

Precision Resolution Letter of Engagement

Thank you for your interest in 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.



Service Request Please select only the services that you wish Precision Resolution to engage in.			
Date of Request: _____		Conference Call Requested after Submission? <input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Medicare Conditional Payment (Parts A/B)	Medicare # _____	Entitlement Date _____	Has the case been reported? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Medicare Advantage Plan (Part C)	Insurance Co. Name _____	Group/ID # _____	Has the case been reported? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Medicare Supplement Plan (Part D)	Insurance Co. Name _____	Group/ID # _____	Has the case been reported? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Medicaid/Public Assistance	State(s) _____ County(ies) _____		Has the case been reported? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> ERISA, Private Health Plan, FEHBA or Other Lien Type	Insurance Co. Name _____	Group/ID # _____	Has the case been reported? <input type="radio"/> Yes <input type="radio"/> No
	If Employer-based plan, specify employer name _____ Please provide Plan Document or Summary Plan Description, if available.		
<input type="radio"/> TRICARE or Veteran's Administration	Treatment Facilities _____	Sponsor SSN _____	Has the case been reported? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Liability Medicare Set-Aside Allocation	<input type="radio"/> Workers' Comp Medicare Set-Aside Allocation	<input type="radio"/> Medicare Set-Aside Submission to CMS	<input type="radio"/> Medicare Set-Aside Opinion Letter

Other Benefits If service not selected above, but benefits received, please indicate below.				
Medicare Part A/B	Medicare Part C (Advantage Plan)	Medicaid/Public Assistance	Social Security Disability Insurance	Supplemental Security Income
Medicare # _____	Insurance Co. _____	State _____	Award Date _____	Award Date _____
Entitlement Date _____	Group # _____	County _____	Application Date _____	Application Date _____
Other/Private: _____		ID # _____	Monthly Benefit \$ _____	Monthly Benefit \$ _____

Claimant Information	Attorney Information
Name _____ <input type="radio"/> Female <input type="radio"/> Male	Name _____
SSN _____ DOB _____	Attorney Email _____
Address _____	Phone _____ Fax _____
City _____ State _____ Zip _____	Firm _____
Has claimant lived in another state since date of injury? <input type="radio"/> Yes* <input type="radio"/> No	Address _____
*If yes, list state(s)? _____	City _____ State _____ Zip _____
Name of Authorized Rep. or Administrator of Affairs _____	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	<input type="radio"/> Motor Vehicle <input type="radio"/> Nursing Home Negligence <input type="radio"/> Medical Malpractice <input type="radio"/> Slip & Fall <input type="radio"/> Product Liability <input type="radio"/> Exposure <input type="radio"/> Other _____
Date of Injury _____	Date of Death (if applicable) _____
Still Treating? <input type="radio"/> Yes <input type="radio"/> 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
<div></div>	<div></div>

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

Has the case settled?	<input type="radio"/> YES	Date _____	Gross Settlement \$ _____	Attorney Fee \$ _____	Case Expense \$ _____	Claimant Net \$ _____
	<input type="radio"/> NO	Mediation/Arbitration Date _____	Anticipated Settlement \$ _____	Anticipated Settlement Date _____		

Liability	SUM/UIM	No Fault <input type="radio"/> Yes <input type="radio"/> No	APIP <input type="radio"/> Yes <input type="radio"/> No
Carrier Name _____	Carrier Name _____	NF Denied? <input type="radio"/> Yes <input type="radio"/> No	APIP Denied? <input type="radio"/> Yes <input type="radio"/> No
Policy Limit \$ _____	Policy Limit \$ _____	NF Exhausted? <input type="radio"/> Yes <input type="radio"/> No	APIP Exhausted? <input type="radio"/> Yes <input type="radio"/> No
Policy # _____	Policy # _____	Carrier Name _____	Carrier Name _____
		Policy Limit \$ _____	Policy Limit \$ _____
		Policy Remaining \$ _____	Policy Remaining \$ _____
Will there be more than one settlement for this date of injury? <input type="radio"/> Yes <input type="radio"/> No			

Comments

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
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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