THE FOLLOWING SERVICES ARE BEING REQUESTED:

□	Medicare Set-aside Analysis	$1,450.00
□	Rated Age	Quotation will be provided depending on vendor

Payment is due with the MSA Request for Service.

This flat fee assumes that all required information is submitted with the request. While the exception fees may be higher should additional medical or prescription drug records be subsequently submitted which require a revision to the MSA. These additional fees are billed at the hourly rate of $395.00.

All fees are the responsibility of the Requesting Attorney/Party and are not contingent upon any contractual relationship between the Requesting Attorney/Party and client or upon the ultimate settlement or approval of the settlement.

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

Upon reasonable request my office will meet once with you and your client to answer any questions you or your client may have. There is no charge for this initial consultation. Additional consultation will be billed at the $395.00 hourly rate. My office does not make direct inquiry of your client and will not engage in ex parte conversations with your client.

The Requesting Attorney/Party warrants to Angelo Paul Sevarino, Esq. that s/he has explained to his or her client (a) there has not been established an attorney-client relationship between their client and Angelo Paul Sevarino, Esq., and (b) the client consents to Angelo Paul Sevarino, Esq. reviewing the submitted documents. .

The signature of the Client or authorized representative is required before the MSA analysis may be prepared or work commenced.

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

PLEASE ATTACH THE FOLLOWING INFORMATION TO THIS REQUST FOR SERVICE AND RETURN, WITH THE APPROPRIATE FEE TO:

Angelo Paul Sevarino, Esq.
110 Day Hill Road
Windsor, CT 06095
wclawyer@aol.com

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 from the workers' compensation carrier or insurance carrier that paid accident related medical services and prescription drug therapy charges.

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, if applicable

6. Sign **authorizations** (2). Only the signature is required. The Law Office of Angelo Paul Sevarino will complete the remainder.

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