PRECISION RESOLUTION, LLC

THE PLAINTIFF'S MSA AND LIEN SOLUTION LLC
PROTECTING PLAINTIFFS FROM MEDICARE ISSUES

Plaintiff's MSA & Lien Solution & Precision Resolution Letter of Engagement

Thank you for your interest in the Plaintiff's MSA and Lien Solution and Precision Resolution's services.

So that we can best serve you, your firm and your clients, please return the below-referenced documents to our office via email at **intake@precisionlienresolution.com** for immediate processing.

For **all service requests,** please submit the following documentation:

- Completed Intake form, clearly indicating the requested service(s) (*attached*);
- Executed HIPAA form (*attached*);
- Copies of any insurance cards;
- Any correspondence sent to or received from the health plan, recovery contractor, state or county agency;
- A copy of the Complaint, Bill of Particulars or case summary, if readily available; and
- Relevant medical records.

For all **Medicare Conditional Payment** service requests please provide:

- CMS Proof of Representation Form: to be signed by your client ("Plaintiff/Auth.Rep") and your firm ("Attorney") (*attached*); and
- Precision Proof of Representation Form: to be copied or printed onto your firm's letterhead and signed by you/retained attorney (*attached*).

For all **Medicare Set-Aside** service requests please provide:

- Records/reports from your client's treating physician(s) for the past two (2) years of treatment or from the date of accident (whichever is shorter);
- IME Reports for the past three (3) years or from the date of the accident (whichever is shorter);
- Print out of payment history for medical benefits for the past three (3) years, if it is readily available

If the plaintiff/beneficiary is deceased please also forward a copy of certificate of death as well as any/all Letters of Administration, Letters Testamentary or Power of Attorney documents. Please notify our office if the plaintiff is a minor (under 18 years of age) and we will send you an affidavit of parentage which will need to be completed.

Once all required documentation has been received for your specific service request(s), our office will initiate lien reporting and resolution engagement. Please note that Precision Resolution can only process new service requests once the corresponding authorization documentation has been provided.

Please note that Precision Resolution will also only engage in services requests as indicated on the attached intake form. Once our firm has engaged in the reporting and resolution process, an invoice will be forwarded to your office. Please contact our office if you notice inconsistencies between the desired scope of work and the services referenced on the invoice.

Please do not hesitate to contact our offices with any further questions by calling 716-712-0417.

Thank you for your confidence in Precision Resolution.

PRECISION RESOLUTION, LLC

PRECISION RESOLUTION, LLC

Do you have questions about this form? Call **888-961-LIEN** & we will walk you through our intake & engagement processes.

PLAINTIFF'S MSA AND LIEN SOLUTION

New Service Request Form

So that Precision Resolution may begin processing your file immediately, please submit this completed form, along with any additional authorization forms to:
intake@precisionlienresolution.com

Service Request Please select only the services that you wish Precision Resolution to engage in.

Date of Request: ____|____|____ Conference Call Requested after Submission? ◯ Yes ◯ No

◯	**Medicare Conditional Payment (Parts A/B)**	Medicare # _____ Entitlement Date ____|____|____ Has the case been reported? ◯ Yes ◯ No
◯	**Medicare Advantage Plan (Part C)**	Insurance Co. Name _____ Group/ID # _____ Has the case been reported? ◯ Yes ◯ No
◯	**Medicare Supplement Plan (Part D)**	Insurance Co. Name _____ Group/ID # _____ Has the case been reported? ◯ Yes ◯ No
◯	**Medicaid/Public Assistance**	State(s) _____ County(ies) _____ Has the case been reported? ◯ Yes ◯ No
◯	**ERISA, Private Health Plan, FEHBA or Other Lien Type**	Insurance Co. Name _____ Group/ID # _____ Has the case been reported? ◯ Yes ◯ No If Employer-based plan, specify employer name _____ Please provide Plan Document or Summary Plan Description, if available.
◯	**TRICARE or Veteran's Administration**	Treatment Facilities _____ Sponsor SSN_____ Has the case been reported? ◯ Yes ◯ No
◯	**Liability Medicare Set-Aside Allocation**	◯ **Workers' Comp Medicare Set-Aside Allocation** ◯ **Medicare Set-Aside Submission to CMS** ◯ **Medicare Set-Aside Opinion Letter**

Other Benefits If service not selected above, but benefits received, please indicate below.

Medicare Part A/B
Medicare # _____
Entitlement Date ____|____|____

Medicare Part C (Advantage Plan)
Insurance Co. _____
Group # _____

Medicaid/Public Assistance
State _____
County _____
ID # _____

Social Security Disability Insurance
Award Date _____
Application Date _____
Monthly Benefit $_____

Supplemental Security Income
Award Date _____
Application Date _____
Monthly Benefit $_____

Other/Private: _____

Claimant Information

Name _____ ◯ Female ◯ Male

SSN _____ DOB ____|____|____

Address _____

City _____ State _____ Zip _____

Has claimant lived in another state since date of injury? ◯ Yes* ◯ No

*If yes, list state(s)? _____

Name of Authorized Rep.
or Administrator of Affairs _____

Attorney Information

Name _____

Attorney Email _____

Phone _____ Fax _____

Firm _____

Address _____

City _____ State _____ Zip _____

Paralegal/Associate Contact _____

Paralegal/Associate Email _____

If the claimant is deceased or party has POA, please forward certificate of death, and letters of administration, or executed POA. If the plaintiff is a minor, please forward birth certificate or parental affidavit.

