

Specific Case Information

Claimant:

Name:
Address:
SSN/HICN:
Telephone Number:
Gender:

Claimant's Attorney

Name:
Address:
Telephone Number:

Employer (if multiple employers list on separate sheet)

Name:
Address:
Telephone Number:

Insurer(if multiple insurers list on separate sheet; indicate related employer)

Name:
Address:
Claim Number:

Insurer's Attorney(if multiple counsel list on separate sheet, indicate related insurer)

Name:
Address:
Telephone Number:

Medicare Coverage Parts (check all that apply):

- Claimant is NOT on Medicare
- Claimant IS on Medicare with Part A: B: C: D:

Date of Injury:

Claimant's Date of Birth:

Body Part(s)/System(s) that are being claimed (be specific) and included in the WCMSA:

Body Part(s)/System(s) that are being disclaimed (be specific) and not included in the WCMSA:

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

Comments/Special Instructions:

The submitting attorney/law firm/party warrants to Angelo Paul Sevarino, Esq. that s/he has explained to their 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 attorney/law firm/party warrants to Angelo Paul Sevarino, Esq. the accuracy of all the information contained herein and supplied in support of the request for WCMSA analysis.

Submitting attorney/law firm/party