



### **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. Last 2 -3 years of Medical Records and Reports 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](mailto:erin@deltasettlements.com)**

	<b>MSA Services</b>	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

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

### CLAIMANT INFORMATION

Claimant Name (Last, First, Middle Initial)			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	MVA	PI	WC	WD	Other
Date of Injury:		Date of last treatment:			Date of Death (If applicable):		
Has Client had surgery as a result of the injury?				If Yes, Surgery Type:			
Yes		No					
Description of Injury:							
Pre-Existing Conditions:							
ICD-9 CODES (VERY IMPORTANT! Enter all codes used when this claim was originally reported to Medicare.):							

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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.)

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## **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*