Date Received:

704 Wagoner Rd • Elon, NC 27244 • Phone: (336) 270-5207 • Fax: (336) 270-5206

CASE REFERRAL FORM

Date of referral: _____

CLAIMANT/PLAINTIFF INFORMATION

Name (First, Middle, Last)_____ Date of Birth _____

Claimant Street Address _____ City _____

State _____ Zip Code _____ Social Security Number _____

Gender (Male/Female)_____Telephone Number _____

CASE INFORMATION

Claim Number _____ State Jurisdiction_____ Date of Injury _____

Defendant/Employer/Insured Name_____

Defendant/Employer/Insured Address_____

Case Type: ☐ Workers' Comp ☐ Liability ☐ No-Fault Auto

SERVICE REQUESTED

☐ MSA ☐ Future Medical Cost Projections ☐ Legal Nurse Consulting

☐ Life Care Plan ☐ Life Care Plan Review

COMMENTS REGARDING SERVICE REQUESTED:

REFERRAL CONTACT & BILLING INFORMATION

Contact Name: _____Telephone Number: _____

Fax Number: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Claim Administration Company:

Name: _____ Telephone Number: _____

Fax Number: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company/Self Insured/State Fund:

Name: _____ Telephone Number: _____

Fax Number: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Billing information if different than referral contact information:

Contact Name: _____Company Name: _____

Telephone Number: _____ Fax Number: _____

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Attorney Information:

Defense Counsel Name: _____Telephone: _____

Fax: _____ Email: _____

Defense Firm Name: _____

Defense Firm Address:_____ City: _____State:_____ Zip: _____

Plaintiff Counsel Name: _____Telephone: _____

Fax: _____ Email: _____

Plaintiff Firm Name: _____

Plaintiff Firm Address: :_____ City: _____State:_____ Zip: _____

Structured Settlement Broker: _____ Telephone: _____

Fax: _____ Email: _____

Structured Broker Contact: _____

Broker Address: _____ City: _____ State: _____ Zip: _____

CASE INFORMATION

Is Claimant/Plaintiff currently receiving Medicare Benefits? ☐ Y ☐ N

If yes, please provide HICN#_____

Has the claimant/plaintiff applied for, been denied and/or appealing or receiving Social Security Disability Payments? ☐ Y ☐ N (If yes, please provide supporting documentation.)

Is the claimant a Medicaid/SSI Beneficiary: ☐ Y ☐ N

Has the claim been settled? ☐ Y ☐ N

If so, provide settlement amount: Total (including all fees) $_____

Medical $_____ Indemnity $_____

If the claim has not been settled, is there an anticipated settlement range? ☐ Y ☐ N

Amount: $_____

Has a rated age been obtained? ☐ Y ☐ N

(If so, please provide documentation.)

If Liability Claim, is there an underlying workers' compensation claim involved? ☐ Y ☐ N

Additional Questions for Cases with Disputed Issues:

Has the entire claim been disputed/controverted/denied? ☐ Y ☐ N

If so, what is the basis for the dispute/controversion/denial?

Are any diagnoses/body parts disputed? If so, list and provide legal and medical reasons:

Is any treatment disputed? If so, list and provide legal and medical reasons:

Please list any prior known injuries/conditions that pre-date this claim:

Please provide the following with your completed referral form:

- ☐ Completed Referral Form
- ☐ Initial notice of injury/police report/injury allegations and records from initial treatment
- ☐ Printed medical claims and indemnity payment history (minimum of last 2 yrs is required for MSA)
- ☐ All Medical records
- ☐ Medication and DME ledger history
- ☐ Signed Medicare and Social Security Releases
- ☐ Any rated ages obtained on life company letterhead (we can obtain if desired).

Please send completed forms to:

Concierge Medical and Risk Consultants
704 Wagoner Rd.
Elon, NC 27244
Phone: 336-270-5207
Fax: 336-270-5206