Lien
Resolution
Partners

Lien Resolution Services

Case Referral Checklist

Please insure the following documentation is included in case file. For your convenience, we have also included a Case Referral Form.

☐ **SERVICES REQUESTED** *(Lien Resolution, Lien Verification, Plan Evaluation or Other)*

☐ **LIEN HOLDER INFORMATION**
- *Plan Type (Private Health/ERISA, Non-ERISA, Medicare, Medicaid, FEHBA, Military, Other)*
- *Lien Amount*

☐ **INJURY INFORMATION**
- *Injury Type (MVA, Med Mal, Product Liability, Work Comp, Other)*
- *Injury description including date and location of injury*
- *Treatment description including last treatment and if future treatment expected*

☐ **CASE INFORMATION**
- *Fund Source(s) (1st party UM/UIM, 3rd party BI, General Liability/Umbrella, Personal Assets)*
- *Case status, claimant employment information, claimant lost wages, and claimant expenses*

☐ **CLAIMANT INFORMATION**
- *Name, address, gender, DOB, phone, and email*
- *If applicable, guardian or personal representative information*

☐ **HEALTH INSURANCE INFORMATION**
- *Provider, policy id's, recovery agent, copy of insurance card (front and back)*

☐ **CLAIMANT ATTORNEY INFORMATION**
- *Name, address, firm, phone, and email*

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CASE REFERRAL FORM

SERVICES REQUESTED:

____ LIEN RESOLUTION ____ LIEN VERIFICATION ____ PLAN EVALUATION
____ OTHER (DEFINE REQUESTED SERVICE):
____

TYPE OF HEALTH PLAN (LIEN):

____PRIVATE HEALTH/ERISA ____PRIVATE HEALTH/NON-ERISA ____FEHBA
____MEDICARE (TRADITIONAL, MEDICARE ADVANTAGE OR SUPPLEMENTAL)
____MEDICAID ____MILITARY (VA OR TRICARE) ____PROVIDER/HOSPITAL ____OTHER

HAS UNDERLYING PERSONAL INJURY CASE SETTLED? Y / N
IF YES, FOR HOW MUCH WAS CASE RESOLVED? ________________________
PLEASE INDICATE SOURCE(S) OF RECOVERY (POLICY LIMITS):
___________ THIRD PARTY BODILY INJURY COVERAGE
___________ FIRST PARTY COVERAGE (UM/UIM)
___________ HOMEOWNER'S POLICY
___________ GENERAL LIABILITY OR UMBRELLA POLICY
___________ DIRECTLY AGAINST THIRD PARTY'S PERSONAL ASSETS
___________ OTHER

WHAT IS ATTY'S CONTINGENCY FEE % __________
TOTAL COSTS (OUT-OF POCKET) OF PURSUING THE CASE? __________________
LOST WAGES: ______________ CASE/LAWSUIT EXPENSES: _________________

CLAIMANT INFORMATION

NAME: __________________________ GENDER: M/F SSN : ________________________
DOB: ______________ ADDRESS: __________________________ CITY: __________________
STATE: ______________ ZIP CODE: ______________ PHONE: (____)_______________
EMAIL: _________________________
FOR DEPENDENT(S), PLEASE PROVIDE GUARDIAN OR PERSONAL REPRESENTATIVE:
_______________________________ TITLE: ____________________
RELATIONSHIP TO DEPENDENT: ________________________ PHONE: (____)________________
EMAIL: ________________________
(PLEASE PROVIDE DOCUMENTATION OF POWER OF ATTORNEY, GUARDIANSHIP/CONSERVATORSHIP LETTERS VIA ATTACHMENT)

CLAIMANT ATTORNEY

ATTY NAME: ___________________ EMAIL: _________________ FIRM: _____________________
ADDRESS: ____________________________ CITY: ____________________ STATE: ______
ZIP CODE: ___________ PHONE: (____)_________________ FAX: (____)____________________

LIEN AMT. (TOTAL PAID BY HEALTH PLAN TO DATE): ______________________________

FUTURE TREATMENT REQUIRED? Y / N

INJURY INFORMATION (PLEASE INCLUDE INFORMATION AVAILABLE ON INCIDENT)

____MVA
____MEDICAL MALPRACTICE
____PRODUCT LIABILITY
____WORKER'S COMPENSATION
____OTHER PERSONAL INJURY

WHERE DID INCIDENT OCCUR? ____
DECRIPTION OF INCIDENT: ____
____
____

DATE OF INJURY: _____________ LAST TREATMENT: _____________
DOD: _____________________IF DECEASED, PLEASE PROVIDE EXECUTOR INFORMATION
HAS CLIENT CLAIMANT HAD SURGERY AS A RESULT OF THE INJURY: Y / N
IF YES, WHAT TYPE OF SURGERY? _____________________________
PLEASE PROVIDE A DESCRIPTION OF THE INJURIES:
____
____

WERE THERE ANY KNOWN PRE-EXISTING CONDITIONS? Y/ N
IF YES, DESCRIBE:
____
____

INSURANCE INFORMATION (INCLUDE COPY OF INSURANCE CARD IF AVAILABLE):

HEALTH INSURANCE COMPANY: _______________________________________
POLICY #: _______________________________
RECOVERY AGENT (INCLUDE CONTACT INFO IF KNOWN):
____
____
CURRENTLY EMPLOYED: Y/N EMPLOYER NAME: _______________________________
EMPLOYED AT TIME OF ACCIDENT: Y / N
EMPLOYER NAME AT TIME OF ACCIDENT: _________________________________

IF MEDICARE: MEDICARE HIC #: _________________________________
MEDICARE ADVANTAGE #: _______________________________________

IF MEDICAID: STATE: ___________MEDICAID ID #: ____________________________

IF MILITARY (VA OR TRICARE):

MILITARY POLICY/SPONSOR ID #: ____________________________
BRANCH: __________________ RANK: _________________________