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| **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: |  | |

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| **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**