



LAW OFFICES OF

*Beverly Manley*  
& Associates, P.C.

### LIABILITY CLAIM INTAKE FORM

This form may be emailed, faxed, or included in the assignment packet that is mailed to the above address. An original signature on the SSA 3288 form is required in order for the SSA office to process form & verify SSDI/Medicare status. Fees for services are due upon completion of the assignment. An invoice will be sent with the final report. If the claim proves unusually complex and requires large expenditures of time beyond what is customary and reasonable, there may be an additional charge. We will communicate with you prior to making this charge.

#### PLAINTIFF

Prefix:	First Name:	Middle Name:	Last Name:	Suffix:
Birth Date:	/ /	SSN:	- -	Sex:
E-Mail:		Carrier File No:		
Street:	City:	State:	Zip:	
Type of liability claim:	<input type="checkbox"/> Auto accident/ <input type="checkbox"/> Medical malpractice <input type="checkbox"/> Products liability/ <input type="checkbox"/> Other		Injury Date(s):	Phone:
SSDI Beneficiary:	Yes : No	Date Medicare Eligible:	/	Guardian Appointed: Yes : No
State of Jurisdiction:				
Settlement Agreement:	\$	Preexisting medical condition(s):		

Description of injury:

Structured Settlement broker (if utilized): Administrator: Phone:

Other Comments:

Has the entire claim been disputed based upon a "no liability" defense? Yes : No Date claim was first disputed? / /

Explain specific condition or care that is being disputed. Include all legal & medical reasons as well as supporting documents/records to support denial of claim

Are there any underlying workers compensation claims involved? Yes : No What are the policy limits? \$

Does settlement include funds for future medical care? Yes : No Has there been any finding of comparable negligence or apportionment of injuries? Yes : No

#### PLAINTIFF ATTORNEY

Prefix:	First Name:	Middle Name:	Last Name:	Suffix:
Firm Name:				
Street:	City:	State:	Zip:	
Email:	Phone:	FAX:		

#### ADJUSTOR

Prefix:	First Name:	Middle Name:	Last Name:	Suffix:
Carrier/TPA/Service Agent:				
Street:	City:	State:	Zip:	
Email:	Phone:	FAX:		

#### DEFENSE ATTORNEY

Prefix:	First Name:	Middle Name:	Last Name:	Suffix:
Firm Name:				
Street:	City:	State:	Zip:	
Email:	Phone:	FAX:		

#### LIABILITY SERVICES – Check selected services

<input type="checkbox"/>	Calculate MSA Allocation for future medical care with settlement language.
<input type="checkbox"/>	Expedited Service (5 day RUSH) for completion of MSA. (Additional Fee Applies)
<input type="checkbox"/>	Revision of MSA
<input type="checkbox"/>	Recovery Claim Search / Notice: No legal argument for compromise / waiver.
<input type="checkbox"/>	Submit to CMS for approval of settlement and set aside arrangement. Payment of final fee is due upon submission to CMS for approval. Any revisions to the proposal to CMS will be completed at negotiated rate.
<input type="checkbox"/>	Liability Claim MSA Bundled Package: Conditional payment research/notice, completion of MSA, and submission to CMS

#### OTHER SERVICES

<input type="checkbox"/>	Compromise of Medicare's Conditional Payment – Request MSPRC removal of inappropriate claims
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