Medicare Set-aside Request

The workers' compensation (WCMSA) or liability (LMSA) analysis will project anticipated work or accident related injury or illness medical services and prescription drug therapy costs which would otherwise be covered or reimbursable by traditional Part A and B Medicare and Part D Medicare. The medical services costs are either promulgated based upon the applicable State fee schedule or full actual charges without consideration of any Medicare deductibles, co-pays or coinsurance. The Centers for Medicare & Medicaid Services (CMS) has established specific guidelines for the calculation of future prescription drug costs currently based upon the average wholesale price as published by Redbook. Further, these costs are calculated on an annual basis and then projected based upon the client's life expectancy either based upon the client's actual chronological age or calculated rated age.

Medical services and prescription drug therapy costs are projected based upon those physician, hospital or prescription drug records provided my office including physician's estimates of future medical services and/or prescription drug therapy needs, an analysis of the past pattern of utilization of medical services and prescription drug usage, workers' compensation carrier medical/pharmaceutical payment recap history(WCMSA only) or medical/pharmaceutical specials recap (LMSA only), previous out of pocket medical/pharmaceutical expenses, the current medical/pharmaceutical treatment regimen, the client's past responses and outcome to the medical treatment provided, as well as, prescription drug utilization as indicated in the medical record. Present day medical services/prescription drug costs will be utilized and no provision is made for future inflation as CMS does not require inflationary pressures to be factored into the WCMSA/LMSA. The recommended WCMSA/LMSA amount is therefore a reflection of those costs that should be "set-aside" from the total future medical funds and designated for Medicare covered or reimbursable medical services and prescription drug therapy expenses.

Non-Medicare covered medical services or prescription drug therapy charges, as well as, annual Medicare deductibles, co-pays and coinsurance should be factored into any final settlement and a separate medical allocation which is not part of the WCMSA/LMSA should be considered. .

While it is not possible to accurately predict all future medical and technological advances for medical services or prescription drug therapy or associated complications pertaining to this analysis, the WCMSA/LMSA analysis is thought to reflect what can be reasonably anticipated for future medical services and prescription drug therapy based on the information provided.

THE FOLLOWING SERVICES ARE BEING REQUESTED:

□	Workers' Compensation Medicare Set-aside Analysis	$1,450.00
□	Liability Medicare Set-aside Analysis	$1,450.00

This fee includes initial analysis and issuance of WCMSA/LMSA report.

Fees for life underwriter charges for rated ages or third party Medicare Set-aside administrators are *in addition* to those of Angelo Paul Severino, Esq. and are payable directly to the outside vendor. Fee quotations are available upon request.

Fees are the responsibility of the attorney or law firm requesting the WCMSA/LMSA analysis and are not contingent upon any contractual relationship between the attorney/law firm and client or upon the ultimate settlement or judgment.

All fees are due and payable net 10 days. Interest of 1.5% per month is charged for all outstanding invoices.

The submitting attorney/law firm warrants to Angelo Paul Severino, Esq. that s/he has explained to their client that (a) no attorney-client relationship is being established between their client and Angelo Paul Severino, Esq., and (b) their client consents to Angelo Paul Severino, 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 attorney/law firm warrants to Angelo Paul Severino, Esq. the accuracy of all the information contained herein.

The signature of the Client or authorized representative is <u>required before</u> the WCMSA/LMSA analysis may be prepared or work commenced.

_____	_____
Client	**Submitting Attorney/Party**
Date: _____	**Date: _____**

PLEASE ATTACH THE FOLLOWING INFORMATION TO THIS INPUT SHEET AND RETURN TO:

Angelo Paul Sevarino, Esq.
26 Barber Hill Road
Broad Brook, CT 06016
wclawyer@aol.com
860-870-3803
860-870-3805(fax)

1. Complete set of **medical reports** for the last two years of treatment. Include all surgical reports and hospital discharge records from date of injury forward.

2. **Pharmacy printout** or statement from treating physician(s) for all prescribed drugs for the last two (2) years of treatment. Include name of drug, unit form (capsule, tablet, patch etc.), prescribed strength and prescribed frequency.

3. **Medical payment recap history** covering the last two years of related medical services and prescription drug therapy charges: (a) from the workers' compensation carrier for WCMSA, or (b) copies of all medical bills for LMSA.

4. If an **implantable device** is being used or recommended you should consult with the appropriate physician and provide the following information:

a. Device, electrodes, receiver manufacturer name
b. Device, electrodes, receiver model # or type
c. Device, electrodes, receiver cost including tax, freight and handling
d. Facility fee, whether inpatient or outpatient, procedure code and cost
e. Surgeon procedure code and cost
f. Anesthesiologist procedure code and cost
h. Programming services procedure code, frequency and cost
i. Other associated costs

5. Copy of **Medicare card**, Medigap card and Prescription Part D plan, as applicable.

6. Completion of "**Specific Case Information**" sheet.

7. Sign (3) **authorizations**

Specific Case Information

Claimant/Plaintiff
Name:
Address:
SSN/HICN:
Telephone Number:

Claimant/Plaintiff's Attorney
Name:
Address:
Telephone Number:

Employer/Defendant (if multiple employers or defendants list on separate sheet
Name:
Address:

Insurer(if multiple insurers list on separate sheet)
Name:
Address:
Claim Number:

Insurer's Attorney(if multiple counsel list on separate sheet)
Name:
Address:
Telephone Number:

Medicare Coverage Parts (check all that apply)**:**

□ Claimant/Plaintiff is NOT on Medicare

□ Claimant/Plaintiff IS on Medicare with:
Part A:□ B:□ C:□ D: □ _____(name of plan)

Date of Injury:

Claimant/Plaintiff's Date of Birth:

Body Part(s)/System(s) that are being claimed (be specific):

Total Settlement Amount: **□ Not yet determined but estimated to be: $**

Comments/Special Instructions:

CONSENT TO RELEASE FORM

I, _____ hereby authorize The Centers for Medicare & Medicaid Services
(Print Name)
(CMS), its agents and/or contractors to release, upon request, information related to my injury/illness

and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:

(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

( ) Workers' Compensation Carrier ( ) Liability Carrier ( ) My Attorney
(X) Other: Submitter

Name of Individual/Entity: Angelo Paul Sevarino, Esq.

