Print Form

CAMS, LLC
An MSA Company
Care, Assessment & Management Systems

MEDICARE SET-ASIDE ASSIGNMENT FORM

CLIENT/BILLING INFORMATION:

CLIENT NAME: _____

CONTACT: _____

ADDRESS: _____

_____

PHONE: _____

EMAIL: _____

FILE NUMBER: _____

INSURANCE CO/SELF INSURED/TPA:

NAME: _____

CONTACT: _____

ADDRESS: _____

_____

PHONE: _____

EMAIL: _____

EMPLOYER/INSURED: _____

DEFENSE ATTORNEY:

FIRM: _____

ADDRESS: _____

_____

PHONE NUMBER: _____

CLAIMANT NAME: _____

ADDRESS: _____

_____

PHONE NUMBER: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

DATE OF INJURY: _____

CLAIM NUMBER: _____

PLAINTIFF ATTORNEY:

FIRM: _____

ADDRESS: _____

_____

PHONE NUMBER: _____

EMAIL: _____

STATE OF JURISDICTION: _____

RECEIVING MEDICARE BENEFITS:

☐ YES ☐ NO

REFERRAL INFORMATION INCLUDES:

- ○ MEDICAL RECORDS
- ○ PAYMENT HISTORY

MSA QUALIFICATION QUESTIONS:

IS THE PATIENT RECEIVING SSDI BENEFITS? ☐ YES ☐ NO

IS THE PATIENT A MEDICARE RECIPIENT? ☐ YES ☐ NO

HAS THE RATED AGE OR LIFE EXPECTANCY BEEN COMPLETED? ☐ YES ☐ NO

SERVICES REQUESTED:

- ☐ CONDITIONAL PAYMENT/LIEN INVESTIGATION
- ☐ MEDICARE SET-ASIDE ALLOCATION
- ☐ FILE SUBMISSION TO CENTERS FOR MEDICARE AND MEDICAID
- ☐ LIFE CARE PLAN/FUTURE MEDICAL COST PROJECTION

ASSIGNMENT FORM COMPLETED BY (PRINT/TYPE NAME): _____

PLEASE SUBMIT TO ANNA SAYRE VIA FAX: (407) 286-0064. PLEASE PHONE (407) 492-5024 WITH ANY QUESTIONS.