completed. Please download and submit the MSPRC Request from http://sevarino.lawoffice.com .
7. Settlement Document Preparation:
[] I will prepare my own settlement documents.
[] Settlement document preparation including Social Security offset language, Informed Consent as to Medical Costs and Notice of Consequences of Your Settlement forms are requested. Please download and submit the Settlement Offset Request from http://sevarino.lawoffice.com .

CONSENT TO RELEASE

I,	hereby authorize The Centers for Medicare & Medicaid Services				
(Print Name)	•				
		equest, information related to my injury or illness			
and/or settlement for t	he specified date of injury/illnes	s to the individual and/or entity listed below:			
CHECK ONLY ON		INDICATE WHO MAY RECEIVE			
	ND THEN PRINT THE REQU				
INFORMATION AT	THE NITKINI THE REQU	ESTED INFORMATION.			
(If you intend to have yo release for each one.)	our information released to more tha	n one individual or entity, you must complete a separate			
() Workers' Comper	nsation Carrier () Liability (Carrier () My Attorney			
(X) Other:	Name of Individual/Entity:	Angelo Paul Sevarino, Esq.			
	Address:	26 Barber Hill Road, Broad Brook, CT 06016			
	Telephone:	860-870-3803			
		CMS MAY RELEASE YOUR			
INFORMATION (Th	ne period you check will run from w	hen you sign the date below)			
(X) One Vear () Ta	wo Years () Other				
(A) One rear () re	(Provide a sr	pecific period of time)			
	(2.22.22. m.)F	F,			
I understand that I mag	y revoke this "consent to release	information" at any time, in writing.			
MEDICARE BENEI	FICIARY INFORMATION AN	<u>ND SIGNATURE</u>			
Panafiaiary Cianatura		Date Signed:			
Denenciary Signature	•	_ Date Signed			
		s document will need to include documentation eneficiary's behalf. Please visit www.msprc.info for			
Medicare Health Insur	rance Claim Number (The number	er as shown on your Medicare card):			
Date of Injury/Illness					

Request for Social Security Information

TO: Social Security Administration	1		
Name Date/Birth			Social Security No.
I authorize the Social Security Adn Angelo Paul Sevarino. Esq., 26 Ba			
Reason I want this information r	eleased:		
	(disability, age or ESRD)) for the purp	ations, date of entitlement to Medicare and bose of my workers' compensation claim.
Please release the following infor	mation:		
and/or D; (F) Supplemental Securit	, age, ESRD); (D) Medity Income entitlement; (C	care status; (ment or date of application if still E) date of entitlement for Medicare A, B entitlement; (H) If not a current Social PIA; (J) ACE and any offset notices or
	hich I know is false to ob		e legal guardian of that person. I know tion from Social Security, I could be
Signature:	Date:Re	elationship:	
	FOR SSA US	E ONLY	
Is the individual <i>currently</i> a Medic	are and/or Medicaid (SSI	() recipient?	Yes No
If yes, Is the individual receiving:	Medicare Part A Medicare Part B Medicare Part D SSI/Medicaid	Yes No Yes No Yes No Yes No	Date of Entitlement: Date of Entitlement: Date of Entitlement: Date of Entitlement:
Is the individual insured for SSDIE	3? Yes No	Number	of Quarters/Credits:
Initial PIA80	0% ACE \$	_ Family M	ax: \$
If the individual is NOT receiving	Medicare or Medicaid b	enefits pleas	se complete the following
Is the individual receiving SS Retir	ement Benefits? Yes No	Effective	Date:
Is the individual receiving SSDIB Is not yet a Medicare beneficiary? Has a claim or request for hearing For SSDIB/SSI benefits been filed	Yes No Date		nt: on:
1 of Solutions of delicities occil flied	. 105 NO Date (от тррпсанс	ль
SSA Representative Signature			