

# ALLSUP INC.

300 Allsup Place  
Belleville, Illinois 62223  
(800) 854-1418  
Fax: (618) 236-5703

## INTAKE INFORMATION FOR ALLOCATION/MSA

### REFERRING COMPANY

Referring Company (Insurance carrier, TPA, Self Insured Employer)	Telephone Number	Fax Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Contact Name	E-mail Address:	
<input type="text"/>	<input type="text"/>	
Address		
<input type="text"/>		

Please check those that apply:

- MSA Verification** (Determine Medicare entitlement date)       **Lien Verification** (Determine and, if applicable, resolve Medicare liens)
- Allocation**       **Lien Resolution**
- Allocation w/CMS Approval**

Allocations will fall into one of the three categories as determined by Allsup:

- **Basic** (Compensable injury(ies) having uncomplicated medical history.)
- **Complex** (Injury(ies) involving complicated treatment history and future medical need for surgeries and/or prescription drugs or disputed claims.)
- **Advanced** (Significant injury(ies) involving life care plans, rated ages, paraplegias, amputations, etc.)

### CLAIMANT INFO

Claimant Name (Last, First, Middle Initial)	Claim Number	
<input type="text"/>	<input type="text"/>	
Claimant Street Address	Date of Birth	Male / Female
<input type="text"/>	<input type="text"/>	<input type="text"/>
City, State, Zip Code	Social Security Number	
<input type="text"/>	<input type="text"/>	
Employer Name	Date of Injury/Date of Loss	
<input type="text"/>	<input type="text"/>	
Employer Address	State Jurisdiction	
<input type="text"/>	<input type="text"/>	

### DEFENSE ATTY

Defense Attorney Name	Telephone Number	Fax Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address		
<input type="text"/>		

Is the claimant represented by an attorney?       Yes       No

### CLAIMANT ATTY

Claimant's Attorney Name	Telephone Number	Fax Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address		
<input type="text"/>		

Please select one

Is the claimant currently receiving Medicare benefits?       Yes       No       Unknown

Is the claimant currently entitled to Social Security Disability?       Yes       No       Unknown

Is the claimant competent?       Yes       No

If not, who is the guardian and can the guardian sign contracts on behalf of the claimant?

Does this referral encompass more than 1 injury?       Yes       No

Is this a denied claim(s)?       Yes       No

Type of Injury(s)? Briefly describe, specify what is accepted and denied to the claim(s):

Has a settlement been reached?  Yes  No

Has it been approved by the court?  Yes  No

If so, what was the settlement amount paid out: \$

Can any amount be defined as a compromise settlement?  Yes  No

Is this a lump sum settlement or a structured settlement?  Lump  Structured

If structured, who is the structured settlement company?

What is the proposed settlement? \$

Indemnity portion \$  Future medical portion \$

Are there any disputed issues in this case(s)?  Yes  No

If so, please describe:

Is there a life care plan prepared on this case?  Yes  No

Is there a rated age on the claimant?  Yes  No

Is the claimant at MMI?  Yes  No

Is there a physician report regarding future medical or lack of future medical?  Yes  No

Is the claimant taking prescriptions? If so, what are the current prescriptions?  Yes  No

\*\*\*\* **(Please be specific: List name and dosage of current prescriptions)**

**DOCUMENTATION NEEDED FROM YOUR FILE:**

First Report of Injury

Medical reports that outline initial treatment and all subsequent treatment.

Medical reports that indicate current condition/status or MMI. **Medical reports should be from the last two years, at least. If no medical treatment in prior two years, include a statement on your letterhead indicating "no medical paid since (indicate last date of treatment)".**

Prescription drug pay history. **Rx pay history should be from the last 2 years, at least. Please include report indicating specific prescription drugs and dosage the claimant is currently taking related to the claim(s).**

Physician's report regarding future medical treatment, if any.

Life Care Plan - if applicable.

Proposed settlement.

Payout pattern (loss run) for both indemnity and medical. If no indemnity or medical has been paid, please indicate this on your letterhead.

If any part of the alleged injury is denied, please explain and include any medical documentation that supports the denial.

Any other reports you feel would explain the injury, the reason for compromise or whether or not future medical treatment is needed.

**Please send completed form and documentation to:**

ALLSUP INC.  
MSA Department  
300 Allsup Place  
Belleville, IL 62223-8626  
(800) 854-1418  
Fax: (618) 236-5703

**Signature of Referring Company**