ATLAS SETTLEMENT GROUP, INC.

Medicare Set-Aside Services

MEDICARE SET-ASIDE EVALUATION REFERRAL FORM

Referral Type: ☐**Medicare / SSD Eligibility** ☐**MSA Allocation Report**

Referring Contact Information:

Name Mailing Address

Phone Number Fax Number Email Address

Claimant Information:

Claimant Name Claim Number

Address City State Zip Code

Date of Birth Social Security Number

Employer Date of Injury State of Loss / Venue

Claimant's Counsel (Name and Phone Number)

Employer's Counsel (Name and Phone Number)

AWW$_____ TTD rate $_____ PPD rate$_____

TTD Paid $_____ Medicals Paid To Date $_____

MMI: ☐ Yes ☐No PD%_____ PD$_____

What was the Claimant's job at the time of loss?

Please give a description of the loss causing event

What is the nature of the accepted injury?

Approximate Settlement Value: $_____

Is the Claimant receiving SSD benefits? ☐ Yes ☐No Is the Claimant Medicare eligible? ☐ Yes ☐No

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