CMS Referral Request Worksheet

1. General Information

Case Type: Workers' compensation

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, 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:

Body Part(s)/System(s) to be excluded from the WCMSA (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:

Employer/Insurer's Attorney:
Address:
Telephone:

2. Settlement

Total Settlement Amount:
If not yet known provide best estimate.

Proposed Settlement Date:

Indemnity Settlement Type: [ ] lump sum

[ ] structured. Please provide quotation summary

Medical Settlement Type: [ ] lump sum

[ ] structured. Please provide quotation summary

3. Medicare Entitlement

(Check appropriate box)

[ ] The Claimant *is* on Medicare (traditional Part A and/or B), Medicare Part C (Medicare Advantage Plan or Medicare Part D (Prescription drug). Indicate the month and year for each coverage. Note, Dates may differ per coverage part. If coverage dates not known check here [ ].

Medicare Part A:
Medicare Part B:
Medicare Part C:
Medicare Part D:

Please provide a copy of the applicable Medicare card(s).

[ ] Claimant *is not* on Medicare but expected to be on:_____

[ ] do not know Claimant'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.

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)

CONSENT TO RELEASE

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 or 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: Name of Individual/Entity: Angelo Paul Severino, Esq.
Address: 26 Barber Hill Road, Broad Brook, CT 06016
Telephone: 860-870-3803

THE FOLLOWING TO 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

Beneficiary Signature: _____ Date Signed: _____

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary'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 (860-870-3803)

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 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:_____

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: _____

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