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**Medicare/Medicaid Set-Aside
Workers' Compensation and Liability
Claim Referral Form**

Claimant's Information

Name (Last Name, First & Middle Initial)	Street Address, City State & Zip Code
Social Security Number:	Date of Birth:
Date of Injury:	State of Jurisdiction:
Employer Name:	Employer Address:
Date of Hire:	Claim#

Carrier/TPA/Claims Professional Contact Information

Claims Professional	Telephone #	E-Mail Address
Insurance Carrier/TPA/Servicing	Address of Claims office	Fax#

Attorney Information (If Applicable)

Defense Attorney	Address	Phone & Fax#'s
Claimant's Attorney	Address	Phone & Fax#'s

Is the Claimant on Medicare? _____ Yes or No _____ or Unknown _____
 Is the Claimant currently receiving SSD _____ Yes or No _____ or Unknown _____
 Date of SSD Eligibility _____
 Has this claim been settled? _____ Yes or No _____
 Total settlement amount: \$ _____ Has it been approved? _____ Yes or No _____
 Do you have a preference for a structured settlement broker? _____ Yes or No _____
 If so, please provide Structured Settlement contact information: _____
 Please list all accepted injuries and date of each injury: _____

 Please list all disputed injuries and reason for dispute: _____

 Do we have your authorization to contact the claimant and/or attorney for any signed releases?
 Yes _____ or No _____

Please complete form and Email-Scan with file materials or mail to:

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