|  |  |  |
| --- | --- | --- |
|  |  |  |
| **MSA REFERRAL SHEET****CLAIMANT INFORMATION** |
| Name: |  | Claim #: |  |
| Address: |  | PIRS Referral #: *(office use only)* |  |
| City/State/Zip: |  | Referral Date: |  |
| Home Phone #: |  | Jurisdiction: |  |
| Type of File: | [ ]  MSA |
| Cell Phone #: |  | Date of Injury: |  |
| E-Mail: |  | Accepted Body Part: |  |
| SS #: |  |  |  |
| Date of Birth: |  | IDC 9/IDC 10 Dx Codes: |  |
| Occupation: |  | Disputed / Unrelated Injury(s): |  |
| Receiving Social Security Disability: | [ ]  YES [ ]  NO | HICN Medicare #: |  |
|  |  **CLAIM** | **INFORMATION** |  |
| Insurance Company | [ ]  YES [ ]  NO | State of Venue: |  |
| Prior Settlement:Prior/Proposed Settlement Information: | [ ]  YES [ ]  NO | Type of Coverage: | [ ]  WC [ ]  Disability [ ]  Auto [ ]  Liability |
| Who will administer the MSA: | [ ] [ ]  Self-administered [ ]  Professional Administration[ ]  Preferred Vendor | Settlement will be: | [ ]  Lump Sum [ ]  Annuity |
| **INSURANCE COMPANY INFORMATION** |
| Insurance Company: |  | Adjuster Name: |  |
| Billing Address: |  | Adjusters Address: |  |
| Adjuster Phone #: Fax #: | P:F:  |
| Billing City/State/Zip: |  | Adjuster E-Mail: |  |

|  |
| --- |
| **EMPLOYER INFORMATON** |
| Name of Company: |  | Contact Name: |  |
| Address: |  | Phone #: |  |
| Fax #: |  |
| City/State/Zip: |  | E-Mail: |  |
| **TREATING PHYSICIAN INFORMATION** |
| Name: |  | Phone #: |  |
| Address: |  | Fax #: |  |
| City/State/Zip: |  | E-Mail: |  |
| Address: |  | City/State/Zip: |  |
| **DEFENSE ATTORNEY** | **PLAINTIFF ATTORNEY** |
| Attorney Name: |  | Attorney Name: |  |
| Name of Firm: |  | Name of Firm: |  |
| Address: |  | Address: |  |
| City/State/Zip |  | City/State/Zip: |  |
| Phone # / Fax #: |  | Phone # / Fax #: |  |
| May we contact this attorney to obtain releases? | [ ]  YES [ ]  NO | May we contact this attorney to obtain releases? | [ ]  YES [ ]  NO |
| E-Mail: |  | E-Mail: |  |
| **Description of Injury:** |
|  |
|  |
| [ ]  **Last 2 years of treatment medical records and all surgical reports**[ ]  **Pharmacy History**[ ]  **Payment History**[ ]  **Rated Age *(PIRS will obtain)*** |

**Please send all referrals to referrals@pirehab.com**