Case Information ◯ Motor Vehicle ◯ Nursing Home Negligence ◯ Medical Malpractice ◯ Slip & Fall ◯ Product Liability ◯ Exposure ◯ Other_____

Date of Injury ____|____|____ Date of Death (if applicable)____|____|____ Still Treating? ◯ Yes ◯ No Date of Last Treatment ____|____|____

Specific Nature of Accepted Injuries | Please submit complaint, BOP or narrative summary

Pre-Existing Conditions | Please submit supporting medical records

Brief Accident Description | If plaintiff treated at hospital, please list facility names and dates, or submit records with this form.

Has the case settled?

◯ **YES** Date____|____|____ Gross Settlement $_____ Attorney Fee $_____ Case Expense $_____ Claimant Net $_____

◯ **NO** Mediation/Arbitration Date ____|____|____ Anticipated Settlement $_____ Anticipated Settlement Date____|____|____

Liability

Carrier Name _____

Policy Limit $_____

Policy # _____

SUM/UIM

Carrier Name _____

Policy Limit $_____

Policy # _____

No Fault ◯ Yes ◯ No

NF Denied? ◯ Yes ◯ No

NF Exhausted? ◯ Yes ◯ No

Carrier Name _____

Policy Limit $_____

Policy Remaining $_____

APIP ◯ Yes ◯ No

APIP Denied? ◯ Yes ◯ No

APIP Exhausted? ◯ Yes ◯ No

Carrier Name _____

Policy Limit $_____

Policy Remaining $_____

Will there be more than one settlement for this date of injury? ◯ Yes ◯ No

Comments

Reset Form

Release 012320.2

Authorization for Use and Disclosure of Protected Health Information
Pursuant to the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) (45 C.F.R. §164.508)

In Reference To:

Patient Name	Date of Birth / / Month Day Year	Social Security Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.

PURPOSE OF AUTHORIZATION:
To provide a full disclosure of any information to Precision Resolution, LLC, its agents, employees, affiliates, subsidiaries, or representatives is to enable an assessment and evaluation to prepare a Future Medical Cost Projection, and/or Medicare Set-Aside Arrangement or commence a lien resolution action. Note that the claimant may revoke this Authorization at any time by written notice to Precision Resolution, LLC, its agents, employees, affiliates, subsidiaries, or representatives, but that any revocation shall have no effect on actions which have been taken prior to receiving. Any personal health information that the Claimant authorized to disclose may be subject to redisclosure and no longer protected by law.

ENTITIES AUTHORIZED TO RELEASE THE INFORMATION:
Healthcare Provider, Insurer, Collection Agent:

ENTITIES AUTHORIZED TO RECEIVE, USE, AND DISCLOSE THE INFORMATION:
Precision Resolution, LLC, its agents, employees, affiliates, subsidiaries, or representatives.

Mailing Address:
Precision Resolution, LLC
4134 Seneca Street
Buffalo, NY 14224

Date or Event on which this authorization will expire:

Until the conclusion of my personal injury action.

LIST OF INFORMATION TO BE RELEASED:
Entire Medical Record, including patient histories, office notes (except psychotherapy notes), lab/test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Name of Entity to Release Information:
Address of Entity to Release Information

I have read and understand the contents of this Authorization and have had the opportunity to discuss same with counsel of my choice. The contents of this Authorization confirm, and are consistent with, my authority, instructions, or directions to Precision Resolution, LLC and their Employees and Representatives and I understand that by executing this Authorization, I am authorizing Precision Resolution, LLC and their Employees and Representatives to use and disclose, as permitted and outlined herein, certain nonpublic information. All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the forms.

Claimant/Injured Party Signature	Claimant/Injured Party Name	Date

OR

Authorized Representative Signature	Print name, and Title (based on authority to act) (i.e.,guardianship /conservatorship letters of authority, powers of attorney, etc. attached)	Date

MSPRC

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

PROOF OF REPRESENTATION

The undersigned Medicare beneficiary informs the Centers for Medicare & Medicaid Services (CMS) that they have given the specified legal representative the authority to represent them and act on their behalf with respect to any claims for liability insurance, no-fault insurance, or workers compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. The undersigned representative agrees that they represent the stated Medicare beneficiary.

Type of Representative:	**Authorized Representative:**
( ) Individual other than an Attorney: (X) Attorney ( ) Guardian* ( ) Conservator* ( ) Power of Attorney*	_____ (Attorney/ Law Firm Name) _____ (Law Firm Address) _____ (Law Firm City) (State) (Zip) _____ (Phone Number)

* If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation in addition to this proof of representation.

Medicare Beneficiary Information:

Beneficiary's Name
(please print exactly as shown on your Medicare card): _____

Beneficiary's Health Insurance Claim Number
(number on Medicare card): _____

Date of Illness/Injury **for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim:** ____/____/_____
Month Day Year

Plaintiff/Auth. Rep Signature_____ Date signed: _____

Attorney Signature: _____ Date signed: _____

Medicare Secondary Payer Recovery Contractor
MSPRC-NGHP
Post Office Box 138832
Oklahoma City, OK 73113

Date: / /

PRECISION RESOLUTION, LLC
PROOF OF REPRESENTATION

RE: **Beneficiary:**
HIC#:
Date of Incident: / /
Month Day Year

Dear Sir or Madam:

Please be advised that , the attorney for the above referenced Medicare beneficiary, has appointed **Precision Resolution**, **LLC** as representative regarding the resolution of any Medicare conditional payment issues pertaining to this file. Please provide **Precision Resolution, LLC** with any information regarding this claim to the following address:

Precision Resolution, LLC
4134 Seneca Street
Buffalo, NY 14224
716-712-0417

Signature of Beneficiary's Attorney: _____

Date:

Representative's Signature: _____

Precision Resolution, LLC

Date: