



MSA ALLOCATION PROCESS

Please submit the following items for the determination of your Medicare Set-Aside Allocation:

1. Completed Intake Form (attached)
2. Signed Consent to Release for CMS (attached)
3. Signed Consent to release for SSA (attached)
4. ~~Any other documents~~ ~~including:~~ Including:
 - First Report of Injury
 - Major Surgeries
 - Depositions from Medical Providers (if available)
5. Life Care Plan (if available)
6. Payment Histories (Indemnity, Medical and Prescription) since the date of injury from the following:
 - Carriers
 - Third Party Administrators
 - Employers
 - Pharmacies
 - Prescription Drug Suppliers
7. Copy of Medicare Card

The following are required in order to obtain approval from CMS:

- Copy of Signed Settlement Agreement (proposed), including proper Medicare language
- Decision on whether Funding the MSA with a Lump Sum or an Annuity
- Decision on whether the MSA will be Self-Administered or Professionally Administered

If you have any questions please contact Erin A. Martin at 1-877-596-5705. All information can be submitted to the address below:

135 West Bay Street, Suite 400 • Jacksonville, FL 32202

Phone: (904)598-1110 or (877)596-5705

Fax: (904)598-1081

erin@deltasettlements.com

| | | |
|--|---------------------|--|
|  | MSA Services | 135 West Bay Street, Suite 400., Jacksonville, FL 32202 Tel. (904)598-1110 or (877)596-5705 Fax. (904)598-1081 |
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REFERRAL FORM

REFERRING COMPANY (If not Claimant Attorney)

| | |
|--------------------|--------|
| Referring Company: | |
| Contact Name: | |
| Address: | |
| City/State/Zip: | |
| Phone: | Email: |

CLAIMANT INFORMATION

| | | | |
|---|-------|--------------------------------------|---------------|
| Claimant Name (First, Middle Initial, Last) | | | Date of Birth |
| Address | | | Phone |
| City | State | Zip | Gender |
| Social Security Number | | Other Contact Person (if applicable) | |

CLAIMANT ATTORNEY

| | |
|----------------|-----|
| Attorney Name | |
| Firm | |
| Address | |
| City/State/Zip | |
| Phone | Fax |
| Email | |

INJURY INFORMATION

| | | | | |
|--|---------|-------------------------|-----------|-------|
| Type of Case: | Med Mal | Personal Injury | Work Comp | Other |
| Date of Injury: | | Date of last treatment: | | |
| Has Client had surgery as a result of the injury? Yes No | | If Yes: Surgery Type: | | |
| Description of Injury: | | | | |

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|--|---------------------|--|
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BENEFIT INFORMATION

| | | | | |
|--|-----|----|---|--------------------------------|
| Medicare Benefits: | Yes | No | Medicare HIC Number: | Entitlement Date: |
| Is claimant receiving SS benefits? | Yes | No | Medicare Coverage: | Was Case Reported to Medicare: |
| | | | A B Both | Yes No |
| Has claimant applied for Social Security Disability? | | | Yes | No |
| Has claimant been denied Social Security Disability but anticipated appealing? | | | Yes | No |
| Is claimant appealing a re-filing for Social Security Disability? | | | Yes | No |
| Has claimant been diagnosed with End Stage Renal Disease? | | | Yes | No |
| Medicaid Benefits: | Yes | No | Medicaid Number (if applicable): | |
| SSI – Supplemental Security Income: | Yes | No | Workers Compensation (applied or received): | Yes No |
| Other (Private Health Insurance): | Yes | No | Company (if applicable): | |

EMPLOYER OR DEFENDANT INFORMATION

| | |
|--------------------------------------|--------|
| Employer or Defendant Name: | Phone: |
| Address: | |
| City/ State/ Zip: | |
| Employer or Defendant Attorney Name: | Phone |
| Firm | |
| Address | |
| City/State/Zip | |
| Email | Fax |

CARRIER INFORMATION

| | |
|----------------|----------|
| Carrier Name: | Claim #: |
| Address | |
| City/State/Zip | |
| Phone | Fax |
| Email | |

SETTLEMENT INFORMATION

| | | | | |
|-----------------------------------|-----|----|--------------------------|-----------------|
| Case Settled: | Yes | No | Date of Settlement: | Gross Recovery: |
| Attorney Fees: | | | Net to Client: | Case Expenses: |
| Other (Private Health Insurance): | Yes | No | Company (if applicable): | |

NOTES, SPECIAL HANDLING (Hearing dates, controverted issues, specific requests, etc.)

CONSENT TO RELEASE

I, hereby authorize

its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement to the individual(s) and/or firm(s) listed below:

PLEASE CHECK:

☐ Claimant's attorney
(Name and/or Firm)

(Address)

☐ Insurance Carrier
(Name and/or Company)

(Address)

☐ Other
(Name and/or Firm)

(Address)

How long can we give out information? (CHECK ONE BOX)

☐ Ongoing, beginning
(Month/Date/Year)

☐ Limited time through
(Month/Date/Year) (Month/Date/Year)

Claimant's Signature

Date Signed

Date of Injury

Medicare Number

If your Power of Attorney (POA) or legal representative signed this form for you, a copy of their POA or representation papers must be sent to us with this form.

Completion and signing of this consent form:

- * Authorizes release of information to the person named above upon their request. This means that information disclosed to the above named person may be re-disclosed by them and may no longer be protected by law.
- * Allows release of claims and other information related to your injury/illness.
- * Is for release of information purposes only and does not affect benefits you are entitled to under the Medicare/Medicaid Program.

A photocopy or facsimile of this Consent to Release Form shall be valid and given the same force and effect as the original.

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name

*Date of Birth

*Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME

*ADDRESS

Delta Settlements

135 West Bay Street, Suite 400

Jacksonville, Florida 32202

*I want this information released because: to determine eligible government
There may be a charge for releasing information.
benefits

***Please release the following information selected from the list below:**

You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____
If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☐ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) _____

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to \$5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship (if not the individual): _____ *Daytime Phone: _____



Medicare Set-Aside Services and Fees

135 West Bay Street, Suite 400., Jacksonville, FL 32202
Tel. (904)598-1110 or (877)596-5705
Fax. (904)598-1081

SERVICES

FEES

| | |
|-------------------------------|------------|
| Medicare Set-Aside Allocation | \$2,500.00 |
|-------------------------------|------------|

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|--------------------------------------|----------|
| Medicare Set-Aside Submission to CMS | \$500.00 |
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| Rush Fee | \$500.00 |
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** There may be additional hourly charges depending on case complexity*

***Rush fee may be applied depending on need, to be determined on case by case basis*