Address: 26 Barber Hill Road
Broad Brook, CT 06016

Telephone: 860-870-3803
Fax: 860-870-3805

INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION (The period you check will run from when you sign the date below)

(X) One Year ( ) Two Years ( ) Other_____
(Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE

Claimant/Plaintiff Signature: _____ Date Signed: _____

Note: If the Claimant/Plaintiff is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the Claimant/Plaintiff's behalf. Please visit www.msprc.info for further instructions.

Medicare Health Insurance Claim Number (The number as shown on your Medicare card):

❑❑❑-❑❑-❑❑❑❑-❑❑

Date of Injury/Illness:_____

Request for Social Security Information

TO: Social Security Administration

_____	_____	_____
Name	Date/Birth	Social Security No.

I authorize the Social Security Administration to release information or records about me to:
Angelo Paul Sevarino. Esq., 26 Barber Hill Road, Broad Brook, CT 06016

Reason I want this information released:

To establish my Social Security Disability status, possible offset implications, date of entitlement to Medicare and the basis for Medicare entitlement (disability, age or ESRD) for the purpose of my workers' compensation or personal injury claim. I understand there may be a charge for releasing information.

Please release the following information:

(A) Social Security entitlement status; (B) date of Social Security entitlement or date of application if still pending; (C) basis for entitlement (disability, age, ESRD); (D) Medicare status; (E) date of entitlement for Medicare A, B and/or D; (F) Supplemental Security Income entitlement; (G) Medicaid entitlement; (H) If not a current Social Security recipient, include number of eligible quarters/credits; (I) Initial PIA; (J) ACE and any offset notices or calculations and (K) Family Max

I am the individual to whom the information/record applies, parent or the legal guardian of that person. I know that if I make any representation which I know is false to obtain information from Social Security, I could be punished by a fine or imprisonment or both.

Signature:_____Date:_____Relationship:_____
Claimant/Plaintiff

FOR SSA USE ONLY

Is the individual *currently* a Medicare and/or Medicaid (SSI**)** recipient? Yes No

If yes, Is the individual receiving:

Medicare Part A	Yes No	Date of Entitlement: _____
Medicare Part B	Yes No	Date of Entitlement: _____
Medicare Part D	Yes No	Date of Entitlement: _____
SSI/Medicaid	Yes No	Date of Entitlement: _____

Is the individual insured for SSDIB? Yes No Number of Quarters/Credits: _____

Initial PIA_____ 80% ACE $_____ Family Max: $_____

If the individual is NOT receiving Medicare or Medicaid benefits please complete the following

Is the individual receiving *SS Retirement Benefits*? Yes No Effective Date: _____

Is the individual receiving SSDIB benefits but
Is not yet a Medicare beneficiary? Yes No Date of Entitlement: _____
Has a claim or request for hearing
For SSDIB/SSI benefits been filed? Yes No Date of Application: _____

SSA Representative Signature _____ Date:_____

Authorization for Release of Protected Health Information

(In compliance with HIPAA Regulations - 45 C.F.R. 164.508)

To: RE: SNN#: Date of Birth:

I authorize the use or disclosure of my protected health information by your office, company or organization as specified below. I understand that signing this Authorization is voluntary and that my medical provider may not require me to sign this Authorization before my doctor, hospital or institution provides me with treatment. I understand that I have the right to revoke this Authorization at any time by providing a signed, written notice of such revocation to my medical provider. I understand that a description of my right to revoke my Authorization is set forth in my medical provider's Notice of Privacy Practices. I understand that information is being released pursuant to this Authorization at my request and that the information may no longer be protected by law or regulation and may be redisclosed by the recipient.

1. a. Please use or disclose the following health information if such information exists:
   - ☐ The entire medical record; or
   - ☐ The following limited health information:

   b. Your medical institution/provider cannot use or disclose certain information unless you specifically authorize such use or disclosure. **Please initial next to each item below if you specifically authorize the release** of health information relating to the testing, diagnosis or treatment for:
   ___HIV/AIDS
   ___Drug and alcohol abuse
   ___Mental health/psychiatric disorders

2. Please specify the time period for the information you described above to be disclosed:

   - ☐ All information maintained at any time by my medical provider or
   - ☐ Information maintained by my medical provider from __/__/__ to __/__/__

3. Please specify who may receive the information requested by this authorization:

   Angelo Paul Sevarino, Esq., 26 Barber Hill Road, Broad Brook, CT 06016 (860-870-3803)

Unless earlier revoked, this authorization will expire one year from the date signed below, unless you specify an earlier date here: __/__/__.

By signing below, I understand and acknowledge the following:

- I have read and understand this Authorization;
- I am authorizing my medical provider to use or disclose the health information to the person(s) and for the purpose(s) identified in this authorization; and
- If I have any questions about disclosure of my protected health information pursuant to this Authorization, I may contact my medical provider's Privacy Officer.
- A photostatic copy of this Authorization shall be considered as effective and valid as the original.

_____	_____
Name of Individual, Date If different then the Patient/Client	Signature of Patient/Client Date or Personal Representative

If signed by the Patient's/Client's personal representative, describe the legal authority of the representative to act on behalf of the Patient/Client._____.

Legal authority of representative verified by:_____