CM Comprehensive Medical
CM Case Management, LLC
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MSA/FMCP Referral Form

Date of Referral*:* _____

Requested Service(s): MSA _____ FMCP ____

The referring party will be responsible for all fees unless otherwise noted **

Claimant's Name:		Date of Birth:	SSN#:	Medicare#:
Claimant's Address & Phone #:		City:	State:	Zip Code:
Employer Name and Address:	Employer Phone #:	Date of Injury:	State of Jurisdiction:	Claim #:

Please complete all the sections and if not applicable indicate N/A.

Referring Party:

Adjuster Name:	Phone Number:	Fax Number:	E-mail Address:
Insurance Carrier/TPA:	Address:		
	Claim #:		
Rated age: Yes _____ No _____	Structure settlement broker name and address:		
Phone and Fax#:	Structure broker contact E-mail address:		

Claimant's Attorney Information:

Claimant's Attorney Name:	Phone Number:	Fax Number:
		E-mail Address:
Firm Name:	Address:	

Defense Attorney Information:

Defense Attorney Name:	Phone Number:	Fax Number:
		E-mail Address:
Firm Name:	Address:	

Expedited/Legal deadline MSA referral (5-10 business days) _____ Yes _____ No
Court Date: _____

Accepted body parts for this claim: _____

Denied body parts for this claim: _____

Has the claimant applied for SSDI Benefits?
_____Yes _____No _____Uncertain

If Yes, has the claimant been deemed eligible for SSDI benefits?
_____Yes _____No ____Uncertain

If the claimant has been deemed eligible for SSDI benefits, please note the date of eligibility:
_____

Is the claimant a Medicare recipient?
_____Yes _____No _____Uncertain

If the Settlement agreement has been reached, what is the proposed settlement amount? _____

Please list your Pharmacy Benefit Management Company: _____
Pharmacy Benefit Management Contact person and Phone #: _____

If this claimant is a Medicare recipient, have any Conditional Payments been made by Medicare on behalf of this claimant related to this claim? _____Yes _____No _____Uncertain
If yes, what is the total amount of the conditional payments? _____

Inquiry Items to determine Medicare Set-Aside Allocation

- Last 2-3 years of claim payment history
- Last 2-3 years of medical records and reports from treating and consulting physicians
- Pharmacy summary
- Life Care Plan (if available)
- Copy of Medicare Card

Inquiry Items to obtain CMS approval

- Completed Intake Form (Download Form @ www.cm2x.com)
- Signed CMS Consent to Release (Download Release @ www.cm2x.com)
- Signed SSA Consent for Release (Download Release @ www.cm2x.com)

If there are any questions concerning this referral or the MSA or FMCP process, please contact us at 888-377-CMCM (2626) or e-mail Jeanine Fastov at j.fastov@cm2x.com