## **CMS Referral Request Worksheet**

#### 1. General Information

Case Type: workers compensation
State of Jurisdiction: [] Connecticut [] Other:
<b>Date of Injury/Illness:</b> Note, if more than one date of injury or illness provide specific details as to nature of injury/illness, which 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) to be included in the WCMSA:
<b>Body Part(s)/System(s) to be excluded from the WCMSA</b> (which have been disclaimed, a finding and dismissal entered as to that body part/system, or is medically determined to exist prior to the work related injury or illness):
Claimant Name:
Address: SSN/HICN: Telephone: Date of Birth: Gender
Claimant's Attorney:
Address: Telephone:
Employer Name:
Address: Telephone:
Insurer:
Address: Telephone: Claim Number:

Angelo Paul Sevarino, JD, MSCC, 26 Barber Hill Road, Broad Brook, CT 06016, (860) 870-3803(office), (860)870-3805(fax), wclawyer@aol.com, http://sevarinolaw.com (July2013)

Employer/Insurer's Attorno Address: Telephone:	ey:
	2. Settlement
<b>Total Settlement Amount:</b> If not yet known prov	ide best estimate.
<b>Proposed Settlement Date:</b>	
<b>Indemnity Settlement Type</b>	: [] lump sum
	[] structured. Please provide quotation summary
<b>Medical Settlement Type:</b>	[ ] lump sum
	[] structured. Please provide quotation summary
	3. Medicare Entitlement (Check appropriate box)
(Medicare Advantage Plan or	Medicare (traditional Part A and/or B), Medicare Part C Medicare Part D (Prescription drug). Indicate the month and year es may differ per coverage part. If coverage dates not known check
Medicare Part Medicare Part Medicare Part Medicare Part	B: C:
Please provide	e a copy of the applicable Medicare card(s).
[ ] Claimant is not on	Medicare but expected to be on:
[ ] do not know Clair	mant's Medicare status.

# 4. Social Security Disability Entitlement

[] Claimant is receiving SSDIB benefits effective:				
[ ] Claimant has applied for SSDIB [ ] Claimant has applied but has been denied SSDIB and anticipates an appeal [ ] Claimant appealed and/or re-filed for SSDIB [ ] Claimant is 62½ years old				
[] Claimant has end stage renal disease but does not yet qualify for Medicare based on ESRD				
[ ] Cliamant has Lou Gerig's disease (ALS)				
5. Workers' Compensation Medicare Set-aside				
A Workers' Compensation Medicare Set-aside (WCMSA) 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 WCMSA analysis has been completed within the last 4 months and is attached.				
[] I am requesting a WCMSA analysis be completed. Please download and submit the Workers' Compensation Medicare Set-aside Request form.				
6. MSA Administration				
[ ] Self-administered [ ] Professional administered by:				
7. 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 Medicare Conditional Payment Request form				

# **8. 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 Workers' Compensation Settlement
Document Request form.

#### **CONSENT TO RELEASE**

I,	hereby authorize The	hereby authorize The Centers for Medicare & Medicaid Services				
(Print Name)						
_		uest, information related to my injury or illness				
and/or settlement for the	e specified date of injury/illness to	the individual and/or entity listed below:				
CHECK ONLY ONE	OF THE FOLLOWING TO	INDICATE WHO MAY RECEIVE				
	D THEN PRINT THE REQU					
•	ur information released to more tha	n one individual or entity, you must complete a separate				
release for each one.)						
( ) Workers' Compen	sation Carrier () Liability C	farrier ( ) 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				
		MC MAN DELEACE NOUD INCODMATION				
		MS MAY RELEASE YOUR INFORMATION				
(The period you check w	ill run from when you sign the date	below)				
(X) One Year () Two	Years () Other					
	(Provide a sp	pecific period of time)				
I understand that I may	revoke this "consent to release	information" at any time, in writing.				
MEDICARE BENEF	ICIARY INFORMATION AN	ND SIGNATURE				
Beneficiary Signature:		_ Date Signed:				
•	-	s document will need to include documentation eneficiary's behalf. Please visit <a href="www.msprc.info">www.msprc.info</a>				
Medicare Health Insur	ance 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	Name Date/F		Social Security No.			
I authorize the Social Security Administration to release information or records about me to:						
Angelo Paul Sevarino. Esq., 26 Bar	ber Hill Road, Br	oad Brook, CT 060	16 (860-870-3803)			
Reason I want this information re	eleased:					
	(disability, age or	ESRD) for the purp	tions, date of entitlement to Medicare and loose of my workers' compensation claim. I			
Please release the following infor	mation:					
(C) basis for entitlement (disability and/or D; (F) Supplemental Securit	, age, ESRD); (D) y Income entitlem	Medicare status; (Interpretation of the Medicaid of the Medica	ment or date of application if still pending; E) date of entitlement for Medicare A, B entitlement; (H) If not a current Social PIA; (J) ACE and any offset notices or			
			ne legal guardian of that person. I know that n from Social Security, I could be punished			
Signature:	Date:	Relationship:				
	FOR S	SSA USE ONLY				
Is the individual <i>currently</i> a Medica	are and/or Medica	id (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:			
Is the individual insured for SSDIB	? Yes No	Number	of Quarters/Credits:			
Initial PIA 80	% ACE \$	Family Ma	x: \$			
If the individual is NOT receiving	Medicare or Med	icaid benefits pleas	se complete the following			
Is the individual receiving SS Retire	ement Benefits? Y	es No Effective I	Date:			
Is the individual receiving SSDIB be Is not yet a Medicare beneficiary? Has a claim or request for hearing For SSDIB/SSI benefits been filed?	penefits but Yes No	Date of Entitlemen	nt:			
SSA Representative Signature: _						

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